



PATIENT

Sebastian Peters

SPECIES

Feline

BREED

Bengal

SEX

Neutered Male

AGE

9 Years

WEIGHT

9.17 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Danielle Shemanski
DVM, MA

HOSPITAL NAME

Western New York
Veterinary Services

REFERRING VET

Robert Lann DVM

INVOICE

16101

DATE

05/12/26

PRESENTING CLINICAL SIGNS

RDVM REASON FOR REFERRAL: Recent weight loss from 10.3lbs BCS 4/9 last 12/20/25 to 9.17lbs BCS 3/9 on 4/30/26. History from Owner: 9-year-old Bengal cat. Vomiting once or twice a month (usually one large vomit of undigested food). Consistent, very watery diarrhea. Good appetite seems consistently hungry. Recently started defecating in inappropriate places. Current medications: Cobalamin 0.3 mL SQ weekly and Prednisolone 5 mg daily (for over a year). Steroids have not really helped the diarrhea. Diet: Solid Gold high protein dry food with a small amount of wet food to administer medication. Also receives bonito flakes as a treat. No flea medication. Indoor only. Had teeth extracted a couple of weeks ago. Owner notes that hindlimb weakness has improved over the last year. **CLINICAL SIGNS:** Vomit occasional and chronic diarrhea. **MEDICATIONS:** Prednisolone 5 mg SID. Cobalamin 0.3 mL SQ weekly

Abnormal PE/Chem/CBC/UA Results: April 30, 2026 Blood Chem WNL CBC WNL

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 largely normal structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some mild age-related loss of curvilinear patterns regarding the capsule and C/M junction. The left kidney was normal in size while the right kidney was subnormal in size. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex. The left kidney measured 3.9 cm in length. The right kidney measured 2.7 cm in length. Dystrophic changes were noted in the kidneys with mineralization and infarcts. Blood flow to the kidneys appeared to be adequate to mildly 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 left adrenal gland measured 0.35 cm width. The right adrenal gland measured 0.58 cm width.

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



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tracts were of 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.

Gastrointestinal

The **duodenum** revealed minor fluid-filled lumen with maintained curvilinear pattern and some hyperperistalsis in the small intestine. The mid abdomen revealed an intussusception measuring 1.4 cm x 3.5 cm. This may be manually reducible. Curvilinear patterns within the intussusceptive intestine were maintained, however, a slight stricturing area was noted adjacent to the intussusception region measuring approximately 1.0 cm. The ileoceocolic junction appeared to be free of evident pathology.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some mild parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. 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 subxiphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

Free Abdomen

Slightly enlarged mesenteric **lymph nodes** were present measuring up to 1.0 cm with a reactive pattern.

ULTRASONOGRAPHIC FINDINGS

- Renal dystrophy- mild/moderate on the left kidney and moderate on the right kidney.
- Focal intestinal lesion with adjacent intussusception.
- Enlarged mesenteric lymphadenopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Surgical intervention with resection of the stricturing lesion and manual reduction in the intussusception is recommended. Intraoperative ultrasound may prove effective in this patient to delineate the lesions as surgically from a cirrhotic standpoint, the infected intestine will likely appear fairly benign.

The focal lesion differentials include granulomatous disease, enteritis, or granulomatous lesion, round cell neoplasia carcinoma, less likely. Chest radiographs are warranted. The prednisone may be suppressing a more significant presentation. Ideally, given the intensity and the intussusception status, appears to have a mild obstructive pattern. I recommend if the patient is stable, 1-2 days of prednisone tapering would be warranted. However, surgical intervention regardless, with the knowledge that delayed healing may be an issue, may be the best approach in this patient. Ideally, prior to surgery, prednisone would be tapered 7-10 days. However, I do not think that the clinical and sonographic presentation would warrant such a delay.



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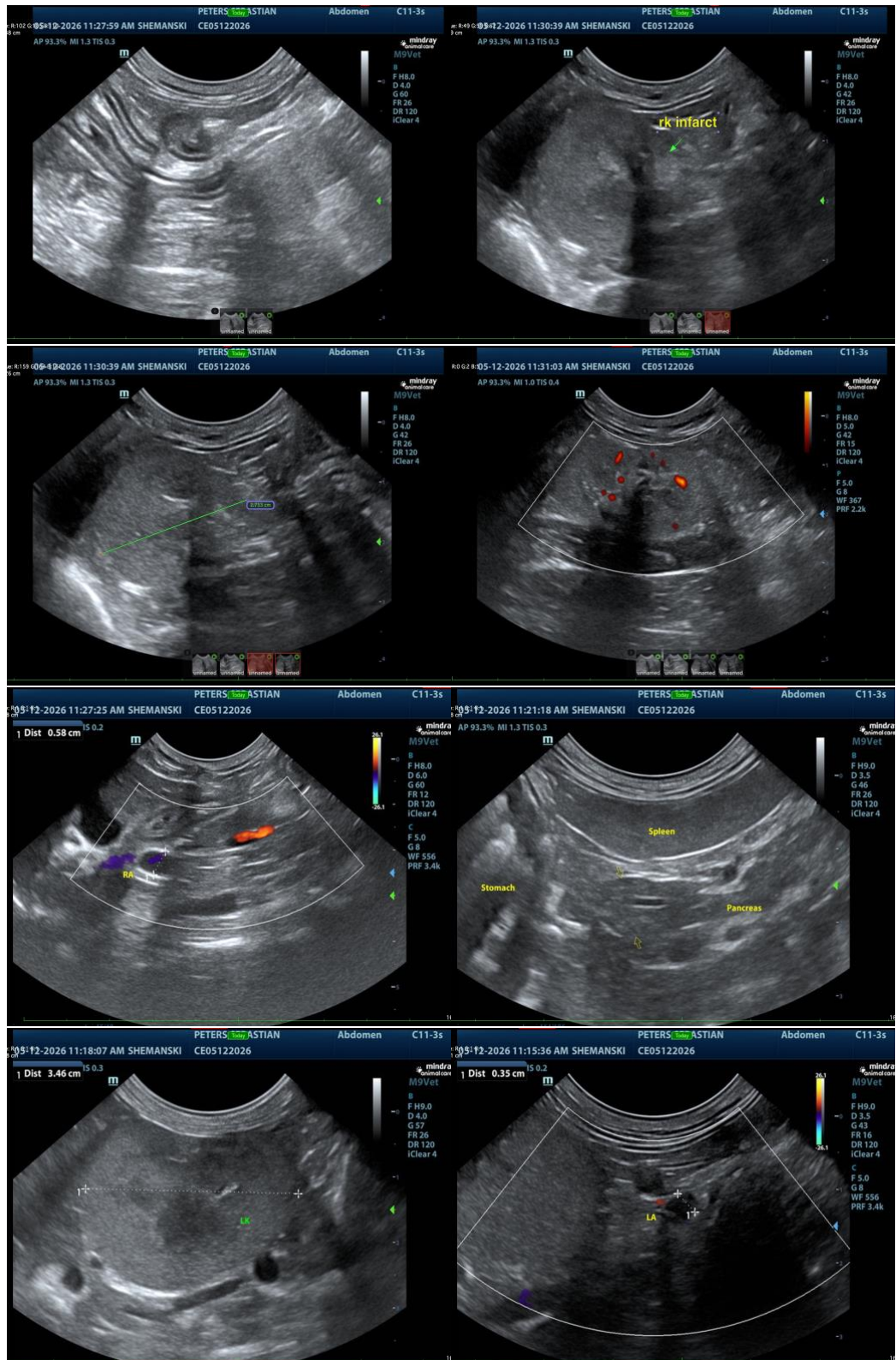
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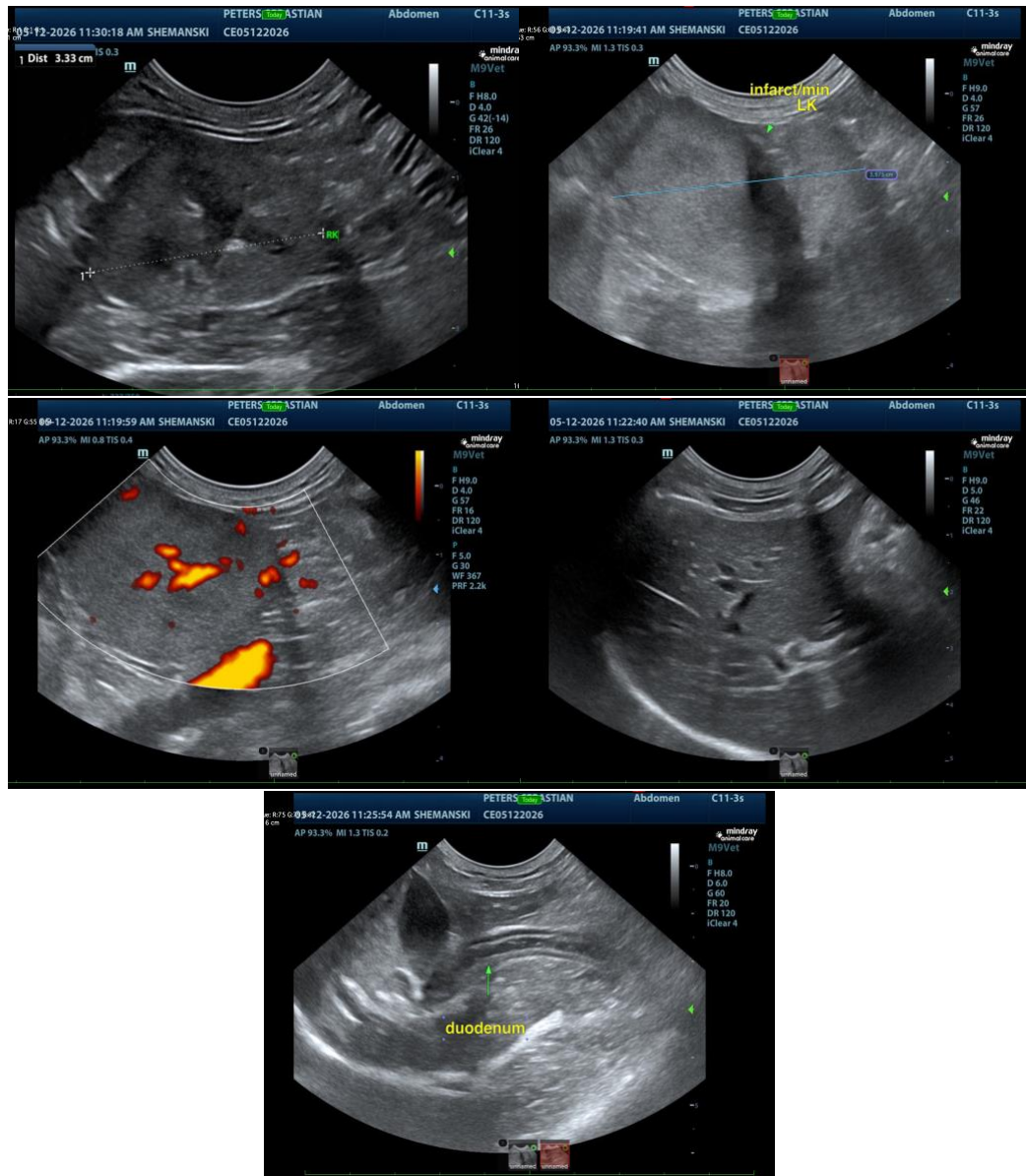
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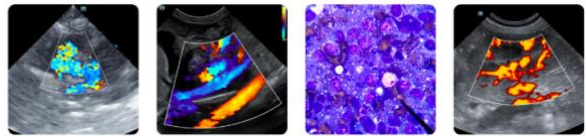
The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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