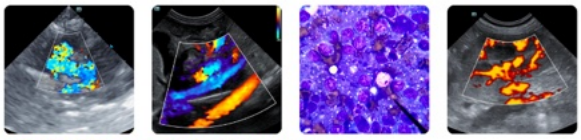


DATE

5/24/26

PATIENT

Heidi Falsetti

SPECIES

Feline

BREED

Domesti Shorthair

SEX

Neutered male

AGE

2017

WEIGHT

4.5 lbs

INTERPRETED BY

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS, CEO of SonoPath.com

HOSPITAL NAME

Mason Dixon Animal Emergency Hospital

REFERRING VET

Dr. Parr

INVOICE

77899

PRESENTING CLINICAL SIGNS

Patient History: Pt has a 2 week hx of pu/pd, weight loss. Was initially dx with DM based on bloodwork. Didn't respond well with initial tx and was seen 1 week ago and dx with suspected pancreatitis. Pt was seen at our ER 5/23 for acute worsening. Dx with renal insufficiency, possible pancreatitis and no overt evidence of diabetes mellitus.
Current Medications: not listed.
Lab Results: not attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: STAT requested.
Imaging Performed by: Rachel Brilhart, RDMS.

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** 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. Pelvic calculus was noted in the left kidney measuring 0.68 cm with trace pyelectasia that measured 0.2 cm. A cortical infarct was noted at the cranial cortex of the left kidney. The left kidney measured 3.86 cm. The right kidney measured 3.77 cm with slight pelvic dilation measuring 0.5 x 1.2 cm. The largest calculus in the right kidney measured 0.68 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. The left and right adrenal gland measured 0.6 cm.

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 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. The muscularis layer was hypertrophied inverting the normal ratio (1:3). The intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic inflammation. No evidence of obstruction was present. Chronic inflammatory bowel disease is probable with a low possibility of an early neoplastic event such as lymphoma or, less likely, dry form FIP can at times be found on biopsy of these presentations. 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 more significant disease than IBD.

Pancreas

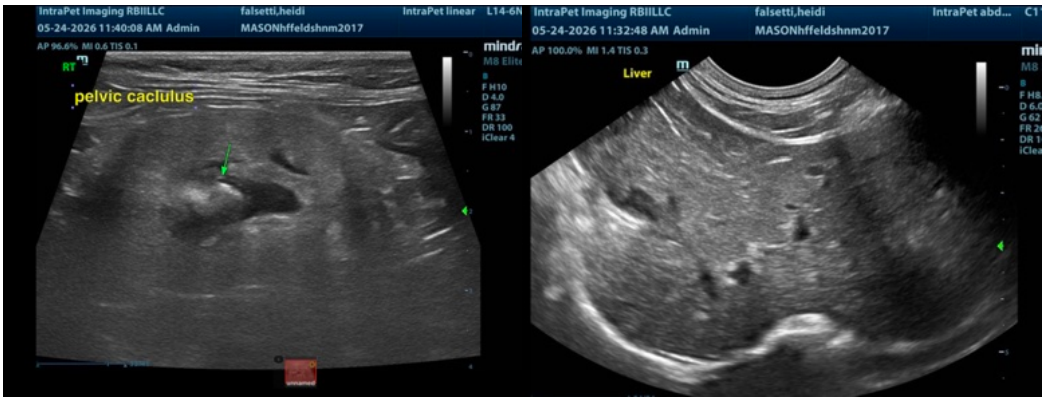
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain 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.

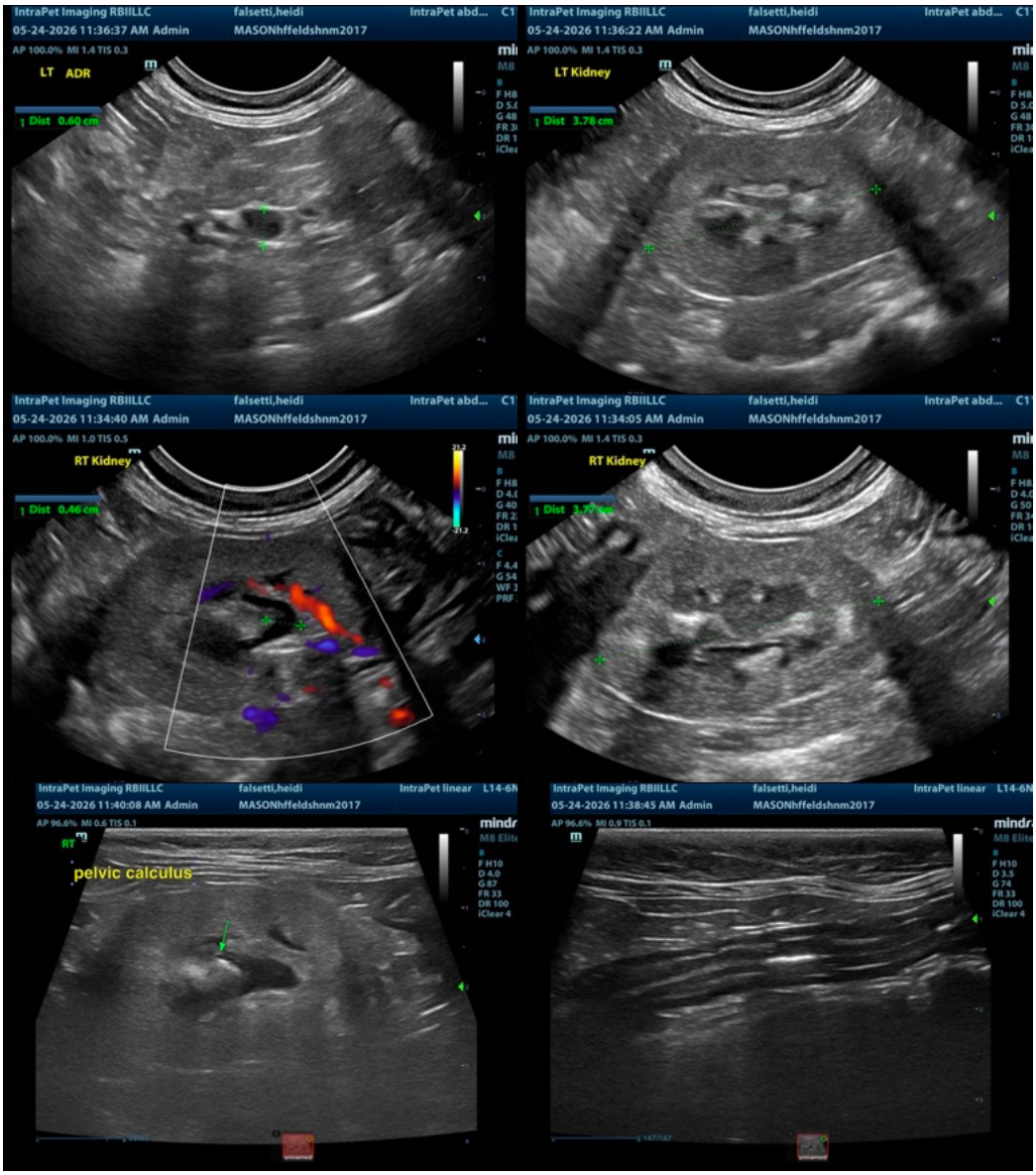
ULTRASONOGRAPHIC FINDINGS

Prominent pancreas, potential low grade pancreatitis.
Mild, diffuse intestinal thickening.
Moderate degenerative renal changes. Nephrolithiasis and pyelectasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Subxiphoid palpation is recommended to assess for pain in the region of the pancreas. There was no overt evidence of neoplasia in this patient. If any cortisone has been utilized in this patient, then this may be suppressing a more significant presentation. Pre-renal and renal disease are likely playing a role in this patient. 72 hour IV fluid protocol, urine culture and blood pressure measurements are indicated. Full urinary work-up and culture are indicated if any inflammatory sediment is present. The patient may be passing calculi periodically, yet no obstructive disease is noted at this time other than minor pelvic dilation in the right kidney.





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 of SonoPath.com
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