



PATIENT

Luna Clark

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

9 Years

WEIGHT

8.1 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Elaina Petrone

HOSPITAL NAME

Long Branch Animal
Hospital

REFERRING VET

Dr. Elaina Petrone

INVOICE

73851

DATE

3/20/26

PRESENTING CLINICAL SIGNS

History of chronic vomiting with acute worsening. Lab work pending.

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 **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 and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. Right kidney measured 3.9 cm. Left kidney measured 3.7 cm.

Adrenal Glands

The regions of the **adrenal glands** were 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 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 revealed congealed sand and bile measuring up to 1.5 cm, non-obstructive.

Gastrointestinal

The **gastrointestinal** presentation revealed mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall with 1:1 muscularis/mucosal ratio. The intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease. Intestinal wall thickness measured up to 0.31 cm. 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.



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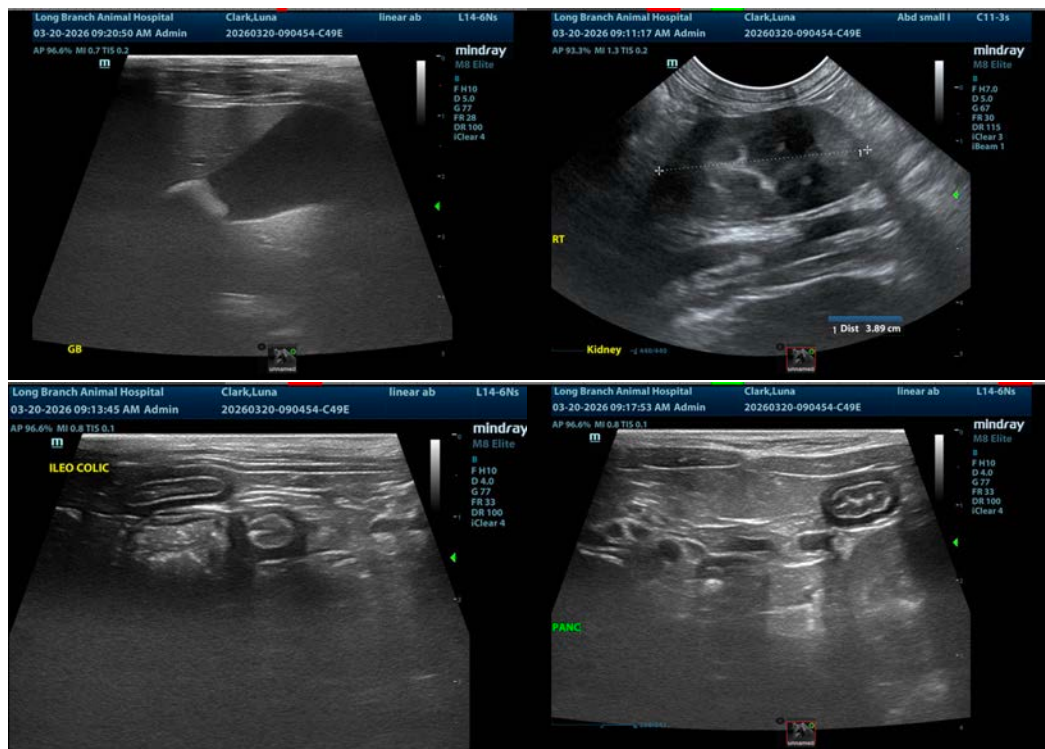
Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxyphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

ULTRASONOGRAPHIC FINDINGS

- Diffuse intestinal thickening with idiopathic muscularis hypertrophy – Likely emerging round cell neoplasia. Dry form FIP is a remote potential.
- Gallbladder calculi.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gallbladder calculi may be contributing to the clinical signs. Full thickness gastrointestinal biopsies and cholecystotomy is justified in this patient for further definition. Otherwise, empirical management with Ursodiol could be considered, but is highly variable in effectiveness on this type of cholelithiasis.





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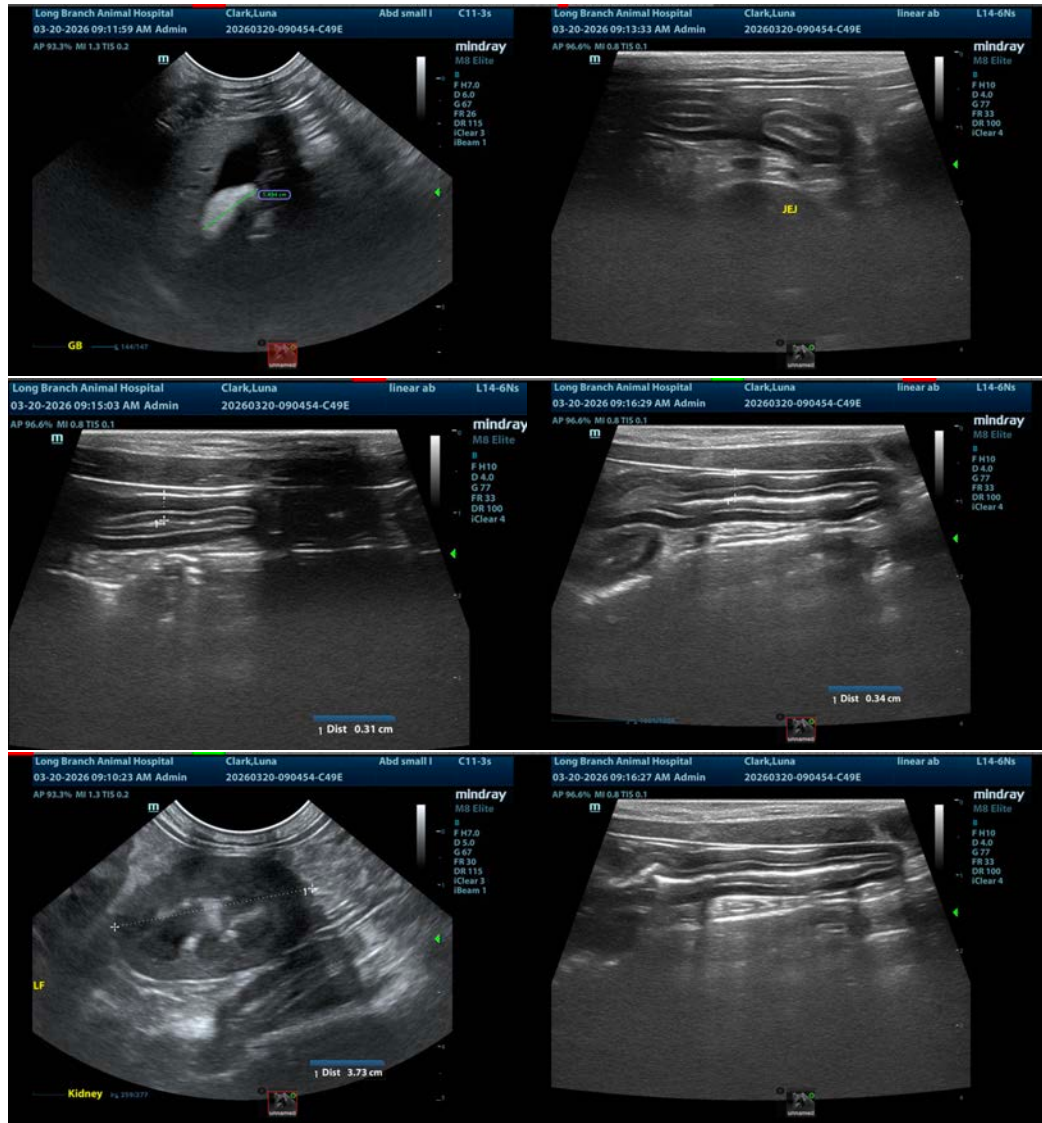
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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