



**PATIENT**

Hudson Iglehart

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Neutered male

**AGE**

9 Years

**WEIGHT**

10.25 lbs

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Dr. Petrone

**HOSPITAL NAME**

Long Branch AH

**REFERRING VET**

Dr. Petrone

**INVOICE**

44126

**DATE**

5/2/23

**PRESENTING CLINICAL SIGNS**

History: Diabetes, IBD - more diarrhea Medications: 3 units Vetsulin BID, Prednisolone 2.5 mg SID, Vitamin B12, Cosequin, Probiotic

**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 was noted. Ureteral papillae were normal.

The **kidneys** presented a relatively uniform cortical hyperechogenicity when compared to the renal medulla, spleen and liver. No overt masses were noted. Corticomedullary definition was nebulous and the ratio favored the cortex slightly. The ureters were not visible and assumed to be normal. These changes are most consistent with chronic interstitial nephritis yet infiltrative disease could not be entirely ruled out without biopsy though neoplasia is not suspected. Hyperechoic medullary rim sign was noted. The left kidney measured 4.17 cm with trace pyelectasia that measured 0.33 cm. The right kidney measured 4.24 cm.

**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** was uniform, but enlarged and measured 1.6 cm.

**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 presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

**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.



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The intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease. 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. The mesenteric lymph node was reactive and measured 0.82 x 0.5 cm.

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***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.

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**ULTRASONOGRAPHIC FINDINGS**

Interstitial nephrosis pattern with medullary rim sign and pyelectasia.

**AGE**

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Splenomegaly.

Otherwise, geriatric abdomen.

**WEIGHT**

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

FNA of the spleen is recommended to assess for reactive state versus round cell neoplasia or less likely splenitis. The Prednisolone may be suppressing a more significant presentation.

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**Potential Causes of Diabetic Dysregulation**

This is a suggestive checkoff list when faced with an unregulated diabetic patient:

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UTI

Dietary indiscretion/intolerance

Pancreatitis

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Hyperthyroidism/hypothyroidism

Exogenous steroids (including topical eye meds)

Cushing's

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Acromegaly

Owner compliance

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Insulin quality issues

Antibodies to insulin

Underlying Neoplasia

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Diffuse liver disease



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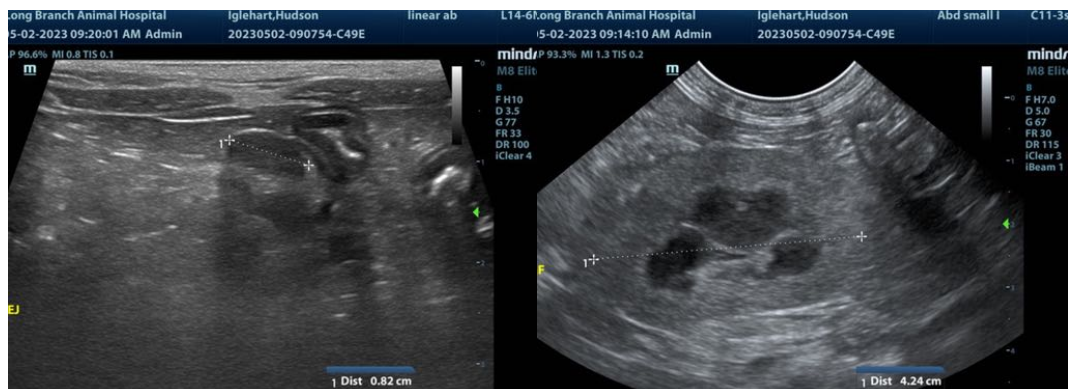
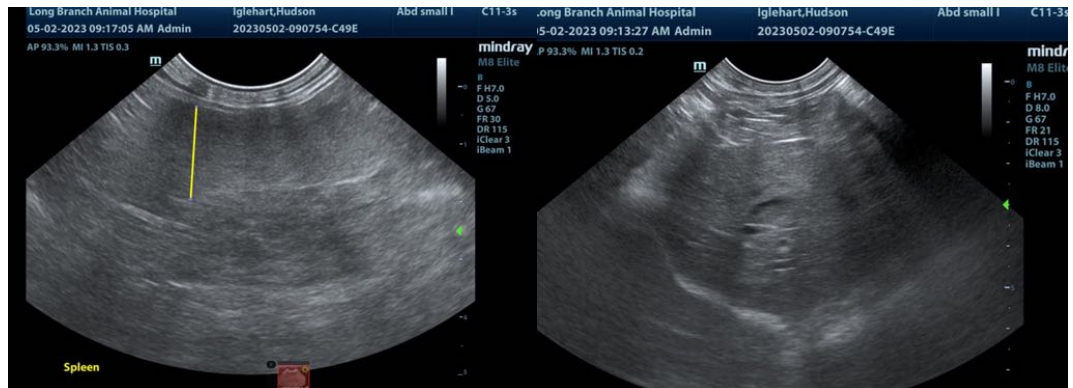
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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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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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**Eric Lindquist**, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com  
info@SonoPath.com

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