



**PATIENT PRESENTING CLINICAL SIGNS**

**Tate Kale**  
History: Weight loss and intermittent diarrhea for the last 3-4 months. BW on 3/24 showed hyperthyroidism, which pt was started on methimazole for/ Also did course of metronidazole which helped the diarrhea, but it returned. Has lost another 0.4lb in the last month despite methimazole and now in addition to diarrhea pt has frequent (more days than not) vomiting, often hours after eating...  
**Feline**  
Finished metronidazole course, only on Methimazole 5mg 1T SID.  
CBC/Chem/Lytes on 3/24/23 Lymphocytes 9372(H), remainder wnl, T4 5.2(H), recheck T4 on 4/24/23 1.7(normal).

**BREED**

Domestic Shorthair

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

**SEX**

Neutered male

The **urinary bladder** and visible pelvic urethra were unremarkable for the level of repletion presented. The urine, however, did present some mildly echogenic debris consistent with mucous, exfoliated cells from renal or bladder origin, and/or blood clots as these echogenic changes can all present similarly. This is often related to urinary tract infection but may represent simple evidence of exfoliated debris or sterile inflammation. Cystocentesis, urinalysis, +/- culture would be recommended to rule out and define any UTI.

**AGE**

9 years

**WEIGHT**

8.3 lbs

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 his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The right kidney measured 4.05 cm. The left kidney measured 4.1 cm.

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**Adrenal Glands**

**IMAGING PERFORMED BY**

Jessica Green

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 0.32 cm. The right adrenal gland measured 0.27 cm.

**HOSPITAL NAME**

Stanglein VC

**Spleen**

**REFERRING VET**

Dr. DiNello-Schleicher

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 was noted. The spleen measured 0.8 cm.

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**Liver**

**DATE**

4/26/23

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



**PATIENT**

Tate Kale

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

**SPECIES**

Feline

***Gastrointestinal***

**BREED**

Domestic Shorthair

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 1:3 muscularis/mucosal ratio. The intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease. The mesenteric lymph nodes measured up to 1.0 cm and appeared reactive. 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.

**SEX**

Neutered male

**AGE**

9 years

***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.

**WEIGHT**

8.3 lbs

**ULTRASONOGRAPHIC FINDINGS**

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

Minor intestinal thickening, enteritis pattern.  
Mild, enhanced mesentery in the midabdomen.  
Reactive mesenteric lymph nodes.

**IMAGING PERFORMED BY**

Jessica Green

**HOSPITAL NAME**

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Maldigestion panel, three view chest radiographs and full CNS examination is recommended to examine for occult disease that could be responsible for the weight loss. Evaluation for competitive eating environments should also be considered.

**REFERRING VET**

Dr. DiNello-Schleicher

Differentials for diarrhea include occult parasitism. Dietary indiscretion, dietary intolerance, antibiotic responsive colitis, intestinal dysbiosis and occult Addison's should all be considered as causes of diarrhea in this patient. A hydrolyzed diet trial may be in this patient's best interest +/- probiotics. 24-hour NPO and reintroduction of bland diet indicated. I recommend a baseline cortisol or ACTH stimulation test, a fresh fecal smear and fecal floatation analysis if not already performed.

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There is no evidence or suspicion of neoplasia in the abdomen.

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**REFERRING VET**

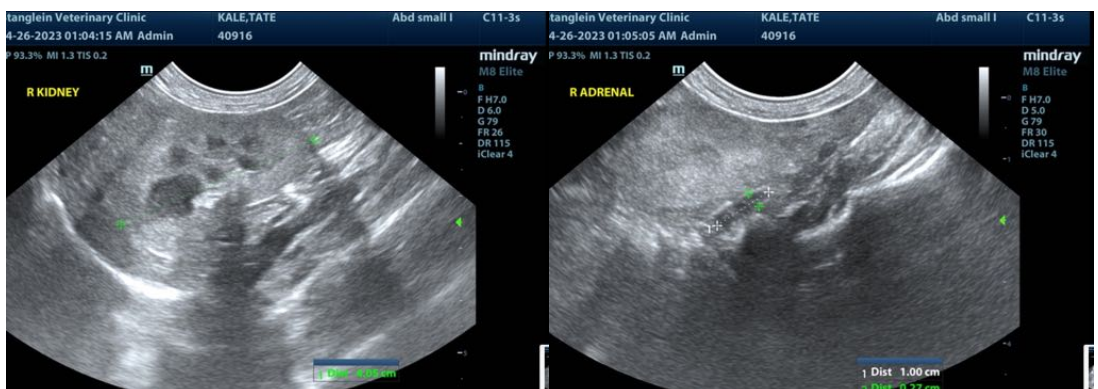
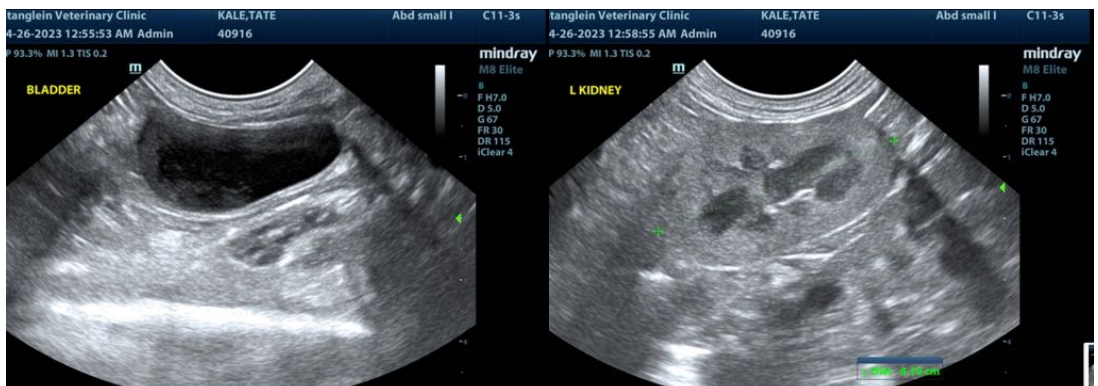
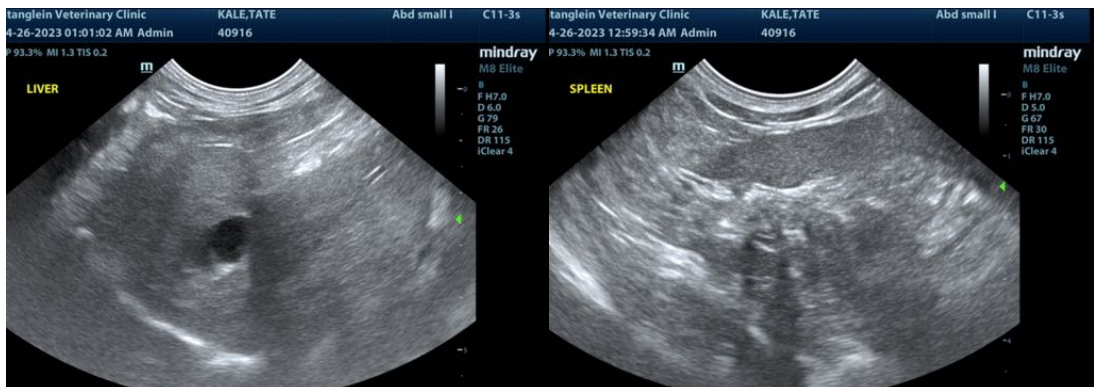
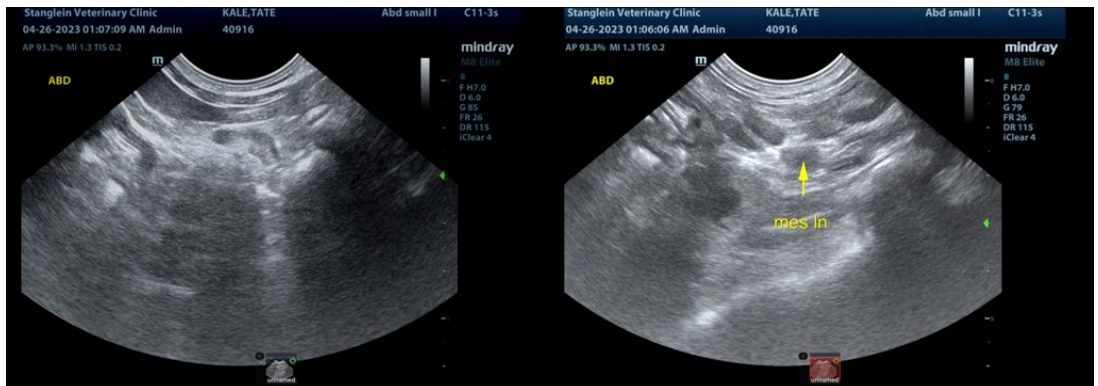
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, Cert. IVUSS, CEO of SonoPath.com  
info@SonoPath.com