



**PATIENT PRESENTING CLINICAL SIGNS**

Pete Lawrence Presented as a diabetic. losing weight, not eating well. History of asthma LEADING DIFFERENTIAL/DIAGNOSIS: Pancreatitis vs gastritis vs other

**SPECIES ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

Feline

**Urinary System**

BREED

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.

DSH

SEX

Neutered Male

The **kidneys** were mildly swollen and slightly enlarged with subcapsular halo on the right kidney and pericapsular inflammation. Potential early expansive infiltrative process. The right kidney measured 4.5 cm. Slight cortical infarct noted in the dorsal cortex of the left kidney with slight pinpoint mineralizations. The left kidney measured 4.08 cm.

AGE

12

**Adrenal Glands**

WEIGHT

5 kg

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 0.40 cm. The right adrenal gland measured 0.47 cm.

INTERPRETED BY

Eric Lindquist, DMV

**Spleen**

DABVP, Cert. IVUSS

The **spleen** was mildly enlarged (1.23 cm) with uniform, but subtly micronodular 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.

IMAGING PERFORMED BY

Kacie Edwards

**Liver**

HOSPITAL NAME

Boren VMTH

The **liver** presented occasional hyperechoic nodule. The gallbladder was unremarkable.

**Gastrointestinal**

REFERRING VET

Dr. Sypniewski

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.

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**Pancreas**

DATE

6/30/23

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 subxyphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

**Other**

Comet tail lung pattern/b-lines noted through the diaphragm. Lung consolidation noted in the caudal thorax.



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Pete Lawrence

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Feline

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**INTERPRETED BY**

Eric Lindquist, DMV

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**IMAGING PERFORMED BY**

Kacie Edwards

**HOSPITAL NAME**

Boren VMTH

**REFERRING VET**

Dr. Sypniewski

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**DATE**

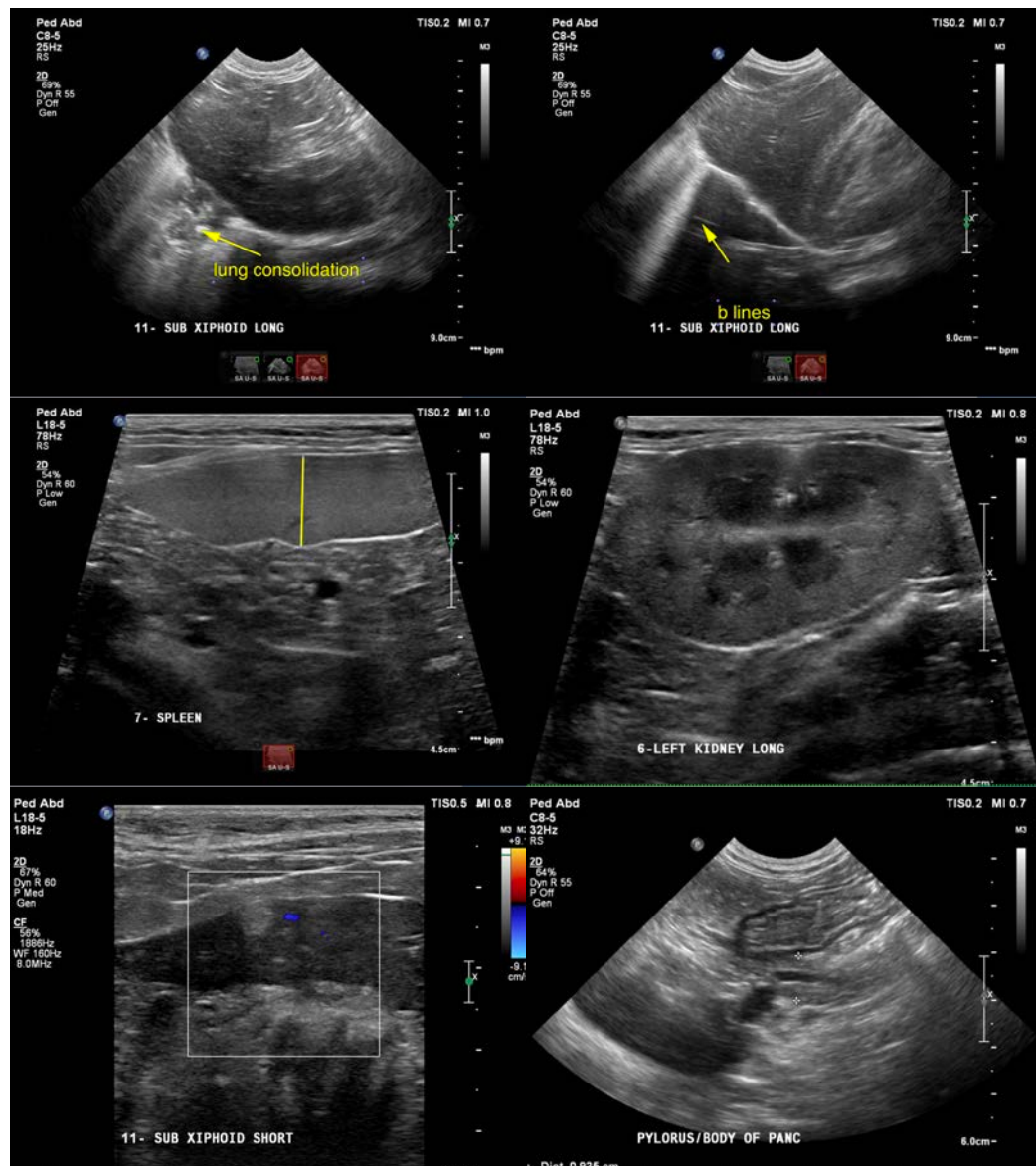
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**ULTRASONOGRAPHIC FINDINGS**

- Swollen kidneys with subcapsular halo and pericapsular inflammation on the right.
- Mildly enlarged, micronodular spleen
- Occasional hyperechoic liver nodule

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The abdomen appears fairly stable, no evidence of neoplasia other than the spleen being slightly enlarged. FNA of the spleen indicated. Full urinary workup warranted to assess for inflammatory sediment. Chest radiographs warranted to assess for alveolar disease that may be playing a role. Given the subcapsular halo, emerging neoplasia of the right kidney may be an issue, such as round cell neoplasia.





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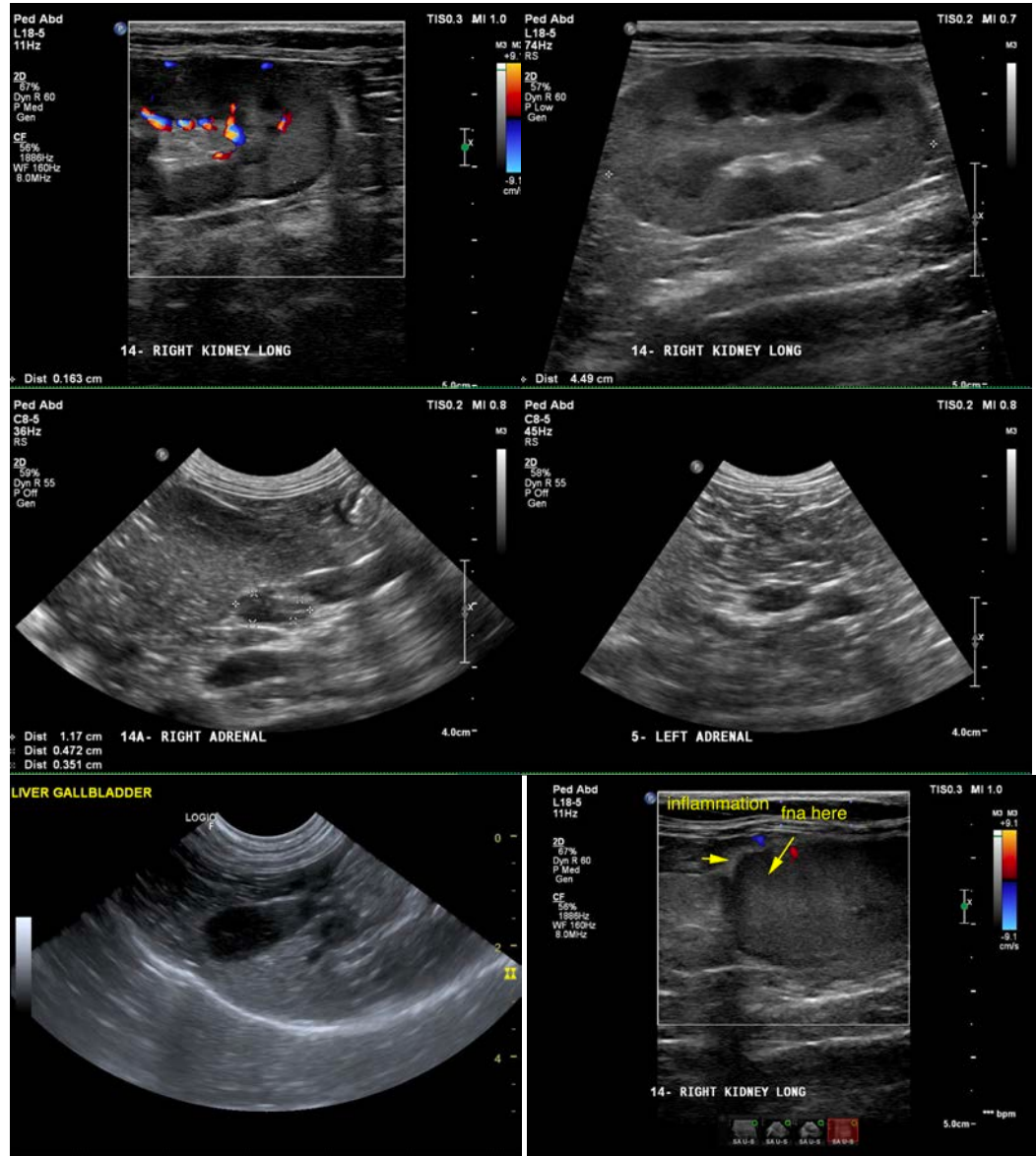
Dr. Sypniewski

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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, Cert. IVUSS, CEO of SonoPath.com

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