



PATIENT

Chloe Page

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

16 years

WEIGHT

7 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Jeremiah Gabriel

HOSPITAL NAME

Central Jersey AH

REFERRING VET

Dr. Gabriel

INVOICE

73519

DATE

3/17/26

PRESENTING CLINICAL SIGNS

- Losing weight (2 LBS), eating less, acting lethargic
- Normal senior profile 1 month ago

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 this age patient. Medullary structure differed distinctly from that of the cortex. Pelvic calculus was noted. There was pyelectasia that measured 0.3 cm. The left kidney measured 3.9 cm. The right kidney measured 4.0 cm.

Adrenal Glands

The **adrenal glands** were not overtly visualized. However, the regions of the adrenal glands appeared 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 was noted.

Liver

The **liver** revealed coarse architecture and heterogenous parenchymal changes. Occasional cystic lesion was noted, subjectively benign. Lobar biliary mineralization was noted in the liver. The gallbladder and common bile duct were unremarkable.

Gastrointestinal

There was some residual chyme and gas was noted in the **stomach**, yet not pathological. This is consistent with post prandial presentation or hairball accumulation. Transit of chyme into the small



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intestine was normal. Curvilinear patterns were maintained throughout the GI tract. No evidence of pathology. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

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 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.

ULTRASONOGRAPHIC FINDINGS

A ge related renal changes with slight obstructive and pelvic nephrolithiasis in the left kidney, stable and non-obstructive.

Hepatic remodeling.

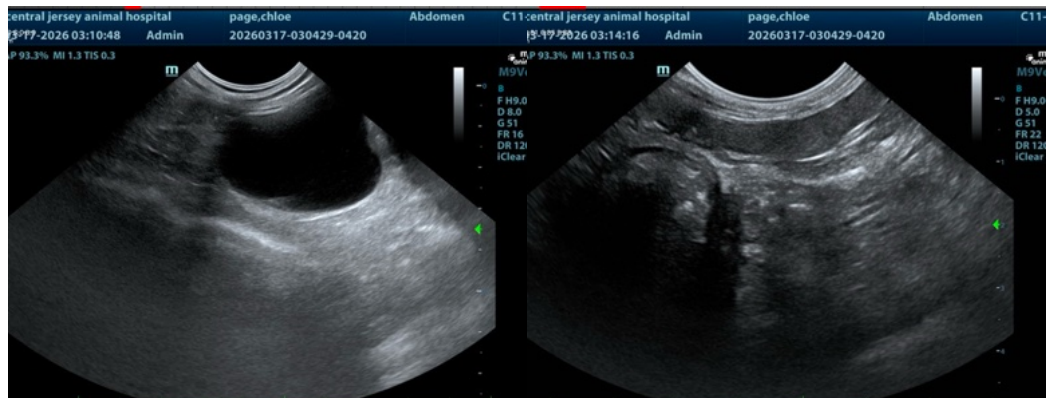
Hairball type density in the stomach.

Geriatric abdomen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of lethargy and hyperoxia and weight loss is not evident. Orthopedic pain, CNS or thoracic disease should all be considered as potential contributors. Urinary work-up and blood pressure measurements are indicated.

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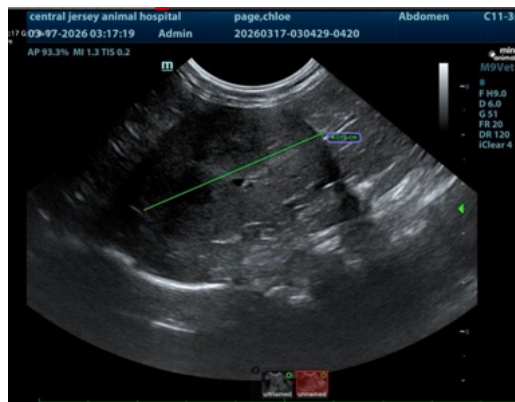
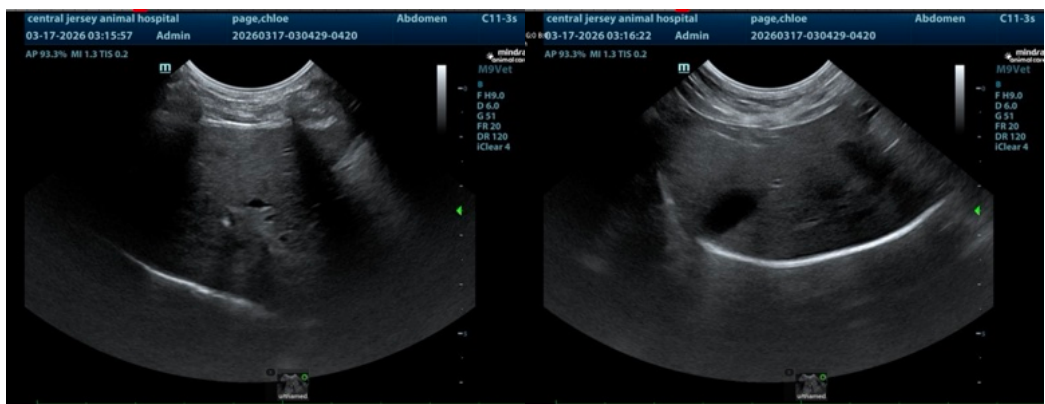
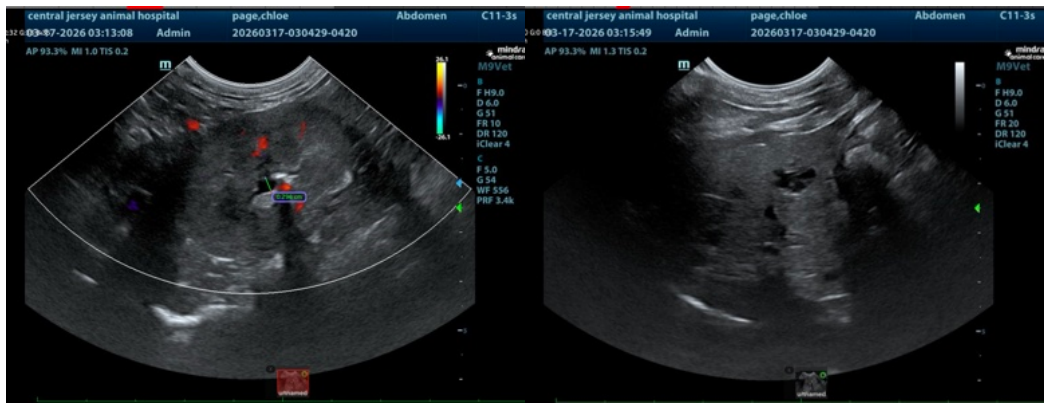
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, CEO of SonoPath.com

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