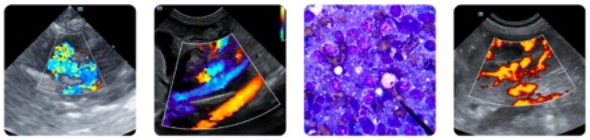

PATIENT

Buster Watts

SPECIES

Feline

BREED

Domestic Longhair

SEX

Neutered male

AGE

7 years

WEIGHT

5 kg

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Harnoor Bhinder

HOSPITAL NAME

Hespeler AH

REFERRING VET

Dr. Bhinder

INVOICE

75212

DATE

5/5/26

PRESENTING CLINICAL SIGNS

History: FIV positive cat, started vomiting in January 2026. Bloodwork normal in Jan 2026. Initial abdominal usg at different DVM noticed steatitis. Mild, generalized small intestinal muscularis thickening, suggesting chronic underlying enteropathy. Started on an allergenic food, cerenia, prednisolone at tapering dose still vomiting frequency reduced , blood work lates normal .now vomiting but now having blood in vomitus

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The pelvic urethra was imaged 1.0 cm beyond the cystourethral junction and appeared normal. 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 normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex. The capsules were acceptably uniform without significant irregularities. Trace pyelectasia of the left kidney was noted. The right kidney measured 4.0 cm. The left kidney measured 4.0 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 adrenal gland measured 0.35 cm. The right adrenal gland measured 0.3 cm.

Spleen

The **spleen** was mildly enlarged with uniform, but subtly micronodular (0.8 cm in width) parenchyma, and undulating capsular contour. This is consistent with reactive spleen owing to immune stimulus or early infiltrative disease such as mast cell disease or lymphoma. 25-gauge FNA would be ideal if weight loss is an issue to differentiate early round cell neoplasia versus splenitis or reactive spleen all of which can present in this manner.

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

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lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

Gastrointestinal

The **stomach** in this patient revealed a concentric gastric mass. The wall thickness measured up to 1.1 cm with loss of structural detail. The concentric mass extended for at least 4.5 cm.

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

Gastric mass with potential splenic involvement. Non-resectable.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ultrasound-guided FNA of the gastric wall mass is indicated for confirmation of underlying round cell neoplasia/lymphoma with adjunctive chemotherapeutic intervention. Granulomatous disease is less likely.

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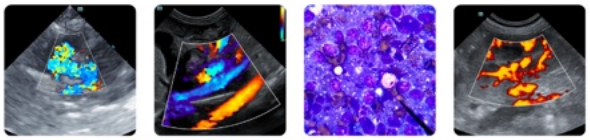

Clinical Sonography & Telecytology
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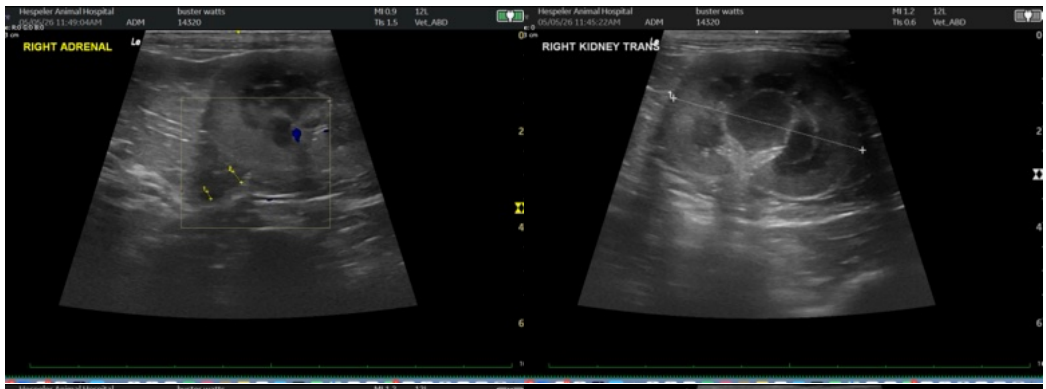
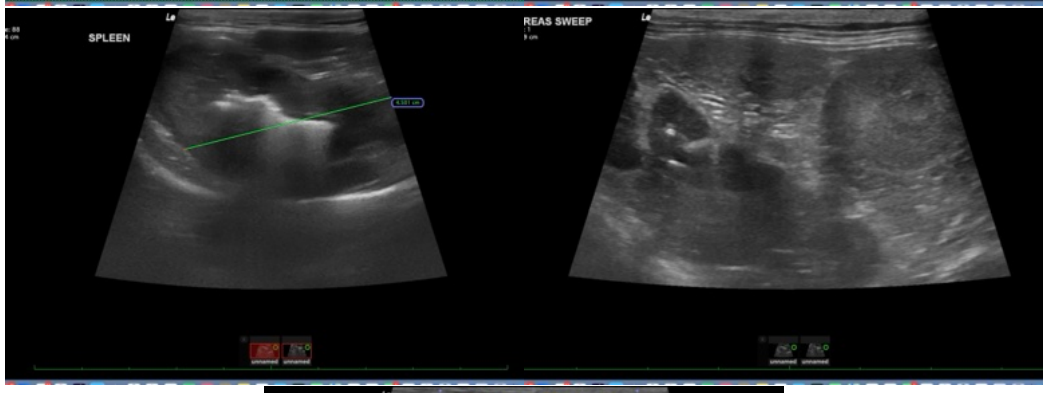
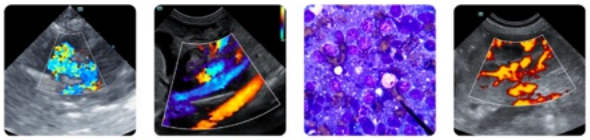




The information and recommendations provided are based on the images presented by the



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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

info@SonoPath.com