



## PATIENT

Tito Handyside

## SPECIES

Feline

## BREED

DSH

## SEX

Neutered Male

## AGE

8 Years

## WEIGHT

6.7 kg

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Melissa Randolph

## HOSPITAL NAME

Shores Veterinary  
Emergency Center

## REFERRING VET

Dr. Emily Brydon

## INVOICE

16199

## DATE

05/14/26

## PRESENTING CLINICAL SIGNS

\*P 5/8 started vomiting and anorexia. P seen on 5/11 for the vomiting, nausea, anorexia, and less defecation. Diagnostics done, outpatient treatment; SQ fluids and cerenia injection. P prescribed proviable capsules, amoxi/clav, emeprev, and sucralfate. P recheck 5/13 for continued anorexia (6 days). P drinking small amounts of water. P is still lethargic and hiding. because P isn't eating, it is difficult to medicate him and he is spitting out Emeprev. P at home was being given amoxi/clav and sucralfate; P had not been given proviable due to anorexia. P did urinate at home on 5/13 2 times both small amounts. P has not had a bowel movement in 5 to 6 days. P admitted for supportive care: iv fluids with KCl, emeprev, unasyn, ondansetron, pantoprazole. P started on mirataz transdermal. P did not eat overnight or today. Today 5/14 at 4 pm P noted to be urinary obstructed. P was sedated with propofol to place a Mila urinary catheter with closed collection system.  
\*concern for gastroenteritis, FLUTD, UTI progressed to UO, Persistent anorexia - r/o combination of gastroenteritis +/- antibiotic administration; Elevated CREA, normal BUN (historic) - r/o normal patient variant vs. renal disease vs. other; History of heart murmur

PE 5/13: heart murmur (historical); comfortable pain 0/4; BCS 7/9; soft on abdominal palpation 5/11  
EPOC: pCO2 29.4 (31-51), BE, ECF -5.1 (-5-2), Potassium 3.3 (3.6-5.6), Creatinine 2.05 (0.501,9), Glucose 184 (63-133); Liver Panel: Glucose 175 (70-130); Feline FPL -1.4 ng/mL (normal) Urinalysis: yellow, cloudy, Protein ++/100, pH 6.0, Occult blood ++50 Hemolyzed, USG 1.060, Refractometer USG >1.050, Leukocytes ++/250, Ascorbic Acid 10, WBC <5/HPF, RBCs 6-20/HPF, cocci bacteria seen in the images; Abdominal radiographs - reported as unremarkable 5/13 EPOC: CREA 2.10 - remainder WNL; Liver Panel: GLU 131 - remainder WNL 5/14 EPOC: creat 2.10

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The **urinary bladder**, trigone, and pelvic urethra to a depth of 2.0 cm 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 size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some moderate 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. A slight cortical infarct was noted in the left kidney. The left kidney measured 4.57 cm in length. The right kidney measured 4.5 cm in length.

### 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 0.3 cm width. The right adrenal gland measured 0.4 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



**PATIENT**

Tito Handyside

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.

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Feline

**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 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.

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Neutered Male

**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.

**AGE**

8 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**

6.7 kg

**INTERPRETED BY**

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

**ULTRASONOGRAPHIC FINDINGS**

- Structurally unremarkable abdomen with minor age-related changes.
- Minor left renal infarct.

**IMAGING PERFORMED BY**

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

No evidence of significant disease. Supportive care should prove effective.

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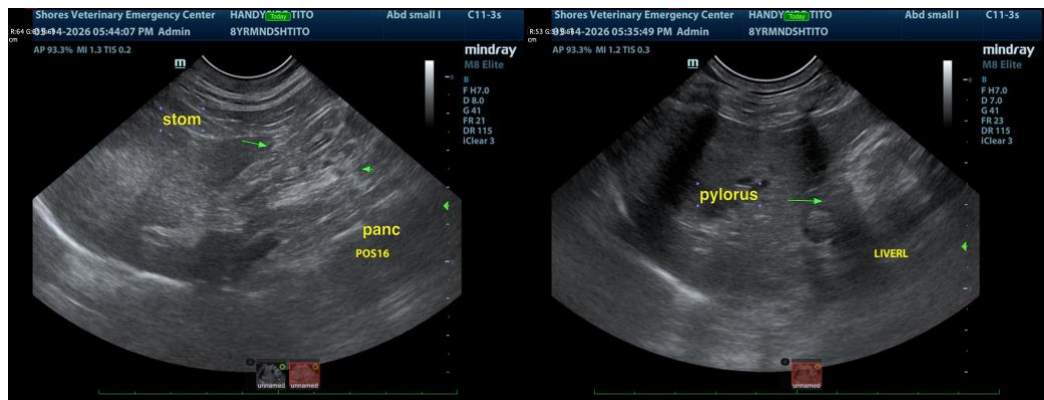
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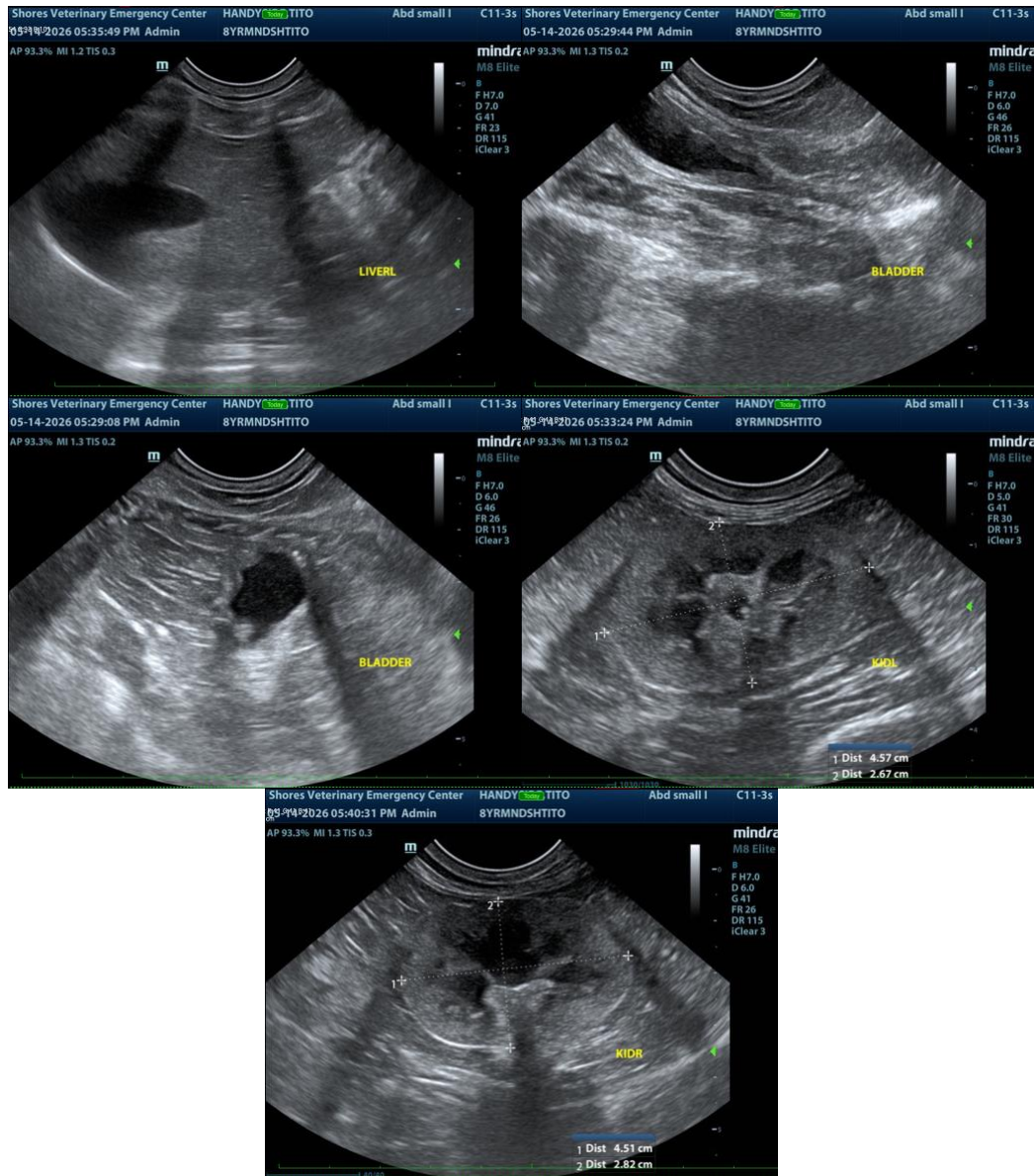
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

[info@SonoPath.com](mailto:info@SonoPath.com)



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