



## PATIENT

Nacho Pauley

## SPECIES

Feline

## BREED

Domestic Shorthair

## SEX

Neutered male

## AGE

12 years

## WEIGHT

9.5 lbs

## INTERPRETED BY

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

## IMAGING PERFORMED BY

Jeremiah Gabriel

## HOSPITAL NAME

Central Jersey AH

## REFERRING VET

Dr. Gabriel

## INVOICE

69210

## DATE

12/1/25

## PRESENTING CLINICAL SIGNS

History: vomiting diarrhea anorexia all started last night lost about 2 LBS history of high ALT, T4  
CBC/chem pending

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 4.4 cm. The right kidney measured 4.5 cm.

### Adrenal Glands

The **adrenal glands** were not overtly visualized. However, the regions of the adrenal glands appeared unremarkable.

### Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

### Liver

The **liver** revealed hypoechoic nodule at the mid left liver. Ultrasound-guided FNA is indicated. The hepatic nodule measured 1.0 cm. Other subtle, micronodular changes were also noted. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident.



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## Gastrointestinal

The **gastrointestinal** presentation revealed mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall. The muscularis layer was hypertrophied inverting the normal ratio (1:3). The intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic inflammation. No evidence of obstruction was present. Chronic inflammatory bowel disease is probable with a low possibility of an early neoplastic event such as lymphoma or, less likely, dry form FIP can at times be found on biopsy of these presentations. Full thickness tissue biopsies via open laparotomy, ideally guided by intraoperative ultrasound in order to obtain the most representative mural sample, would be necessary to rule more significant disease than IBD.

## Pancreas

The **pancreas** was hypoechoic and irregular with enhanced surrounding mesentery. The pancreatic duct was dilated.

## ULTRASONOGRAPHIC FINDINGS

Liver nodule and mild hepatic remodeling. Nodular hyperplasia, abscessation, round cell neoplasia or carcinoma are all possible with the liver nodule.

IBD GI pattern.

Prominent, irregular pancreas. Likely pancreatitis, pancreatic carcinoma cannot be ruled out.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ultrasound-guided FNA of the hepatic nodules is recommended with treatment for pancreatitis.





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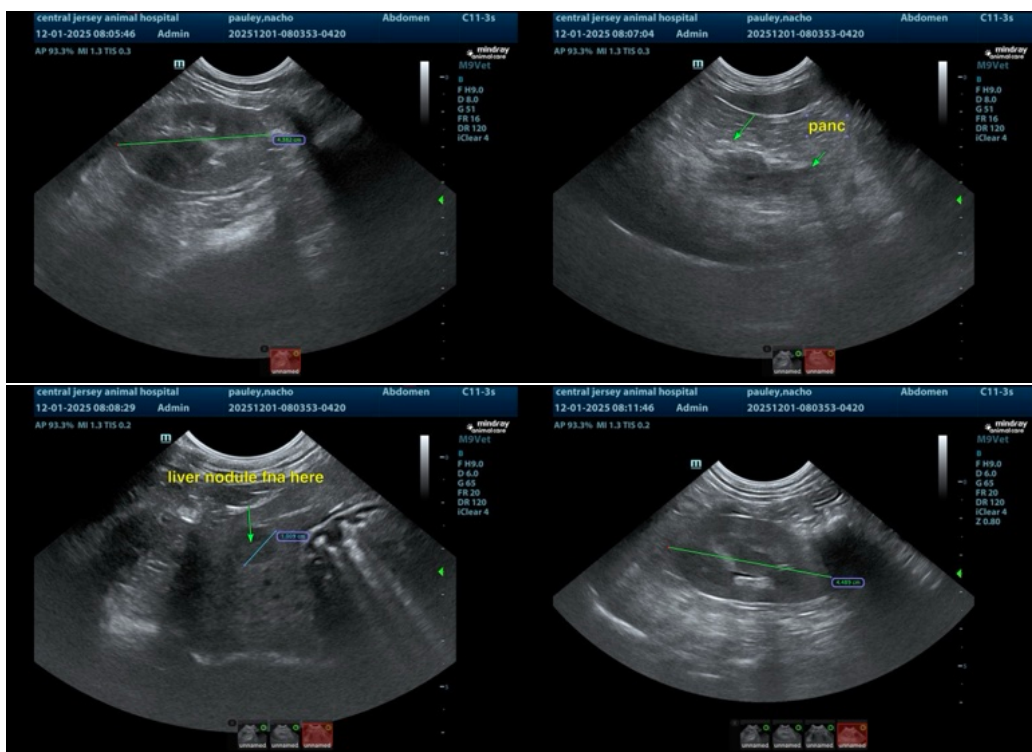
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS, CEO of SonoPath.com

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