



## PATIENT

Clyde Schmidt

## SPECIES

Feline

## BREED

DSH

## SEX

Neutered Male

## AGE

10 Years 11 Months

## WEIGHT

7.1 pounds

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Dr. Layna Irwin DVM

## HOSPITAL NAME

Boise Cat Clinic

## REFERRING VET

Dr. Layna Irwin DVM

## INVOICE

14449

## DATE

03/19/26

## PRESENTING CLINICAL SIGNS

- Indoor/outdoor, retroviral negative. Initially presented on 3/11/2026 for significant weight loss (4 lbs in 9 months), lethargy, and poor balance.
- No prior major medical history
- Not on current medications

PE: cachexia, pruritic rash on the back of the neck (improving on clavamox), dental disease, grade 3/6 heart murmur, small kidneys. CBC - unremarkable Chem - high SDMA (15), creat wnl (1.1), low BUN (12), phos wnl (4.1), K wnl (4.9), low n alb (2.7), glob wnl (4.3), liver enzymes wnl Spec fPL - wnl (0.5) Cardiopet - high (169) T4 - euthyroid (T4 1.7, fT4 10.3) UA - USG wnl (1.045), pH wnl (6.0), 3+ proteinuria, 4+ hematuria, >50 rbc, suspected cocci, no pyuria, no casts, UPC high (1.1) CXR - pending, no obvious pathology

## 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 was visualized, and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal. The lower urinary tract was unremarkable. Some suspended debris was noted in the urinary bladder.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex. The capsules were acceptably uniform without significant irregularities. The left kidney measured 3.8 cm in length. The right kidney measured 3.4 cm in length. The left kidney revealed a cortical infarct with cortical medullary mineralizations present. The right kidney revealed cortical infarcts as well.

### *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. The left adrenal gland measured 0.40 cm width. The right adrenal gland measured 0.40 cm width.

### *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



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pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

### *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 1:1 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. 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

- Renal mineralizations and infarcts.
- Intestinal thickening with muscularis hypertrophy.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The patient is likely passing calculi or hematuria may be deriving from the renal infarcts. No evidence of active inflammation at the time of the sonogram. Management for underlying UTI is indicated.

### **Feline Chronic UTI Protocol**

I recommend **Enrofloxacin** (5-10 mg/kg SID PO) (In patients > 1 year of age) in an adequately hydrated patient without renal failure to avoid complications. This assumes that culture supports this use. Repeat **culture** at 3-4 weeks and continue treatment at least 7-10 days post negative urinary sediment and negative culture. *Note: Negative culture does not necessarily mean lack of UTI especially with elevated urinary WBC with low urine specific gravity.* Other favorite antibiotics for chronic UTI include Zithromax 50mg/cat SID or potentiated bet lactam antibiotics.



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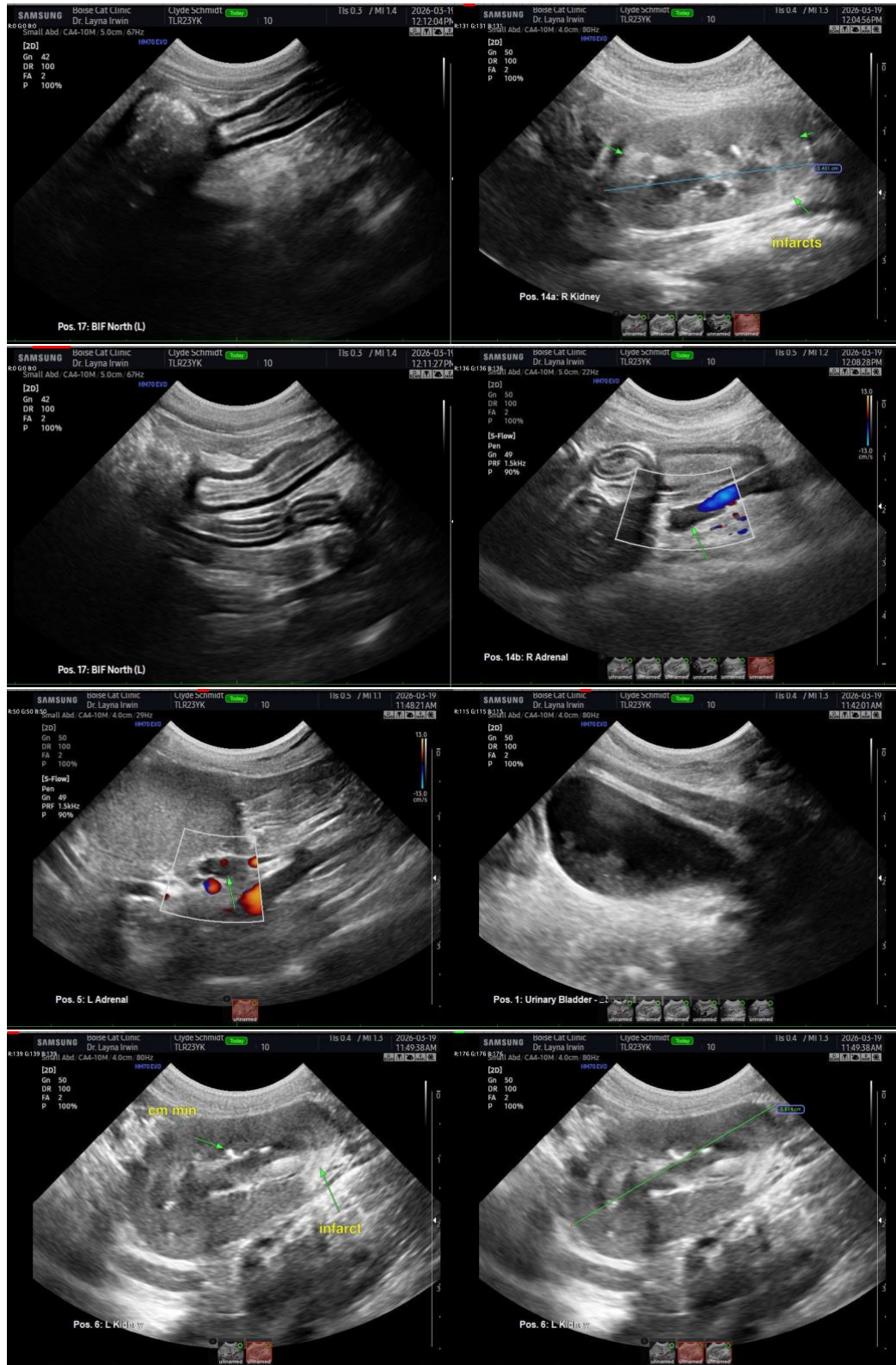
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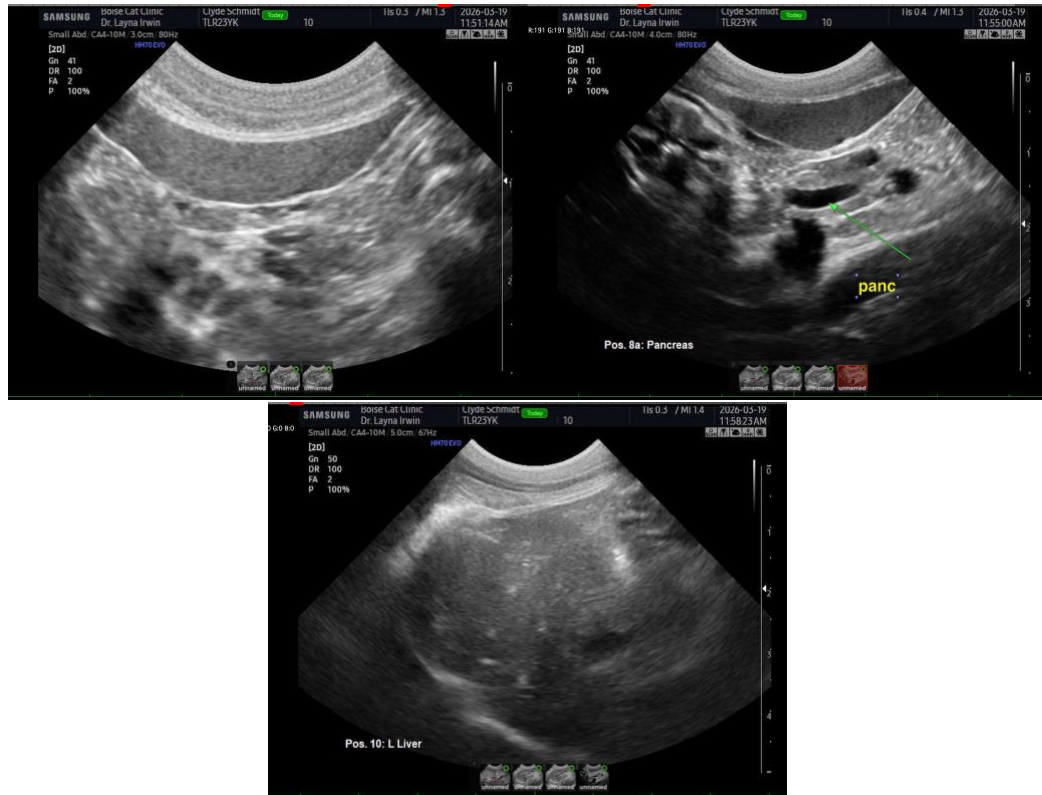
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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(CFM), Cert. IVUSS,**

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