



PATIENT

Nefer Kittii Casapolla

SPECIES

Feline

BREED

DSH

SEX

Female

AGE

5 Months

WEIGHT

5.5 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Chloe Lowe

HOSPITAL NAME

Harmony Animal
Hospital

REFERRING VET

Dr. Gruber

INVOICE

13630

DATE

02/06/26

PRESENTING CLINICAL SIGNS

- collapse, hypocalcemia, enlarged left kidney, adopted ~3 months ago always small, rx flagyl for giardia but cat collapsed with Brady cardia, hypothermia, ca gluconate, iv fluids, dextrose/insulin, batryl, left kidney large with dilation of renal pelvis.

Abnormal PE/Chem/CBC/UA Results: WBC 40k, Neut 37k, BG 489, BUN 45, Phos >16.1k, Ca 5.5, Na 139, K > 10.0, Cl 103, ALB 4.2, ALT 229

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra to a depth of 1.0 cm 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** were upper limits of normal in size for an adult, however, given the age of this patient, they are both bilaterally enlarged in size, and presented with heterogenous cortical changes and a hyperechoic medullary rim sign. This is an idiopathic finding, however, this can be related to underlying FIP, yet no effusion or other evidence of FIP are present. The right kidney revealed slight cortical infarcts at the cranial pole. The left kidney measured 4.2 cm in length. The right kidney measured 4.0 cm in length. Blood flow to the kidneys appeared to be adequate.

Adrenal Glands

Both **adrenal glands** were not visualized.

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 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

The **stomach** revealed progressively shadowing luminal chyme. This would be normal if the patient was not NPO at the time of the sonogram. The density of the material in the stomach would be that of hair or similar. Transit of chyme into the small intestine appeared to be occurring. The small intestine and colon were unremarkable.



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Pancreas

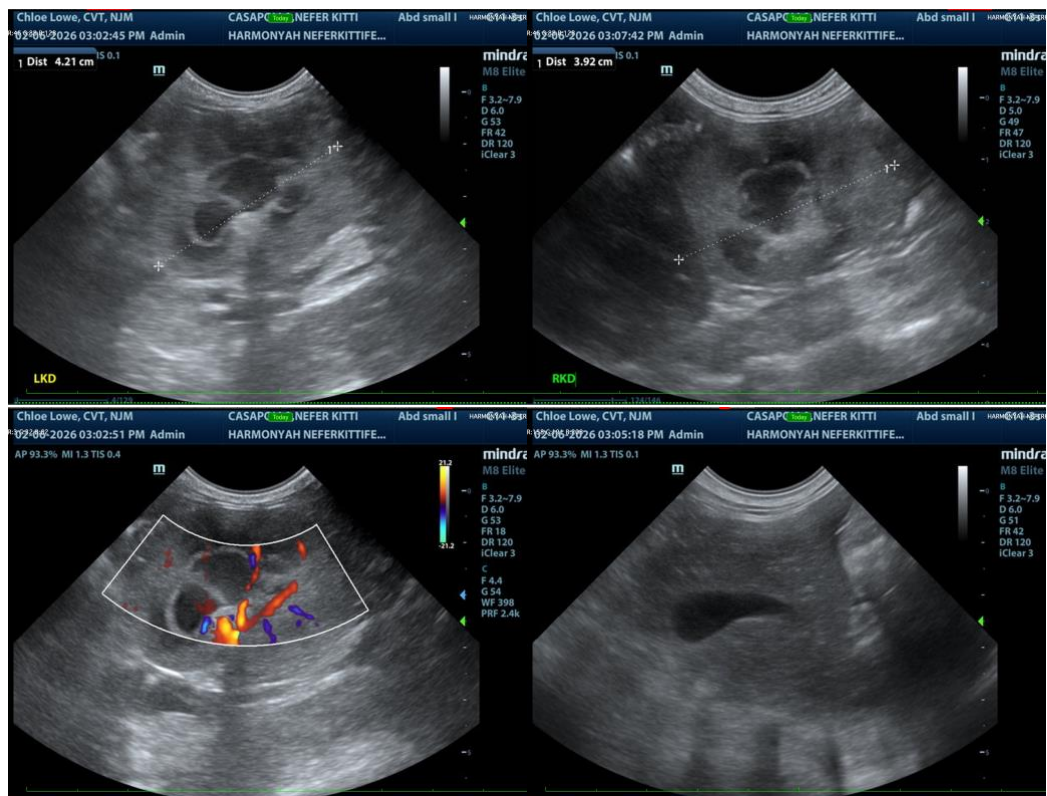
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

ULTRASONOGRAPHIC FINDINGS

- gastric luminal material.
- Idiopathic medullary rim kidneys- potential emerging FIP or lymphoma.
- Unremarkable abdomen otherwise.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Toxin exposure is a potential in this patient. Prognosis is guarded. Ultrasound guided FNA of the kidneys would be appropriate after coagulation panel if the patient is not responding to medical management.





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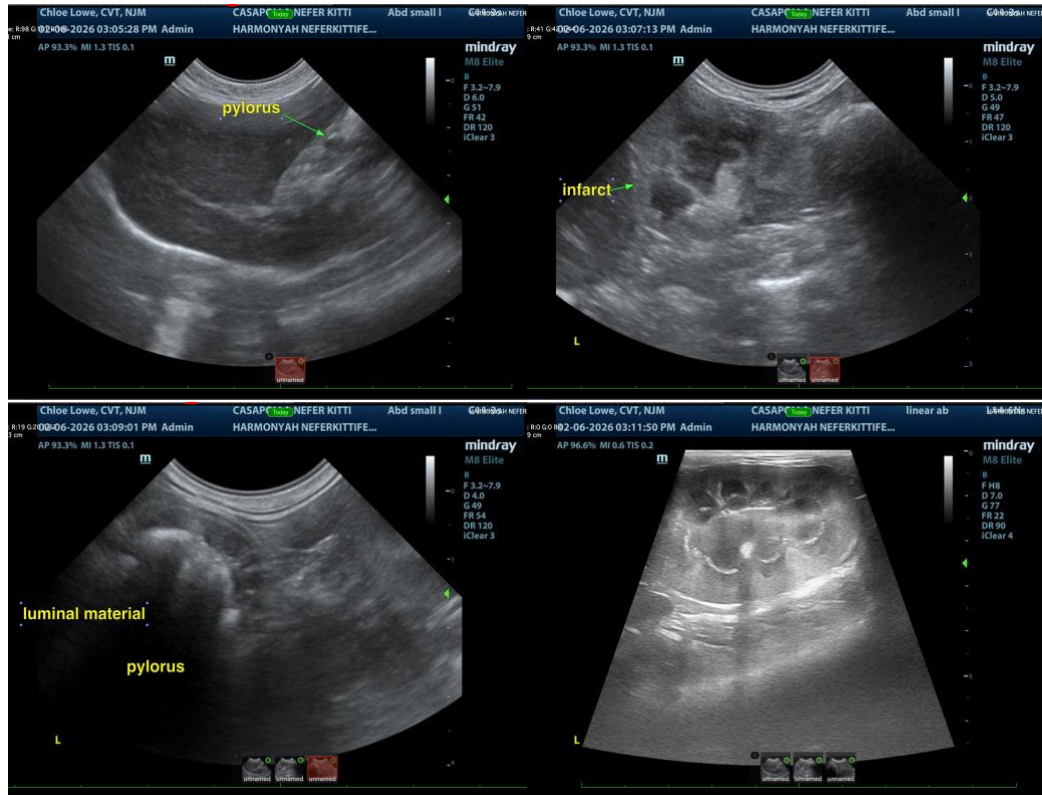
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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