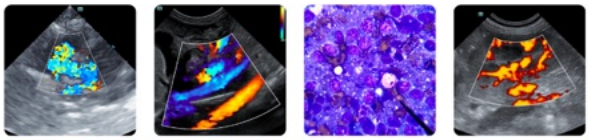

PATIENT

Carter Bachus

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

17 years

WEIGHT

6.3 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Ian Anderson

HOSPITAL NAME

Chester AC

REFERRING VET

Dr. Ramirez

INVOICE

74334

DATE

4/9/26

PRESENTING CLINICAL SIGNS

History: History of urolithiasis; PU surgery previously. Two episodes of vomitus recently, reduced appetite
Grade 2 heart murmur, lenticular sclerosis, Moderate dental plaque, generalized muscle atrophy AFAST suspicious for gastric/intestinal thickening and blood clot in bladder vs stone Mild hypoalbuminemia, Mildly increased T4, blood in urine (attached)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** revealed minor wall thickening noted measuring up to 0.27 cm. The ureters were not visible which is normal. Sand accumulation was noted and measured up to 1.0 cm. The urethra was not visualized.

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. The right kidney measured 4.1 cm. The left kidney measured 3.4 cm. Blood flow to the kidneys appeared to be adequate on color flow 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.

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 was noted.

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 wall was mildly thickened.

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Gastrointestinal

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. There was retention of ingesta in the stomach. The intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease. 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. 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

Variable intestinal thickening without overt neoplastic criteria. I cannot rule out a preneoplastic state. Otherwise, chronic IBD GI pattern.

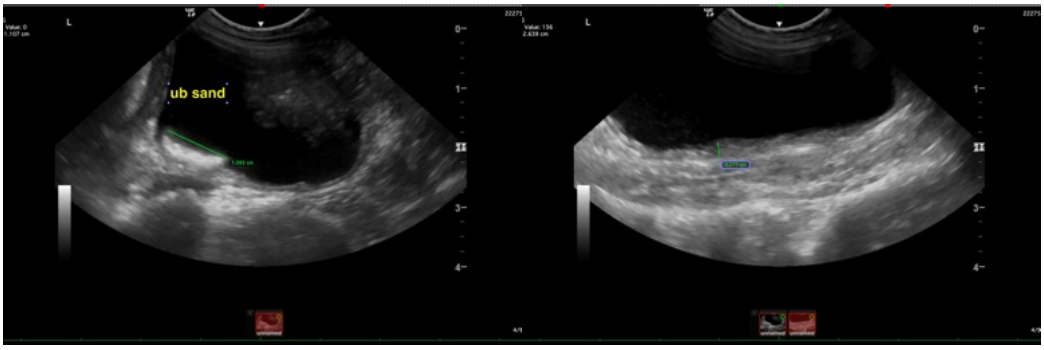
Bladder sand.

Geriatric abdomen otherwise.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A cystotomy, sand analysis and culture are all indicated as well as GI biopsies or empirical management for inflammatory bowel, dietary intolerance and parasitic disease can also be considered.

If clinical signs persist then I recommend a recheck sonogram to assess if neoplastic criteria is developing in the GI tract or elsewhere.



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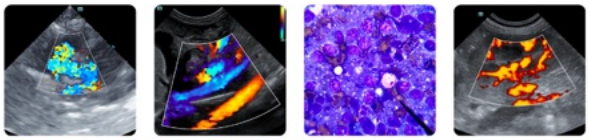

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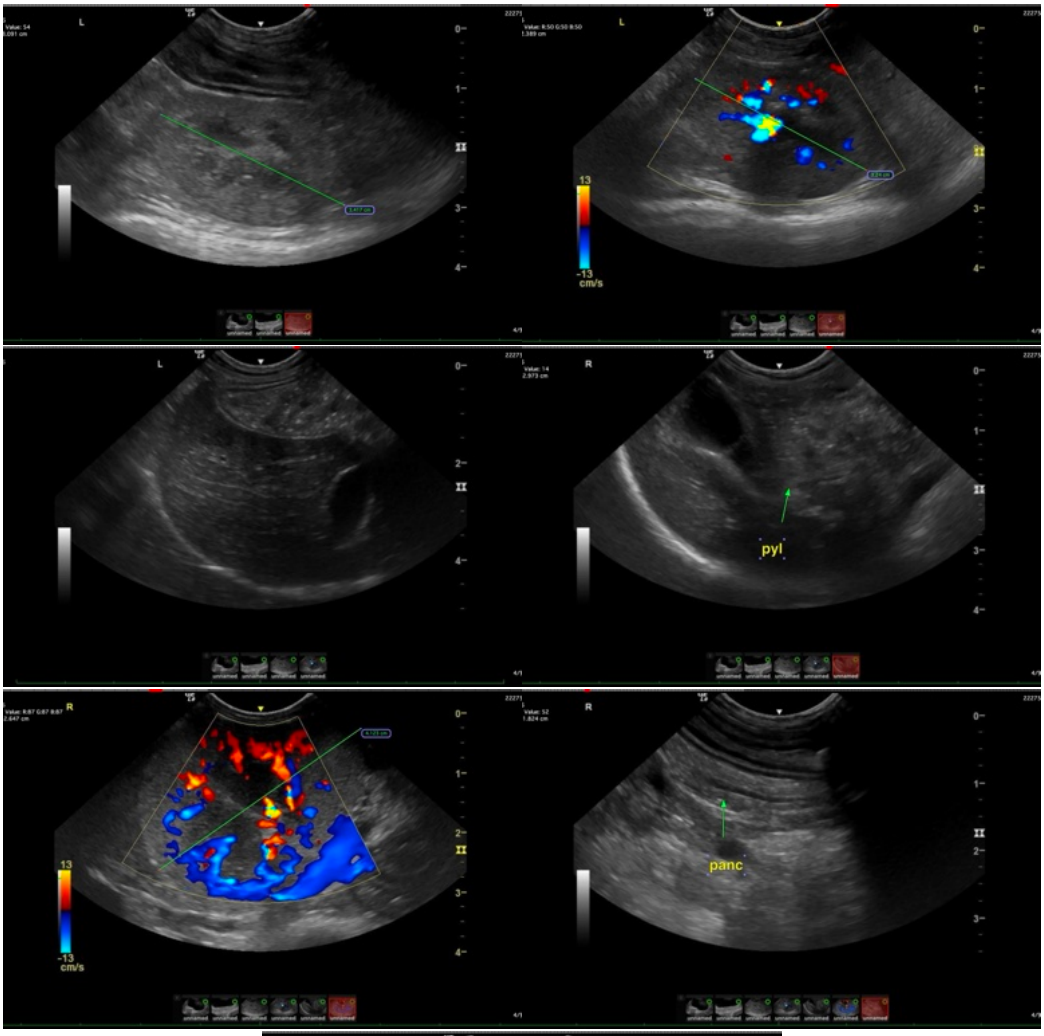

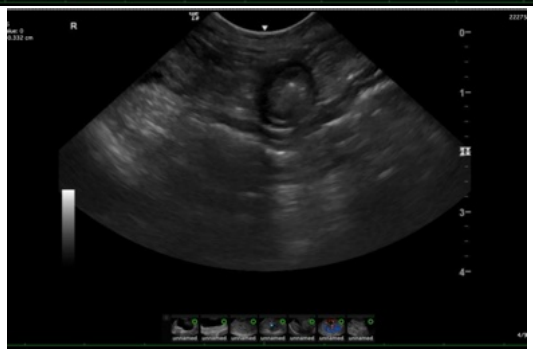

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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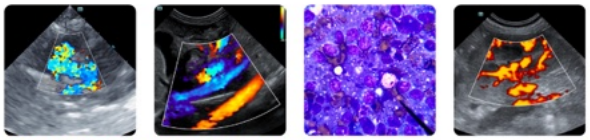

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