



**PATIENT**

Mischa Brown

**SPECIES**

Feline

**BREED**

Persian

**SEX**

Spayed Female

**AGE**

9 Years

**WEIGHT**

6.7 Pounds

**INTERPRETED BY**

Eric Lindquist, DMV

DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Dr. Amanda Favis

**HOSPITAL NAME**

Ruidoso AC

**REFERRING VET**

Dr. Amanda Facis

**INVOICE**

44764

**DATE**

2/3/23

**PRESENTING CLINICAL SIGNS**

Chronic, intermittent vomiting. Good appetite.

Abnormal PE/Chem/CBC/UA Results: Low normal albumin (2.8) and globulin (3.0), T4 wnl

**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 **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some 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 his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 3.84 cm. The right kidney measured 3.78 cm.

**Adrenal Glands**

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

**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 were noted.

**Liver**

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. Increased portal markings noted. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

**Gastrointestinal**

The **stomach** itself was unremarkable. The distal small intestine appeared slightly thickened with a minor amount of free fluid. Jejunal wall thickness measured 0.60 cm. Potential emerging round cell neoplasia.

**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. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain



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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.

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**Free Abdomen**

Mesenteric lymph nodes were mildly enlarged, largest of which measured 1.5 cm.

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**ULTRASONOGRAPHIC FINDINGS**

- Inflammatory bowel and lymphadenitis with sectorial early loss of mural detail, potentially meeting neoplastic criteria
- Age related renal changes
- Age related hepatic changes
- Age related pancreatic changes

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

FNA of the accessible mesenteric lymph nodes for cytology, culture +/- special staining for lymphoma may all be appropriate. However, intraoperative ultrasound identifying the portion of intestinal thickening, resection or biopsies, and lymph node biopsies would be the most direct way for definitive diagnosis in this patient. Concurrent malassimilation/maldigestion should also be considered.

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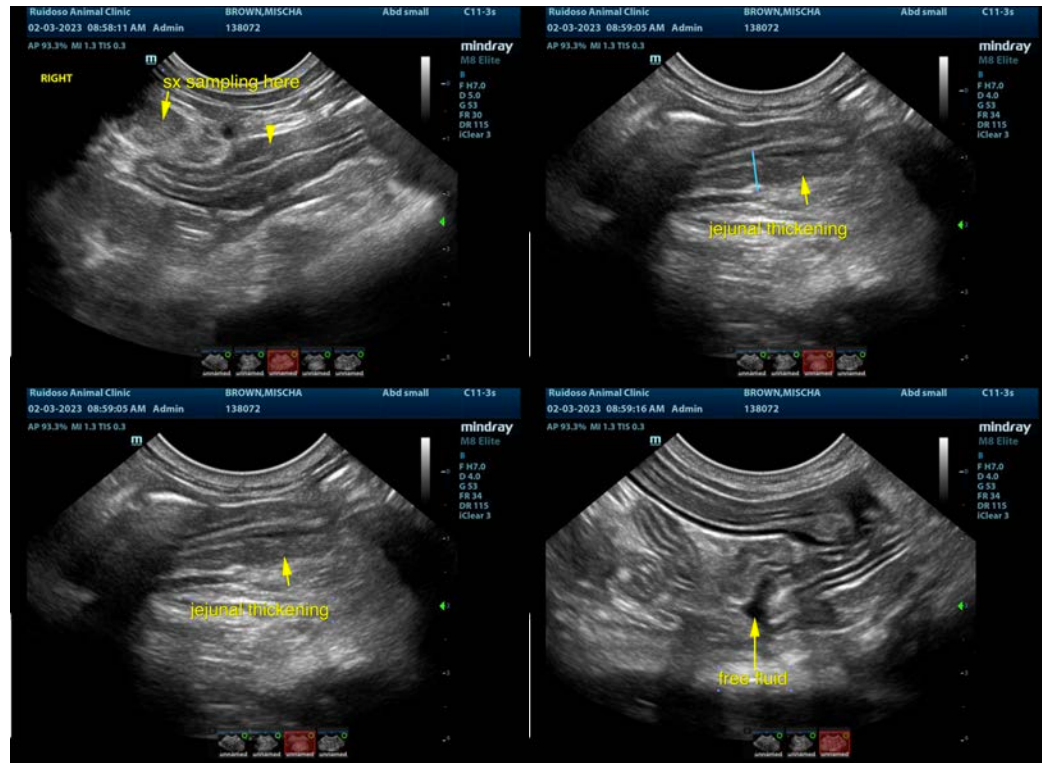
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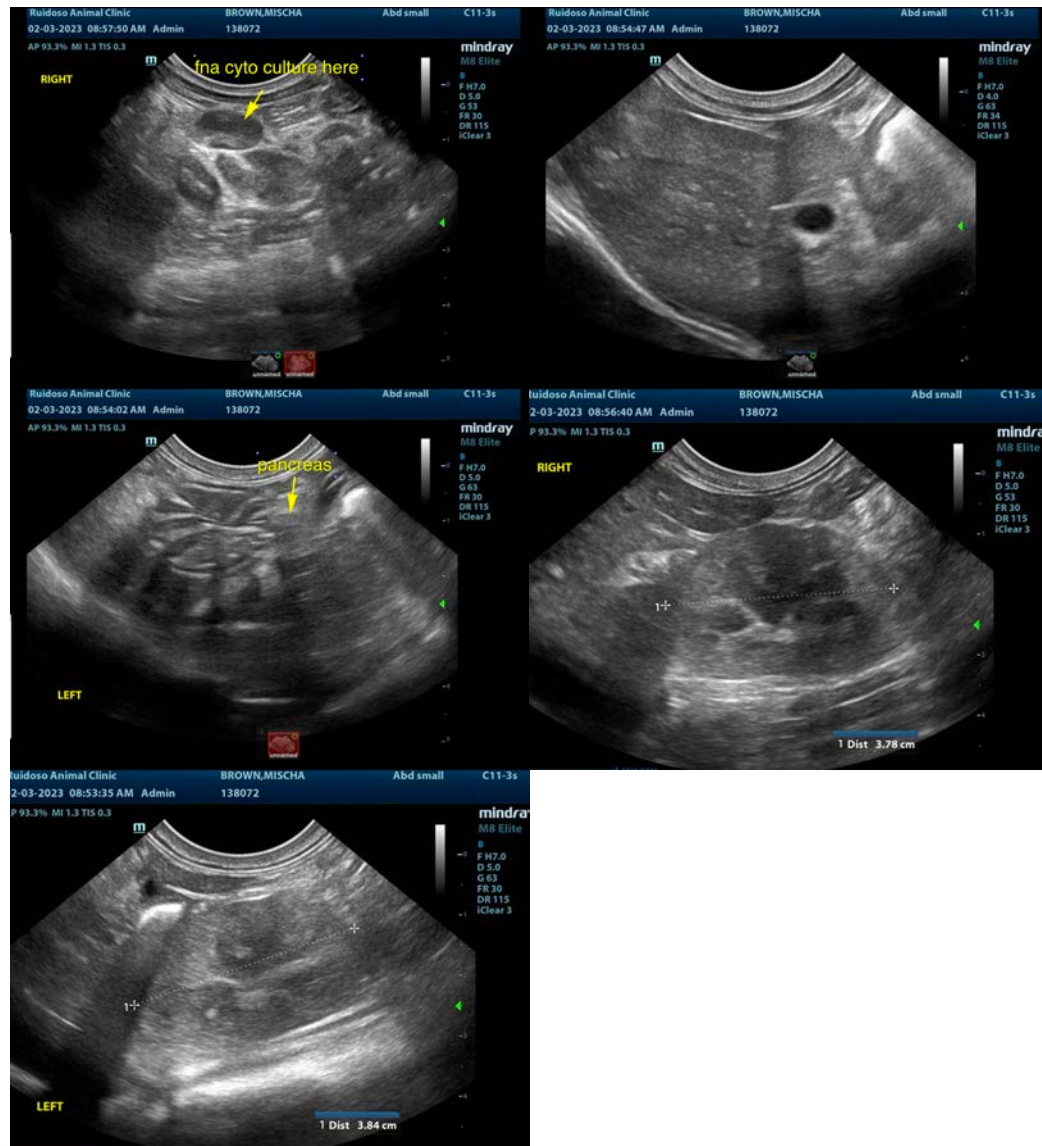
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, Cert. IVUSS, CEO of SonoPath.com**

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