



**PATIENT**

Chops Unser

**PRESENTING CLINICAL SIGNS**

Age is an estimate adopted cat could be older. Anorexic with vomiting and increased globulins on blood work  
Abnormal PE/Chem/CBC/UA Results:   Hyperglobulinemia on geriatric screen

**SPECIES**

Feline

**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.

**BREED**

Domestic Shorthair

**SEX**

Neutered male

**AGE**

8 years

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 4.63 cm. The left kidney measured 4.22 cm.

**WEIGHT**

4.3 kg

**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 right adrenal gland measured 0.28 cm. The left adrenal gland measured 0.32 cm.

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Dr. Belan

**Spleen**

The **spleen** revealed subtle, heterogenous micronodular changes.

**HOSPITAL NAME**

Cranston VC

**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. The common bile duct measured 0.23 cm. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

**REFERRING VET**

Dr. Nielson

**INVOICE**

94753

**Gastrointestinal**

The gastric wall was mildly hypertrophied with an empty lumen. There were areas of "ropey" small intestinal wall with slight disruption of the normal 1:3 muscularis/mucosal ratio. The intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease.

**DATE**

12/20/21



<b>PATIENT</b>	The epigastric lymph node was reactive and measured 0.33 cm. The mesenteric lymph node was reactive and measured 0.58 cm.
Chops Unser	
<b>SPECIES</b>	<b>Pancreas</b>
Feline	The <b>pancreas</b> revealed coarse architecture with undulating contour. The pancreas was at the upper limits of normal in size and measured 0.83 cm with a dilated duct at 0.4 cm. Nodular changes were noted.
<b>BREED</b>	
Domestic Shorthair	
<b>SEX</b>	<b>Free Abdomen</b>
Neutered male	Sublumbar lymph node was mildly enlarged and hypoechoic measuring 0.52 cm. The length to width ratio was maintained.
<b>AGE</b>	<b>ULTRASONOGRAPHIC FINDINGS</b>
8 years	Diffuse intestinal thickening with reactive lymphadenopathy, gastritis and heterogenous spleen. This is likely inflammatory bowel with reactive lymph nodes. However, emerging round cell neoplasia cannot be completely ruled out.
<b>WEIGHT</b>	<b>INTERPRETATION OF THE FINDINGS &amp; FURTHER RECOMMENDATIONS</b>
4.3 kg	Screening 25-gauge FNA of the spleen and sublumbar lymph nodes with cytology and culture would be ideal in this patient. If sampling is not an option a clinical trial of the following could be considered as well as protein electrophoresis given the elevated globulins. Chronic infectious agents should be considered as possible underlying issues.
<b>INTERPRETED BY</b>	
Eric Lindquist, DMV DABVP, Cert. IVUSS	
<b>IMAGING PERFORMED BY</b>	<b>Triaditis/Pancreatitis protocol</b>
Dr. Belan	Part or all of this protocol may be considered based on your clinical impression of the patient:
<b>HOSPITAL NAME</b>	Recommend pain management when anorexic with <b>Buprenorphine</b> (0.01-0.02 mg/kg IM or SC), clinical trial of <b>Zithromax</b> (50 mg sid/cat x 10 days, 3 weeks if bartonella +), <b>Prednisolone</b> (0.5-2 mg/kg tapering over 1 week to minimal effective dose), and <b>B12 injections</b> if weight loss (Cyanobalamine 250 mcg sub-q once-weekly x six weeks, then every other week for six weeks and then once-monthly, long-term if necessary), <b>novel-protein or hydrolyzed diet</b> ( <i>Hydrolyzed diets have been shown to be more effective in dietary intolerance case management compared to hypoallergenic diets</i> ) or the <b>magical Purina DM</b> (changing protein source is crucial and may need rotation every 6 months if clinical signs recur) Diet trials is a whatever works phenomenon. If vomiting becomes a persistent issue then endoscopy would be warranted and/or recheck sonogram to assess more emerging disease. One diet does not work for all patients so different trials may be necessary or protein source rotation every 6 months as new sensitivities develop.
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DABVP, Cert. IVUSS

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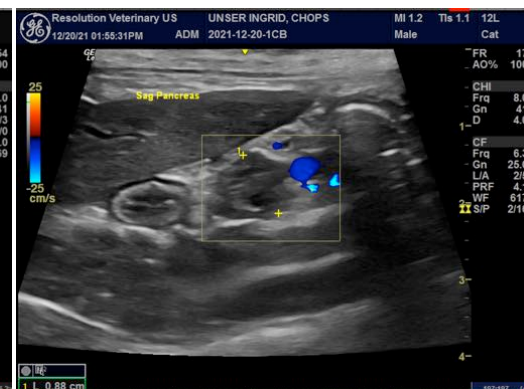
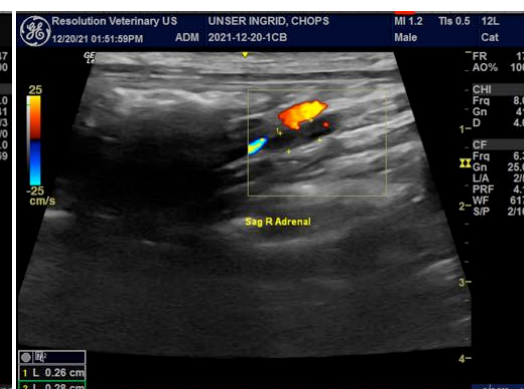
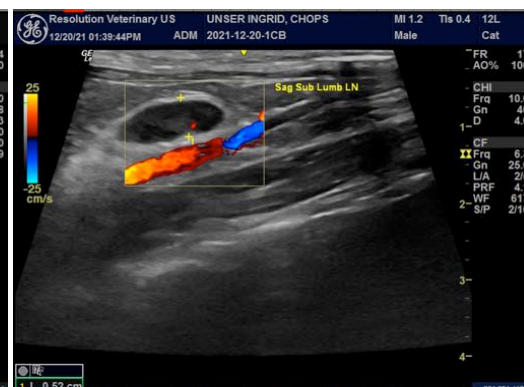
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, Cert. IVUSS, CEO of SonoPath.com  
info@SonoPath.com