



## PATIENT

Mikhail Chan

## SPECIES

Feline

## BREED

DLH

## SEX

Neutered Male

## AGE

13 Years

## WEIGHT

3.21 kg

## INTERPRETED BY

Eric Lindquist, DMV,  
DABVP(CFM), Cert.  
IVUSS

## IMAGING PERFORMED BY

Dr. Jill Rankin

## HOSPITAL NAME

Fish Creek PH

## REFERRING VET

Dr. Corlene

## INVOICE

35989

## DATE

12/21/25

## PRESENTING CLINICAL SIGNS

History: Presents with anorexia, black watery diarrhea, and straining, with key findings including normal blood work and a possible unidentified fluid-filled structure caudal to the bladder on ultrasound. Patient's current issues began in November with self-resolving upper respiratory symptoms. On an unspecified Tuesday, he became anorexic and developed diarrhea without vomiting. He was seen by his primary veterinarian on Wednesday for these signs plus straining, and received SQ fluids and supportive therapy. As of Friday, he was still anorexic with diarrhea, and blood work, including a T4, was performed and found to be normal. He was prescribed Cerenia, Mirtazapine, Metronidazole, and Clavamox. Since the day before presentation, the owners report the diarrhea has become black and watery, and he has been observed walking in a crouched position and scooting. During the current evaluation, an ultrasound revealed a fluid-filled structure located caudal to the urinary bladder, which appeared to be separate from the bladder. The origin of this structure is undetermined, with possibilities including enlarged abdominal lymph nodes or a colonic mass. The gallbladder was noted to be visible and distended with hypoechoic fluid also. Approx. a decade ago, the patient was hit by a car, sustaining pelvic fractures and a diaphragmatic hernia. In May 2016, he underwent surgery to repair the hernia, during which several liver attachments to the pericardial space were broken down.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The **urinary bladder** and visible pelvic urethra were unremarkable for the level of repletion presented. The urine, however, did present some mildly echogenic debris consistent with mucous, exfoliated cells from renal or bladder origin, and/or blood clots as these echogenic changes can all present similarly. This is often related to urinary tract infection but may represent simple evidence of exfoliated debris or sterile inflammation. Cystocentesis, urinalysis, +/- culture would be recommended to rule out and define any UTI. This is a mild change.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some mild 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 kidneys measured 4.0 cm each.

### *Adrenal Glands*

The regions of the **adrenal glands** revealed no evident pathology.

### *Spleen*

The **spleen** revealed uniform enlargement. The spleen measured up to 1.7 cm in width.

### *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*



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The **gastrointestinal** presentation revealed mild uniform prominence of the gastric mucosa as well as areas of "ropy" 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. No concerning lymphadenopathy was visible. No evidence of obstruction was present. Chronic inflammatory bowel disease is likely with a low possibility of an early neoplastic event such as lymphoma. 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 out this possibility. This is a mild change. Soft stool was noted in the colon.

### *Pancreas*

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some mild parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation, then low-grade smoldering chronic pancreatitis should be suspected.

### *Free Abdomen*

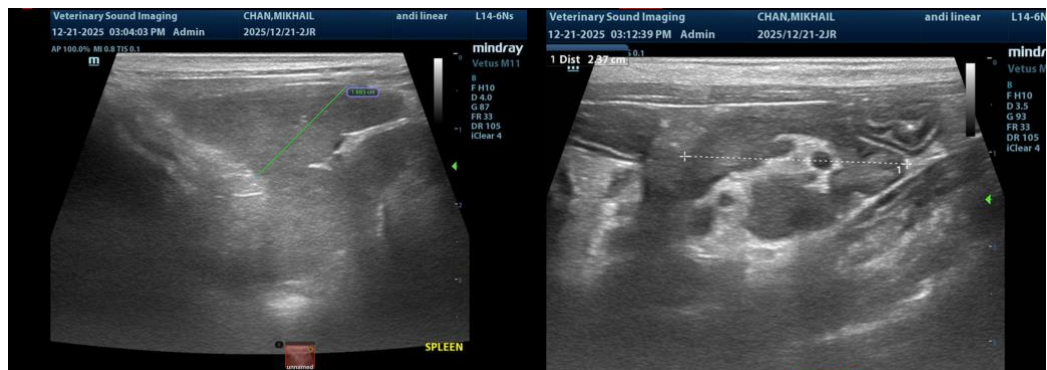
A mesenteric **lymph node** cluster was noted, measuring approximately 2.4 cm. This was somewhat rounded.

## ULTRASONOGRAPHIC FINDINGS

- Mesenteric lymphadenopathy
- Splenomegaly
- Urinary bladder debris
- IBD GI pattern
- Age-related pancreatic changes

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Strong concern for emerging round cell neoplasia. 25-gauge FNA of the spleen and mesenteric lymph nodes is warranted. Management for gastrointestinal upset and inflammatory bowel is warranted in the meantime. Prognosis is guarded.





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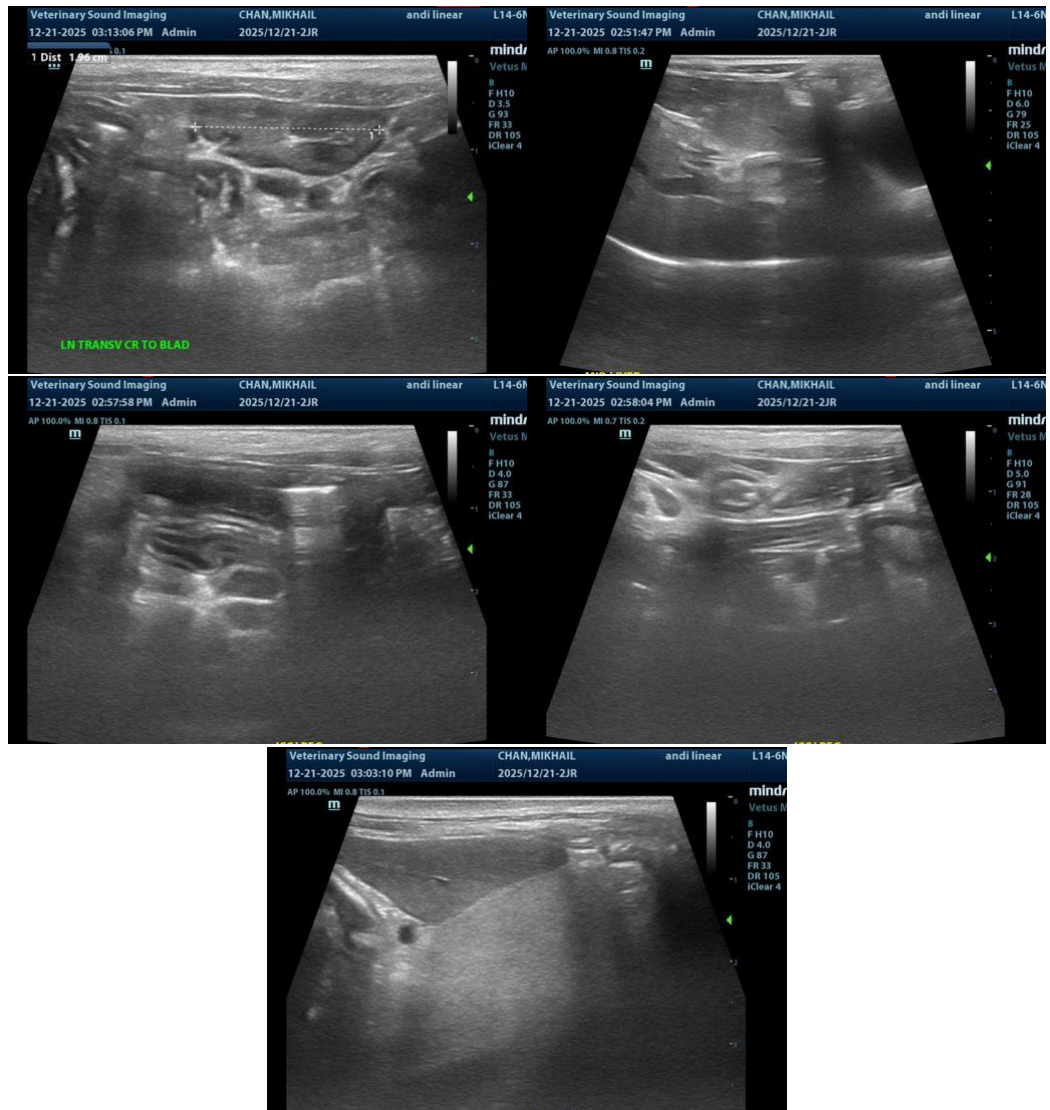
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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,  
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