



PATIENT

Hattie Fishel

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

5.5 Years

WEIGHT

4.77 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary
Emergency Center

REFERRING VET

Dr. Logan Law

INVOICE

14488

DATE

03/20/26

PRESENTING CLINICAL SIGNS

- P was seen 10 days ago at urgent ER for vomiting and lethargy. At that time, no rads obtained, bloodwork showed an elevated ALT and prolonged PT (normal PTT). Treated with SQ fluids, Cerenia, Convenia, Denamarin (liver protectant), and vitamin K1. Initially remained lethargic for one day post-treatment, hiding (unusual behavior), then returned to normal the following day. Was normal until yesterday morning (9:30 AM), P was running, jumping, and playing. By evening, P noted as lethargic. P vomited once with food. Anorexia this morning 3/20. History of chewing on plastic and paper. No known recent ingestion of foreign material or toxins. P presented to Shores for vomiting, lethargy, and ADR. admitted for supportive care: iv fluids and Cerenia, continued Denamarin.
- concern for Acute hepatopathy with markedly elevated ALT (>3600) and elevated total bilirubin - r/o cholangiohepatitis, acute liver insult, toxin exposure, biliary obstruction; Recurrent vomiting and lethargy - r/o hepatopathy (as above), pancreatitis, gastrointestinal disease; Small, rounded kidneys (incidental finding) - r/o chronic kidney disease, congenital renal dysplasia of left kidney

PE: soft on abdominal palpation, mildly reactive 3/11/26 RAET CBC: WBC 11.6 H, Mono 0.03 L; CHEM: Ca 8.6 L, Glob 4.9 H, Gluc 222 H, ALT 187 H; EPOC: pH 7.439 H, K 3.4 L, iCa 1.15 L, Gluc 195 H; PT/aPTT: 23 H (15-22 sec)/91 (65-119 sec) 3/20 icteric serum; EPOC: K 3.2 L, Lact 3.74 H; Liver panel: ALT 3680 H, Tbili 2.3 H; fPL: 2.2 Normal rads: Stomach appears fairly empty. SI appear normal/fluid-filled with gas dilation in one loop of SI (not overtly dilated). Colon contains a small amount of soft non-formed stool. Hepatomegaly. Left kidney small and rounded, right kidney appears normal size, more normal shape but slightly rounded. Normal Spleen, urinary bladder.

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 iliac trifurcation was unremarkable.

The **left kidney** 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 and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 4.0 cm in length.

The **right kidney** was subnormal in size and measured 2.27 cm in length with corticomedullary mineralizations and cortical infarcts.

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 0.30 cm width. The right adrenal gland measured 0.31 cm width.



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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. The spleen measured 1.38 cm width.

Liver

The **liver** revealed swollen hypoechoic irregular parenchyma with thickened/over distended gallbladder. Slight increased portal markings with enhanced surrounding mesentery suggestive of inflammation. The common bile duct was dilated and over distended in this patient measuring 0.70 cm with congealed bile/mucoduct.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. 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. 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

- Degenerative right kidney/dystrophy with normal left kidney- mild potential for round cell neoplasia, infectious agents such as toxoplasmosis and Bartonella.
- Cholangiohepatitis pattern with dilated common bile duct- potential dysfunctional duodenal papilla.
- Scalloped spleen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ultrasound guided FNA of the liver/spleen with cystocentesis and culture of the gallbladder are indicated for further definition. Prognosis is guarded. Eventual surgical intervention may be necessary in this patient. For bile duct deviation procedure depending upon response to therapy.



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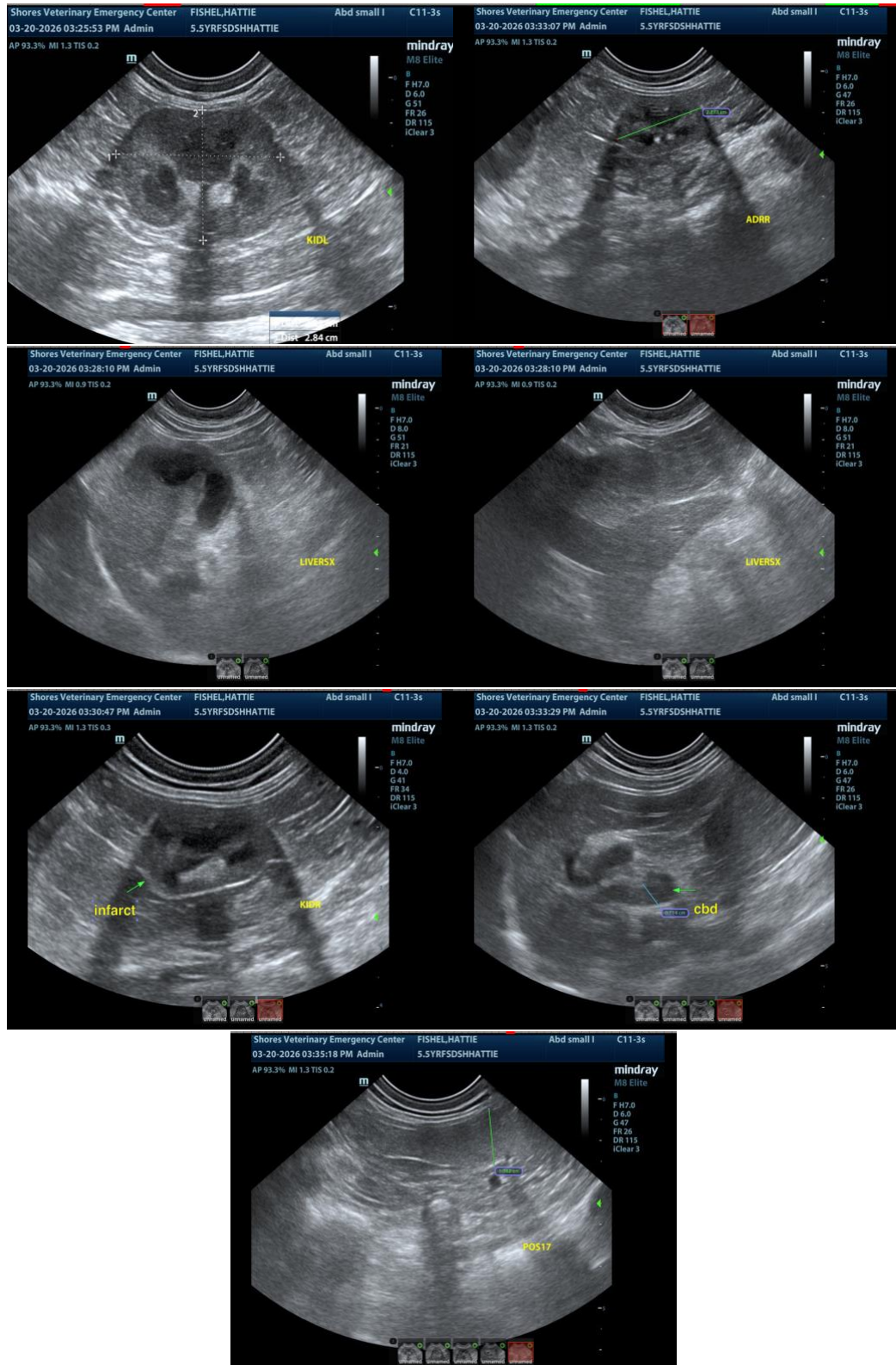
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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