



PATIENT

Snap Carrigan

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

13 Years 8 Months

WEIGHT

2.53 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Kirsten Henderson

HOSPITAL NAME

Riverside Small Animal
Hospital

REFERRING VET

Dr. Noreen Carrigan

INVOICE

72762

DATE

12/24/25

PRESENTING CLINICAL SIGNS

P has grade 4/6 heart murmur PMI left apex. Not wanting to eat. Losing weight. Abd u/s preformed in November was unremarkable. P received 0.2mg/kg torb IV and bolus alfax 1 mg/kg for FNA of liver and spleen. P received total of 0.39 mls. After last bolus P HR crashed and Emergency intervention took place. Dr. Henderson impressions: 1. Bilateral chronic kidney disease is suspected, with the left kidney appearing more affected than the right. The hyperechoic striations in the left cortex are suspected to be associated with previous renal infarcts. 2. Findings in the pancreas are concerning for possible pancreatitis or pancreatic neoplasia, with an associated cystic structure. 3. Mild jejunal muscularis thickening with associated jejunal lymphadenomegaly. The elongated shape of the lymph nodes suggests they are reactive. Enteritis such as IBD is suspicious, but neoplasia is also a possibility.

Abnormal PE/Chem/CBC/UA Results: CBC changed from Sept. RBC decrease from 8.94- 6. Neutrophils and eosinophil decreased. TP 6.8g/dl

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 were noted. Ureteral papillae were normal.

The **left kidney** was mildly subnormal in size, measuring 2.83 cm, with echogenic cortical remodeling and infarcts. The **right kidney** was largely normal in size at 3.85 cm with slight pyelectasia of 0.14 cm. The kidneys do not appear end stage. However, periodic infarcts primarily in the left kidney owing to smoldering inflammatory disease likely.

Adrenal Glands

The regions of the **adrenal glands** were unremarkable.

Spleen

The **spleen** was mildly enlarged (0.96 cm) with uniform, but subtly micronodular parenchyma, and undulating capsular contour. This is consistent with reactive spleen owing to immune stimulus or early infiltrative disease such as mast cell disease or lymphoma. 25-gauge FNA would be ideal if weight loss is an issue to differentiate early round cell neoplasia versus splenitis or reactive spleen all of which can present in this manner.

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

The **gastrointestinal** presentation revealed mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall with 1:1 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.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Some heterogeneous parenchymal changes were noted in the left limb. 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 subxyphoid palpation, then low-grade smoldering chronic pancreatitis should be suspected.

Free Abdomen

A jejunal **lymph node** was slightly enlarged with swollen contour. There was no loss of parenchymal detail. This is most consistent with reactive lymphadenitis or lymphatic hyperplasia.

ULTRASONOGRAPHIC FINDINGS

- Moderate degenerative left renal changes with infarcts.
- Minor degenerative right renal changes with pyelectasia.
- Variable diffuse gastrointestinal thickening with muscularis hypertrophy.
- Micronodular spleen.
- Pancreatic remodeling.
- Reactive jejunal lymph node.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The kidneys do not appear end stage. Full thickness GI biopsies would be ideal for further definition. Neoplastic criteria is not overtly present. However, I cannot rule out an emerging neoplastic state. Subxyphoid palpation is recommended to assess for pain or discomfort associated with the left limb of the pancreas.

Maldigestion panel, three view chest radiographs and full CNS examination is recommended to examine for occult disease that could be responsible for the weight loss. Evaluation for competitive eating environments should also be considered.



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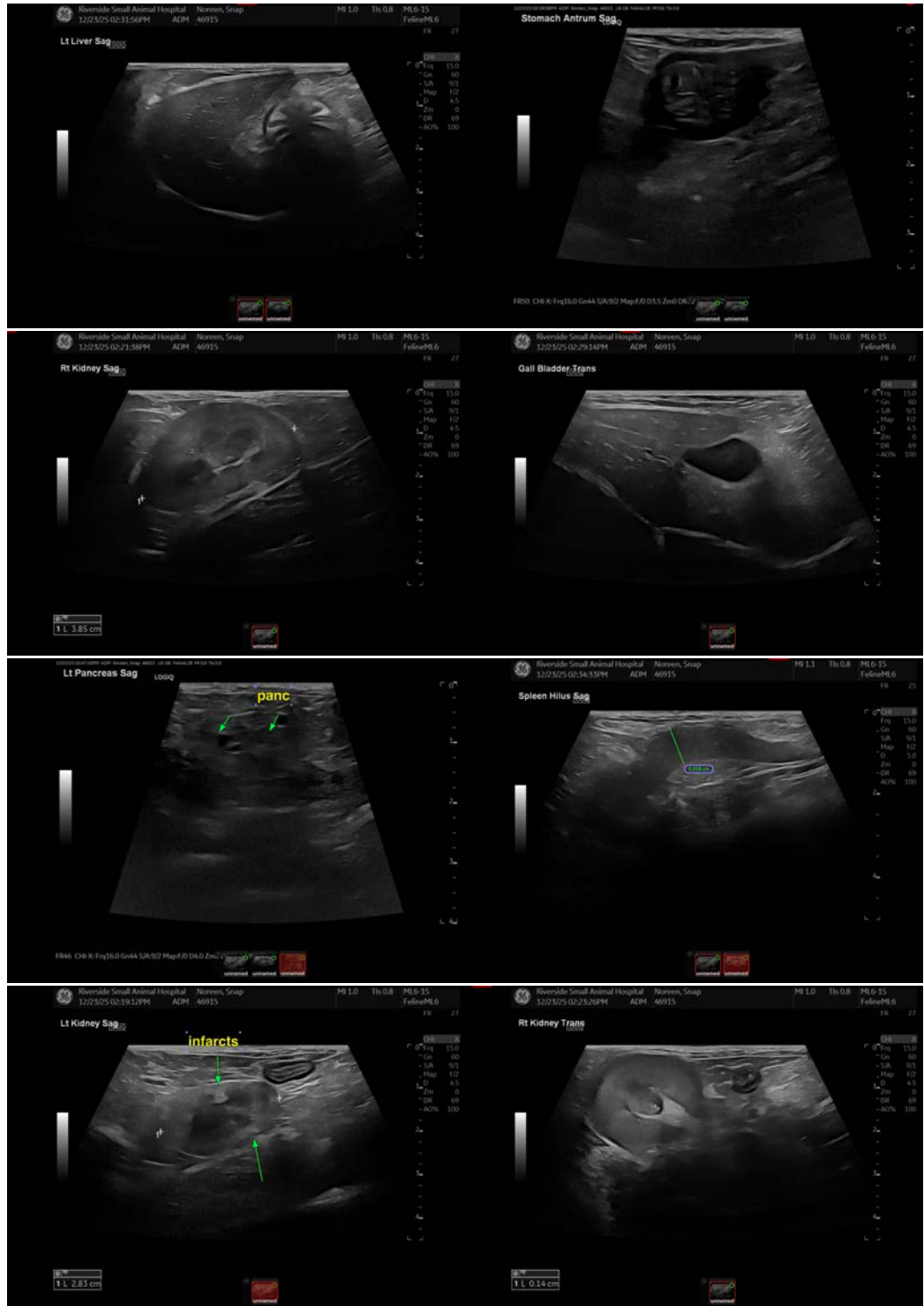
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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