



PATIENT

Nala Camerieri

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

12 years

WEIGHT

12.3 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Jocelyn Hollway

HOSPITAL NAME

Valley Green VH

REFERRING VET

Dr. Oberer-Gerber

INVOICE

73691

DATE

3/23/26

PRESENTING CLINICAL SIGNS

- Initially presented 2/12/26 for constant vomiting, poor appetite and lethargy. She sometimes lays in the litterbox. O noted a new lump on P's neck and also notes that P has been scratching at her neck/face, creating lesions. P returned 3/18/26 with no improvement and continued weight loss.
- 2/12/26 RADS: The diffuse, moderate bronchial pattern is supportive of lower airway disease of inflammatory (as with asthma or chronic bronchitis), infectious (bacterial or viral), or parasitic (lung worms or heartworm) etiology. These disease processes cannot be distinguished radiographically.
- Presumed normal postprandial abdomen. Gastrointestinal foreign material cannot be excluded but is not considered likely.
- Although spondylosis deformans is typically incidental, this is particularly severe in this patient and may be associated with discomfort.
- Moderate, bilateral elbow degenerative joint disease.
- Inguinal lymphadenopathy may be reactive or neoplastic.
- BAR. ABD = NSF. Heart/Lungs = NSF. Pain on extension of hips bilat. MASS: L lat neck dermal approx 1/4 inch diameter firm. MASS: Large mass ventral ABD within the primordial pouch, SQ. Patient is uncomfortable with palp of this mass. Non-ulcerative. Inconclusive FNA. Scabby lesions on neck, ventral chin and rostral to ears AU. Mod brown exudate. Itchy AU. Gr2-3 ddz. +/- plump submandibular LNs bilaterally. 3/18/26 HCT = 37.5% Creat = 1.7 (IRIS STAGE 2) LT = 138 HIGH fPL = 2.8 normal T4 = 2.5 normal Ear cytology = severe otitis externa AU 2/12/26 HCT = 41% normal Creat = 1.8 (IRIS Stage 2) Glob = 5.2 HIGH (2.8-5.1) ALT = 214 HIGH (12-130) T4 = 2.2 normal FNA Lateral left neck: Low amounts of keratin, possible keratinizing lesion FNA Abdominal area: Inconclusive due to low cellularity

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The pelvic urethra was imaged 2.0 cm beyond the cystourethral junction and appeared normal. 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 and no evidence of pelvic dilation was present. Slight pinpoint mineralization was noted. The left kidney measured 3.3 cm. The right kidney measured 3.6 cm. Blood flow to the kidneys appeared to be slightly subnormal on Power Doppler assessment.

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 right adrenal gland measured 0.4 cm.



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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 up to 1.3 cm.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

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.

Free Abdomen

The subcutaneous lesion imaged is consistent with lipoma and measured 2.0 cm.

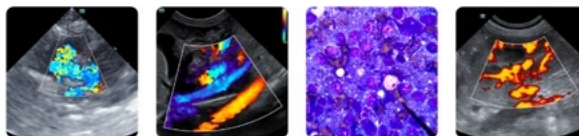
ULTRASONOGRAPHIC FINDINGS

Unremarkable age related abdominal changes.

Slight pinpoint mineralization.

Splenic enlargement. Reactive hyperplasia is likely, potential emerging round cell neoplasia.

Lipoma.



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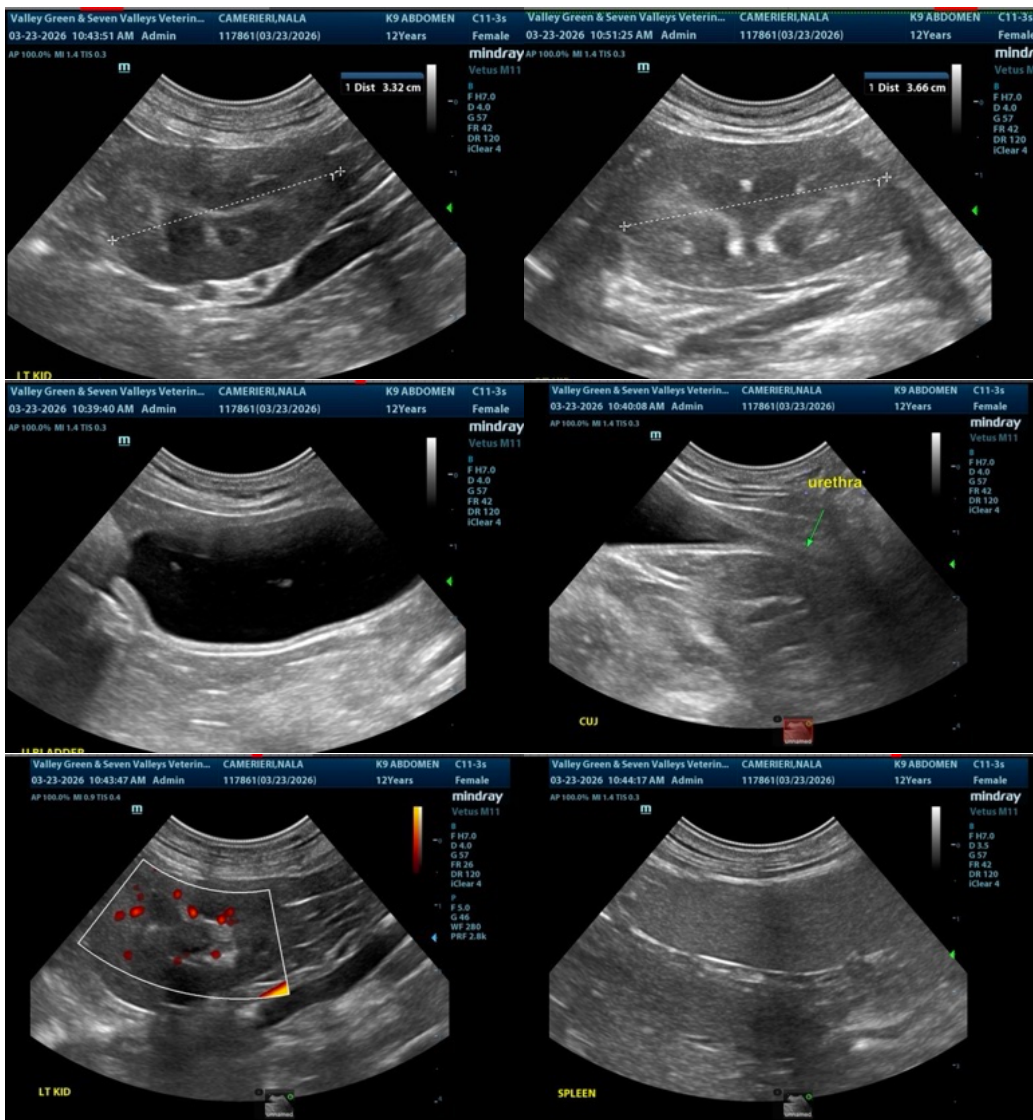
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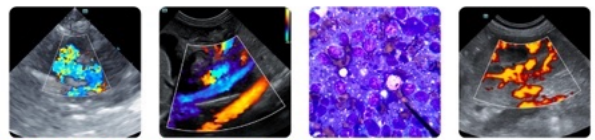
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The kidneys appear subjectively unremarkable. 25-gauge FNA is indicated. Periodic prerenal disease may be playing a role in the renal profile in this patient as the kidneys appear unremarkable.





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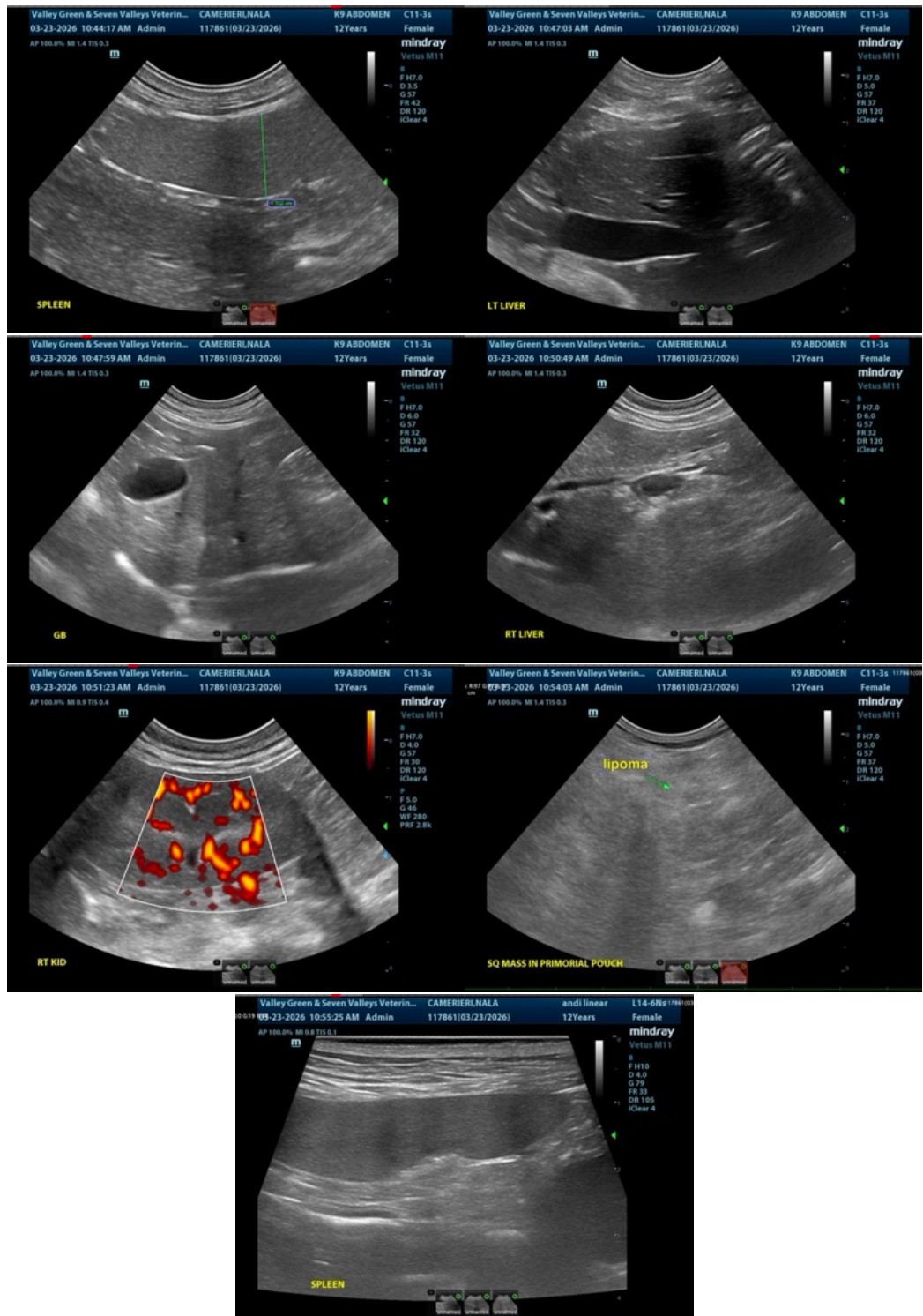
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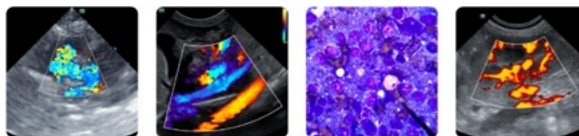
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology



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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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