



PATIENT

Boots Romig

SPECIES

Feline

BREED

Siamese

SEX

Neutered male

AGE

12 years

WEIGHT

8.38 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Casita

HOSPITAL NAME

Companion AC

REFERRING VET

Dr. Casita

INVOICE

42662

DATE

2/8/23

PRESENTING CLINICAL SIGNS

History: Lethargy, weight loss, and abdominal discomfort since early January, eating well, no diarrhea, heaved recently without vomiting some urination outside of the box 1# weight loss since August

Abnormal PE/Chem/CBC/UA Results: mild weight loss, abdominal discomfort without masses palpated Chem: ALT 304, ALP 109 (renal values WNL) CBC: plats 195 UA 1.048, 2+ protein

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.

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 4.0 cm. The right kidney measured 4.3 cm.

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.

Spleen

The **spleen** was mildly enlarged 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** was slightly enlarged and uniform with mildly increased portal markings. The gallbladder and common bile duct were unremarkable.

Gastrointestinal

The **gastrointestinal** presentation revealed mild uniform prominence of the gastric mucosa as well as 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,



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chronic disease. A mesenteric lymph node mass was noted in this patient. The largest node measured 3.9 x 1.8 cm, yet smaller lymph nodes were also enlarged.

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Pancreas

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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.

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Free Abdomen

SEX

Slight areas of free fluid were noted, likely owing to lymphatic congestion.

Neutered male

ULTRASONOGRAPHIC FINDINGS

AGE

Mesenteric lymphadenopathy with a diffuse intestinal thickening.

12 years

Otherwise, age related abdominal changes.

Mild splenic and hepatic enlargement.

WEIGHT

8.38 lbs

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

INTERPRETED BY

I recommend FNA of the spleen, liver and mesenteric lymph nodes with cytology and culture for further definition. Lymphadenitis and dry form FIP are mild potentials. The prognosis is guarded. Round cell neoplasia/lymphoma is suspected.

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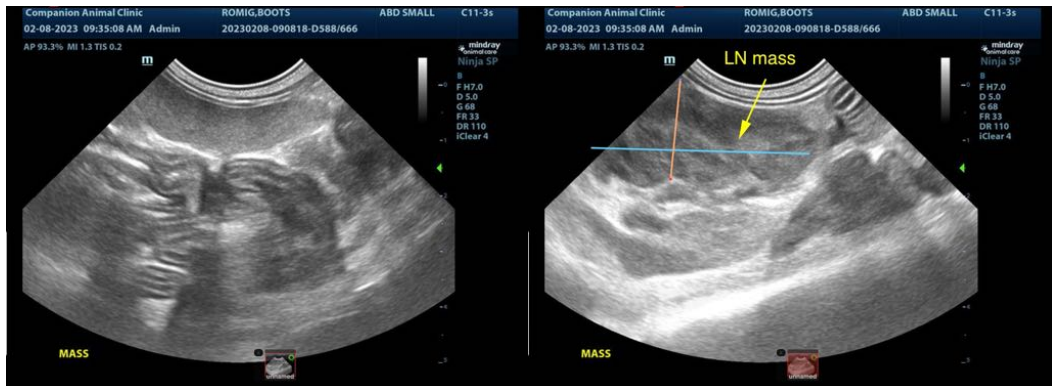
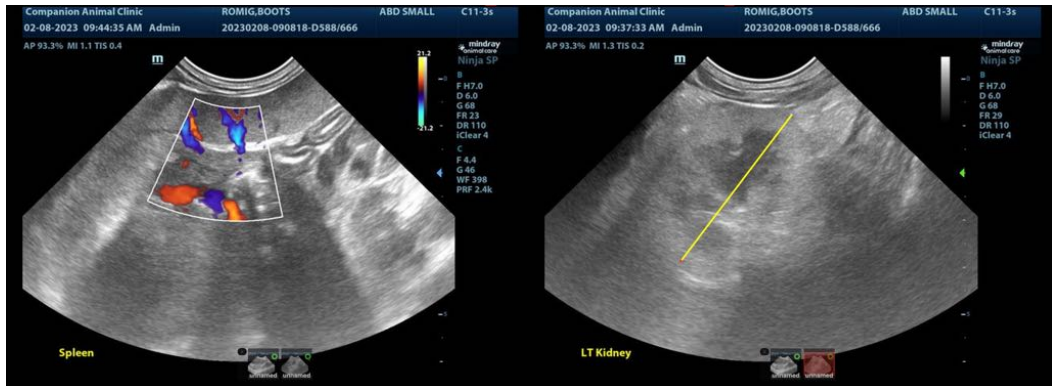
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@SonoPath.com