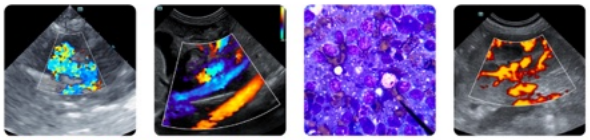

PATIENT

Shiloh Hardisky

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

10 years

WEIGHT

11 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Sam Doverspike

HOSPITAL NAME

Franklin Animal Clinic

REFERRING VET

Dr. Doverspike

INVOICE

69383

DATE

12/17/25

PRESENTING CLINICAL SIGNS

History: *Intermittent vomiting historically over ~ 1 year *Overall healthy cat but does seem to be ADR during vomiting episodes *Historically lab work has shown some renal issues Consistently mild BUN elevations; Creat & SDMA had mild elevations last year but have been normal in recent labs; Urine Spec Grav: 1.021; had elevated sPL test in July 2025
fPL today normal at 3.8 Urine today quiet w spec grav of 1.035 Other labs pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The pelvic urethra was imaged 2.0 cm beyond the cystourethral junction and appeared normal. 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 **right kidney** revealed mildly thickened cortices, yet was normal in size and measured 4.1 cm. The **left kidney** revealed multiple infarcts. Multi-centric cortical collapse was noted. The left kidney measured 3.4 cm with slight pinpoint mineralization.

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 0.38 cm and the right adrenal gland measured 0.41 cm.

Spleen

The **spleen** was slightly enlarged and folded upon itself measuring 1.02 cm.

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.

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Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

Pancreas

The **pancreas** was prominent, hypoechoic and mildly irregular in the left limb measuring 1.06 cm. There was no overt evidence of inflammation. However, low-grade inflammation is possible. Left subxiphoid palpation is recommended to assess for pain in the region of the pancreas.

ULTRASONOGRAPHIC FINDINGS

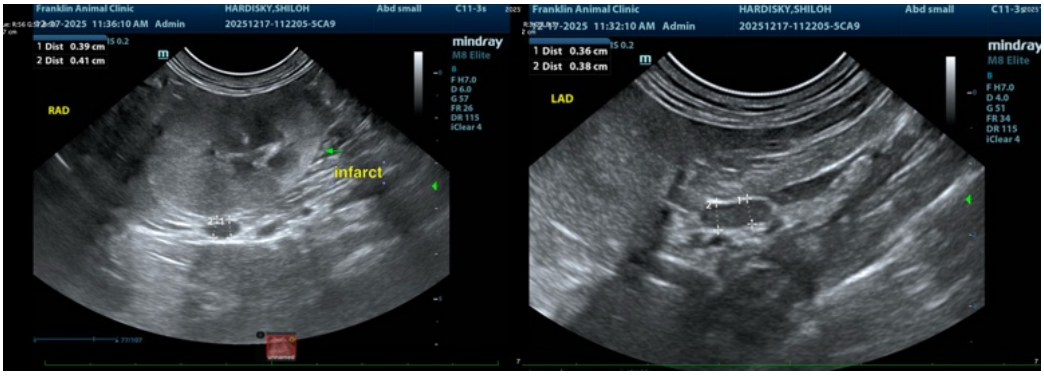
Renal dystrophy, moderate on the left and mild to moderate on the right with cortical infarcts.

Slightly enlarged spleen. Likely reactive spleen.

Prominent pancreas, potential concurrent prerenal disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Blood flow to the kidneys was subnormal on color flow assessment. 72-hour IV fluid protocol, urine culture and blood pressure measurements are all indicated. Prognosis is guarded long term. The kidneys do not appear end stage even though significant infarcts and remodeling are present. 25-gauge FNA of the spleen would be ideal to ensure no significant underlying disease is noted. Given the azotemia the renal and prerenal component is likely playing a role in this patient.



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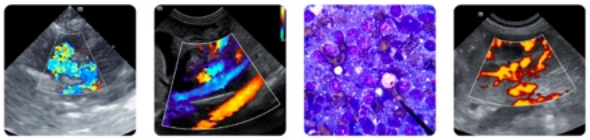

Clinical Sonography & Telecytology
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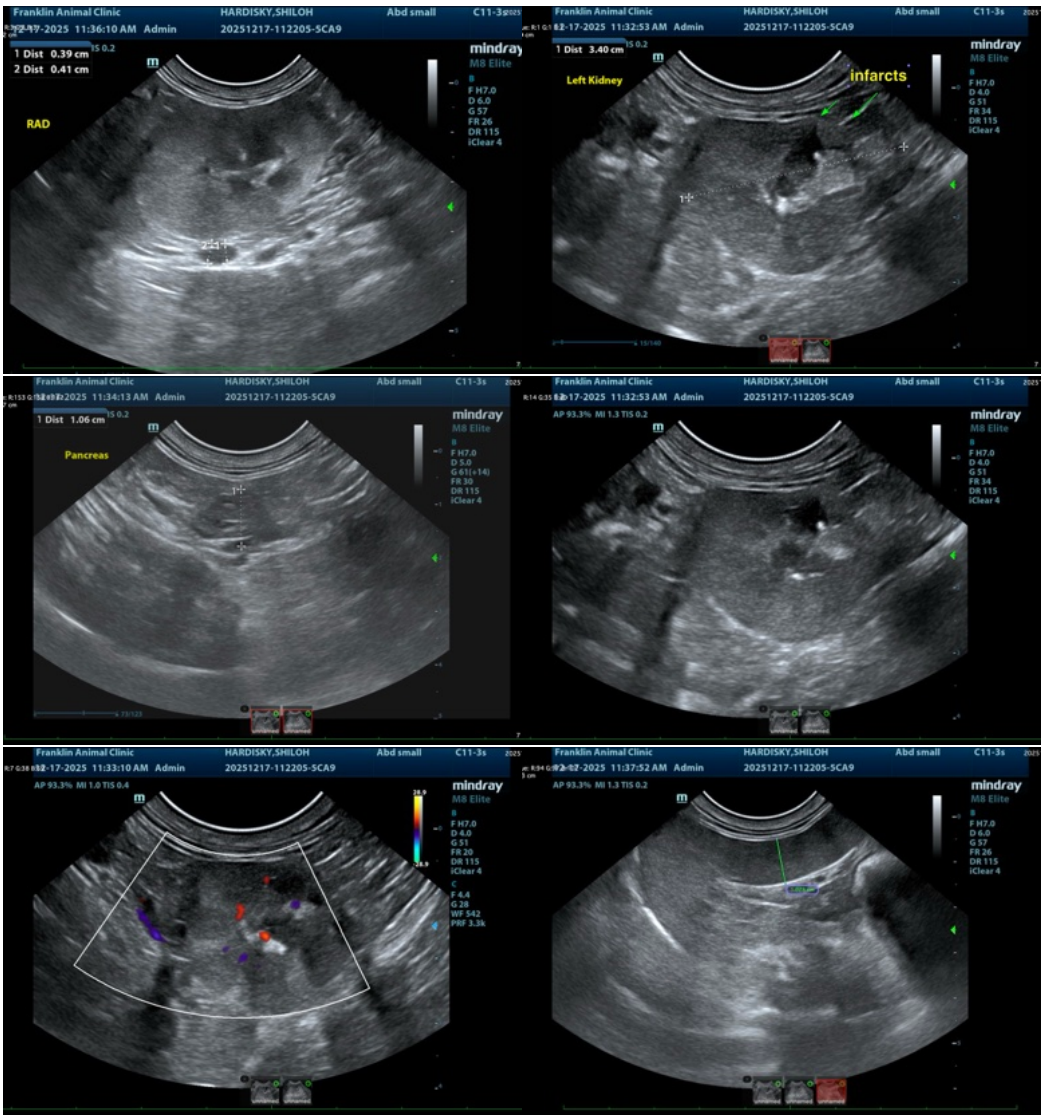

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@SonoPath.com