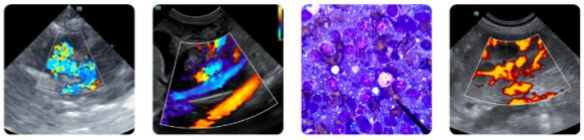



**PATIENT**

Mango Fewless

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Male

**AGE**

4 Years 4 Months

**WEIGHT**

8.18 pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Dr. Andrew Beachy

**HOSPITAL NAME**

Linn Veterinary Hospital

**REFERRING VET**

Dr. Andrew Beachy

**INVOICE**

14783

**DATE**

04/02/26

## PRESENTING CLINICAL SIGNS

P has CH (cerebellar hyperplasia) since birth. Came in 3/11/26 for frequent urination- Diagnosed with diabetes from bloodwork and u/a. Prozinc insulin started at 1 unit BID. Spot BG recheck 3/18/26 was 256. P eating well and urinating less often. Seemed to be improving overall. Came in 3/26/26 for not eating well. Severely dehydrated. Hospitalized him on 3/26/26 for 24 hours on IV fluids. blood work and radiographs done, no major findings seen. The next day he was eating on his own and sent him home. Was also treated with Cerenia and convenia. Came in 4/1/26 for same symptoms not E/D, lethargic. O elected to hospitalize again and an abdominal ultrasound. Weight loss noted: 11/8/24- 12.5lbs, 3/11/26- 9.3lbs, 3/18/26- 9.13lbs, 3/26/26- 8.3lbs, 4/1/26 8.18lbs

Abnormal PE/Chem/CBC/UA Results: From 3/26/26: CBC: NSF Chem: Glu 247, GGT 8 Pancreatic lipase 5.1

## 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 with no evidence of thrombosis.

The **left kidney** was enlarged with thickened, hyperechoic 'patchy' cortices measuring 5.1 cm in length. Some loss of mural detail and pyelectasia was also present.

The **right kidney** presented with similar changes to the left kidney and swollen irregular contour measuring 5.8 cm in length with patchy echogenic nodular changes and infarcts.

### *Adrenal Glands*

Both **adrenal glands** were not visualized.

### *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.

### *Liver*

The **liver** presented with swollen hyperechoic to falciform fat. The gallbladder and common bile duct 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

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demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

### *Pancreas*

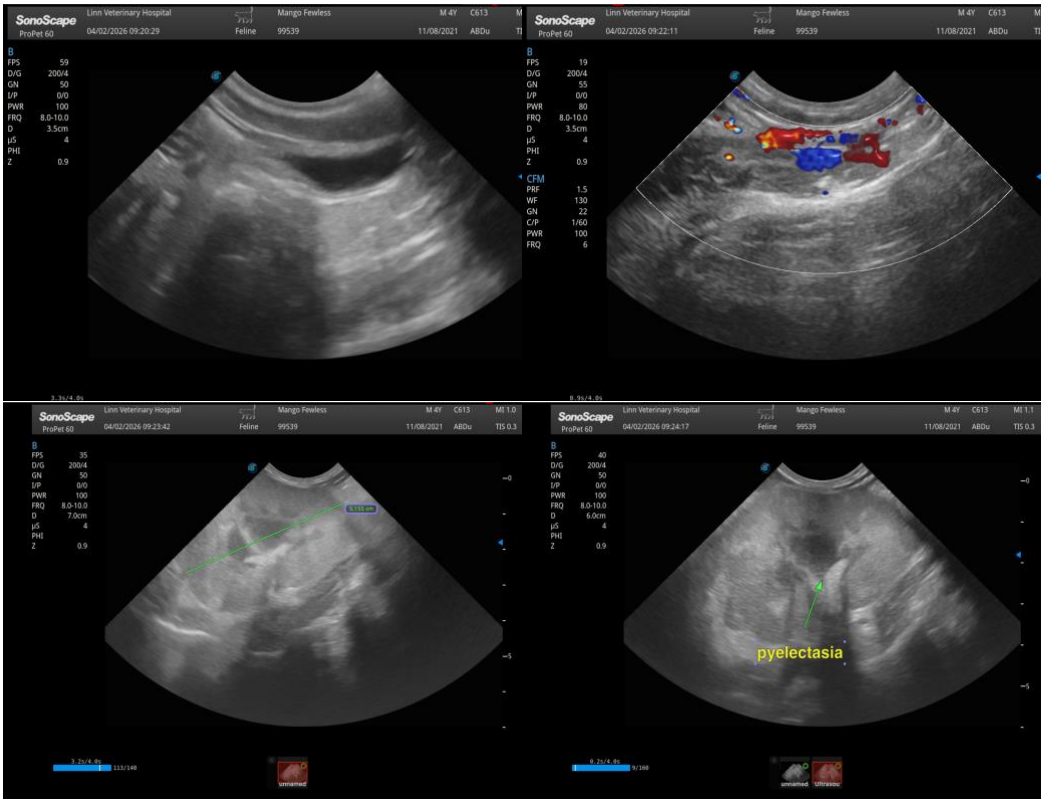
The **pancreas** presented hypoechoic and irregular with enhanced surrounding mesentery measuring up to 0.95 cm and suggestive of pancreatitis.

## ULTRASONOGRAPHIC FINDINGS

- Minimal falciform fat with swollen liver.
- Bilateral renomegaly with pyelectasia, nephritis and cortical infarcts.
- Swollen spleen.
- Concurrent pancreatitis pattern.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Concern for acute and chronic nephritis versus emerging renal neoplasia/lymphoma. Dry form FIP is also a potential Coagulation panel, 25-gauge FNA of the spleen and kidney is recommended. Management for pancreatitis is indicated with broad-spectrum antibiotics, IV fluid support, pain management and reassessment of the clinical signs. Prognosis is guarded.



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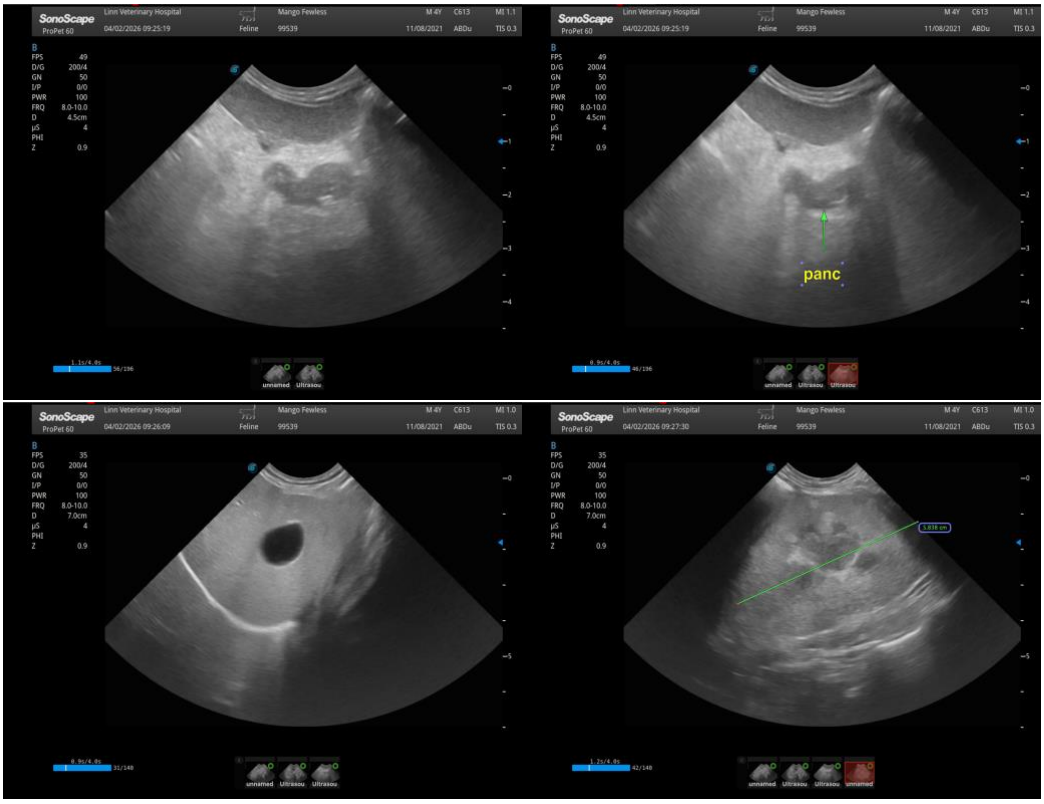


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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, Owner, Founder -- SonoPath.com

info@SonoPath.com