



## PATIENT

Baxter Filipiak

## SPECIES

Feline

## BREED

Domestic Shorthair

## SEX

Neutered male

## AGE

8 years

## WEIGHT

6.7 lbs

## INTERPRETED BY

Eric Lindquist, DMV  
DABVP, Cert. IUUS

## IMAGING PERFORMED BY

Dr. Coe

## HOSPITAL NAME

Riverside Animal Clinic

## REFERRING VET

Dr. Coe

## INVOICE

69226

## DATE

12/12/25

## PRESENTING CLINICAL SIGNS

History: Chronic diarrhea for past 4 years. Owner reports feces leak from rectum/anus all over the house, when picked up, etc. Bowel movements are "noisy"/audible. History of perianal scalding from feces. Trial hydrolyzed diet (Hill's z/d) and DepoMedrol injection in 8/2024 (another clinic) - no reported improvement (only fed diet for one bag, incomplete diet trial). Began vomiting off-and-on in 11/2024. Patient prescribed metronidazole, Panacur, and B12 injections - no reported improvement in fecal consistency, but resolved vomiting. Owner did not finish b12 injection series. Most recently prescribed Hill's W/D (high fiber) diet since 3/2025, with no reported improvement. Prescribed ProViable Kit one week prior to ultrasound, and diarrhea persists. Indoor-only. Other feline housemates feces normal. E/D normally. No current medications.

Abnormal PE/Chem/CBC/UA Results: PE reportedly WNL at neighboring clinic in 9/2024 and 11/2024. PE 3/2025 here: WNL Wt 7.89lbs, BCS 4/9 PE today: Wt 6.7lbs, BCS 3/9, audible borborygmi, palpable fluid filled bowel loops. Otherwise WNL CBC/Chem 3/2025: Mild hypokalemia (3.3), mild stress hyperglycemia (169), Otherwise unremarkable. FeLV/FIV SNAP 3/2025: Negative TT4 3/2025: WRI Giardia SNAP: Negative Texas GI Panel 3/2025: All WRI Fecal PCR 3/2025: Negative CBC/Chem today: All WRI fPL today: WRI

## 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 normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The right kidney measured 4.05 cm. The left kidney measured 4.14 cm.

### Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 0.53 cm. The right adrenal gland measured 0.56 cm.

### 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.



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## Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

## 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. The colon was particularly thickened in this patient with thickened submucosal layer. 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. Slight areas of free fluid were noted. The colonic lymph nodes were enlarged measuring up to 1.0 cm.

## Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

## ULTRASONOGRAPHIC FINDINGS

IBD GI Pattern with **thickened** colon.

Regional lymphadenopathy.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is concern for emerging round cell neoplasia even though no overt neoplastic criteria is met. Full thickness GI biopsies would be ideal. Ultrasound-guided FNA of any accessible lymph nodes with cytology, culture and potential PAR analysis for lymphoma may be appropriate. However, given this particular presentation full thickness GI biopsies are strongly encouraged. If sampling is not an option then parasite management, diet change and Prednisolone trial would all be appropriate. The prognosis is guarded.



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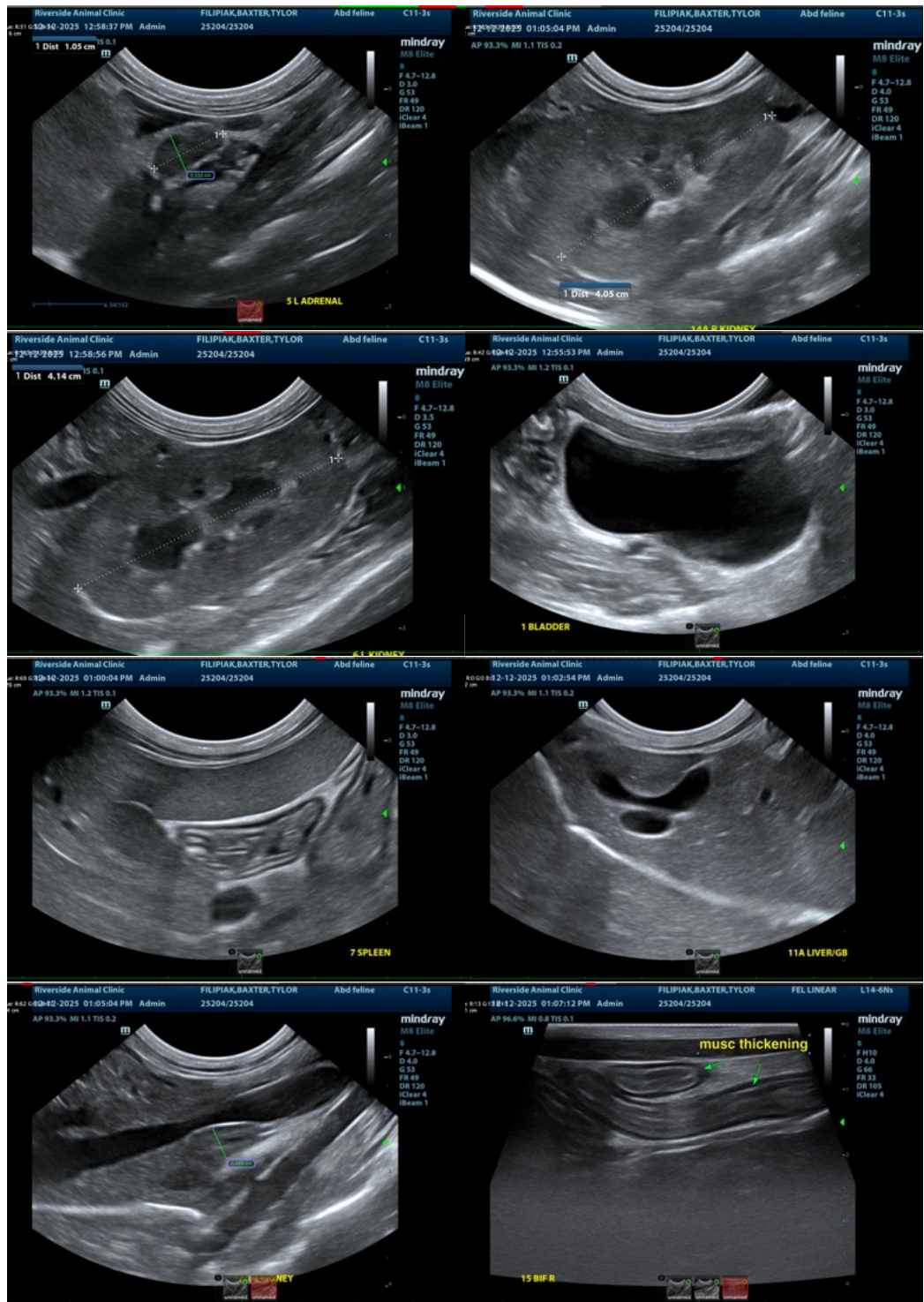
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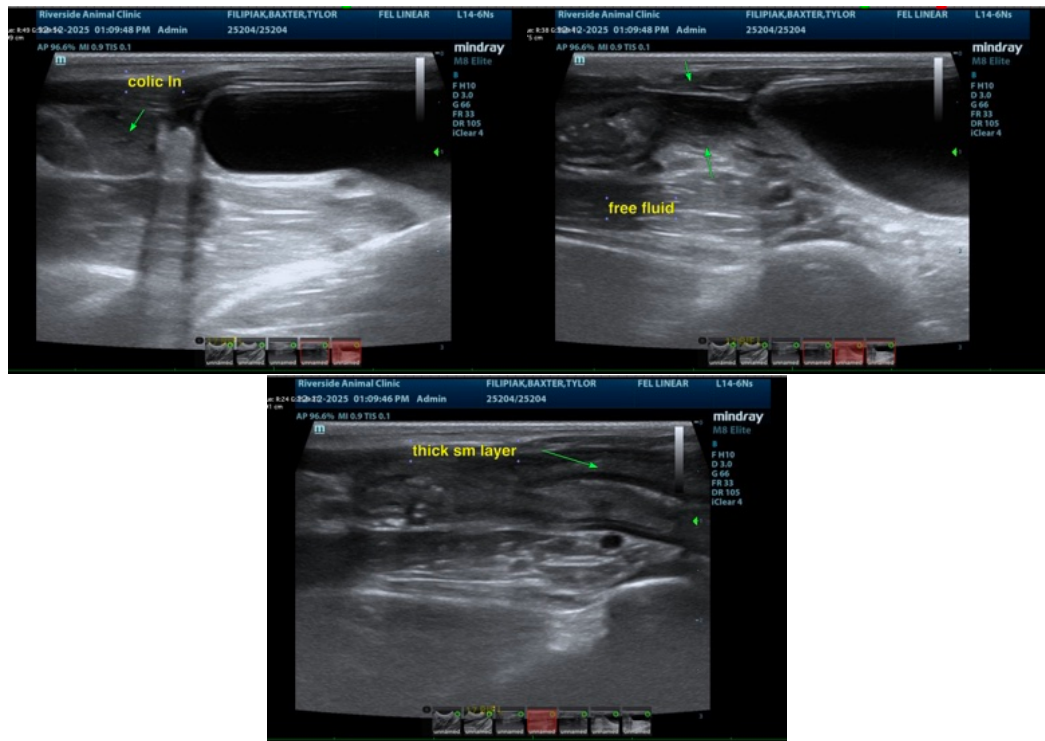
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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