



**PATIENT**

Tommy Foster

**SPECIES**

Feline

**BREED**

Tommy

**SEX**

Neutered Male

**AGE**

9 Year

**WEIGHT**

11.5 Pounds

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Marti Williams

**HOSPITAL NAME**

Limestone VH

**REFERRING VET**

Marti Williams

**INVOICE**

16514

**DATE**

7/6/22

**PRESENTING CLINICAL SIGNS**

History: Weight loss without other clinical signs or abnormal lab work. Appetite good. No GI signs

Abnormal PE/Chem/CBC/UA Results: CBC, Chem NSF, T4 1.5, USG 1.052, Protein 2+, RBC >50, UPCR 0.3, FT4 35.5

**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 were noted. Ureteral papillae were normal. The pelvic urethra was imaged 1.0 cm beyond the cystourethral junction.

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 and no evidence of pelvic dilation was present. Slight mineralization was noted. The left kidney measured 4.21 cm. Cortical infarct was noted in the cranial pole of the right kidney. The right kidney measured 4.14 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 right adrenal gland measured 0.5 cm. The left adrenal gland measured 0.37 cm.

**Spleen**

The **spleen** was mildly enlarged 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. The spleen measured 1.1 cm.

**Liver**

A mild amount of remodeling was noted in the **liver**. A benign anechoic cyst (1.0 cm) was noted in the right cranial liver. A complex cystic mass was noted in the left medial liver, consistent with cystadenoma, measuring approximately 2.5 cm. Variable other cysts were also noted. The gallbladder was deviated caudally, yet no evidence of pathology.

**Gastrointestinal**

The **gastrointestinal tract** revealed an infiltrative mass, measuring 3.0 cm x 1.5 cm. The upper gastrointestinal tract was largely unremarkable with the exception of the regional jejunal mass with adjacent lymphadenopathy. This does not appear resectable given the lymph node involvement. Reactive mesentery was also noted.



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**Pancreas**

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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**

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- Polycystic liver with cystadenomas, subjectively benign
- Regional intestinal lymphoma pattern with lymphadenopathy-this is not a surgical presentation
- Splenic enlargement
- Age-related renal changes with mineralization and right kidney cortical infarct

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

FNA of the intestinal mass, lymph nodes and spleen indicated. Immediate chemotherapeutic intervention indicated. Small cell lymphoma is suspected, intermediate or blastic possible. Minor potential for granulomatous disease.

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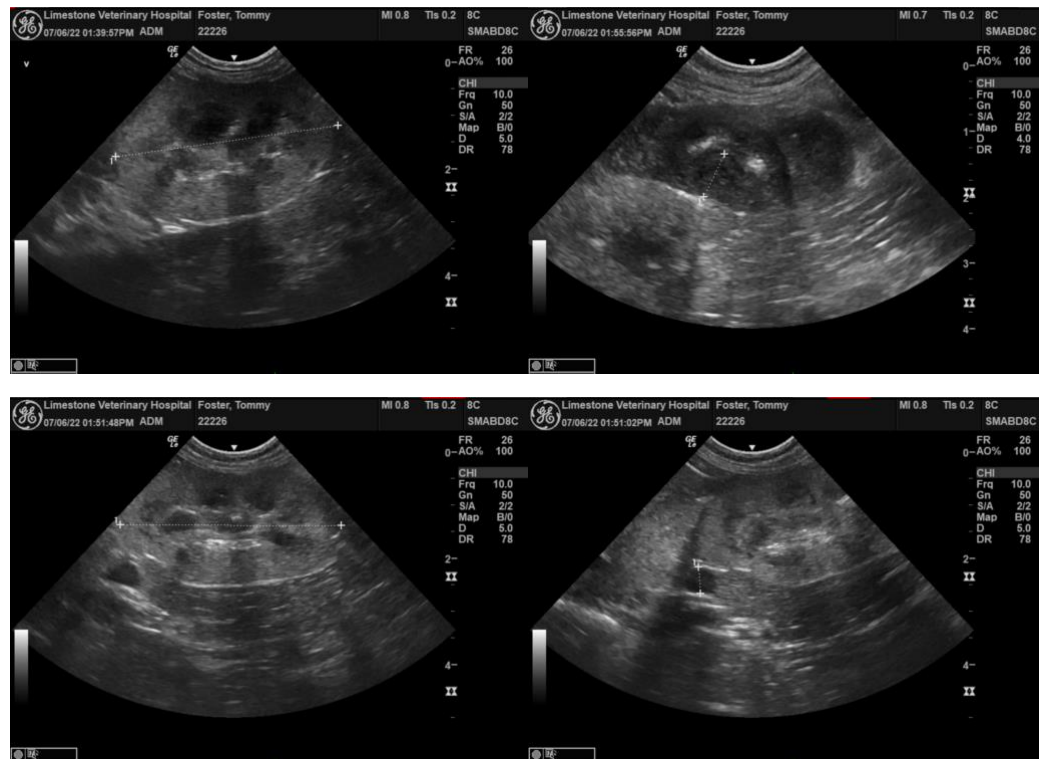
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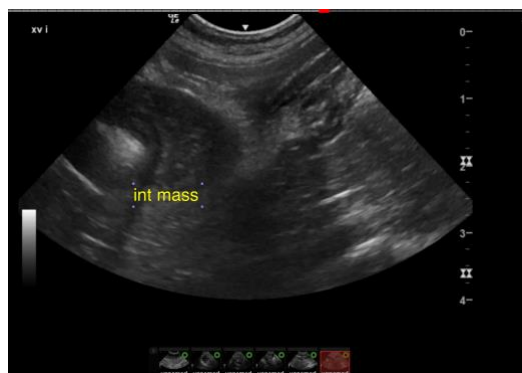
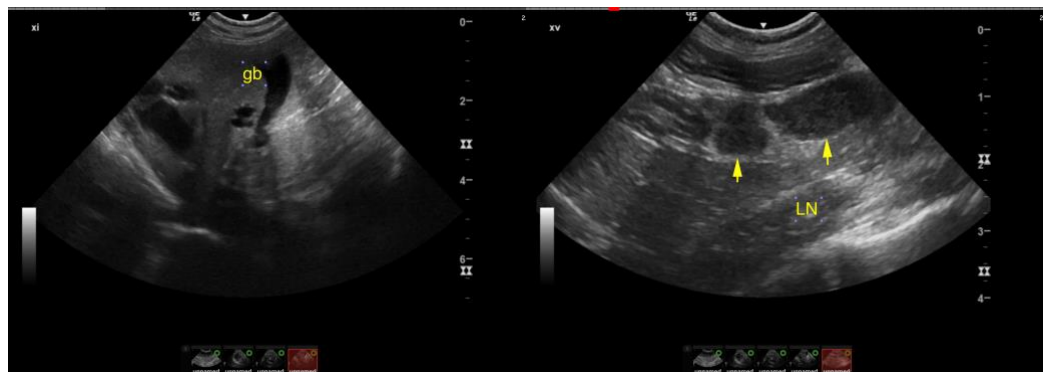
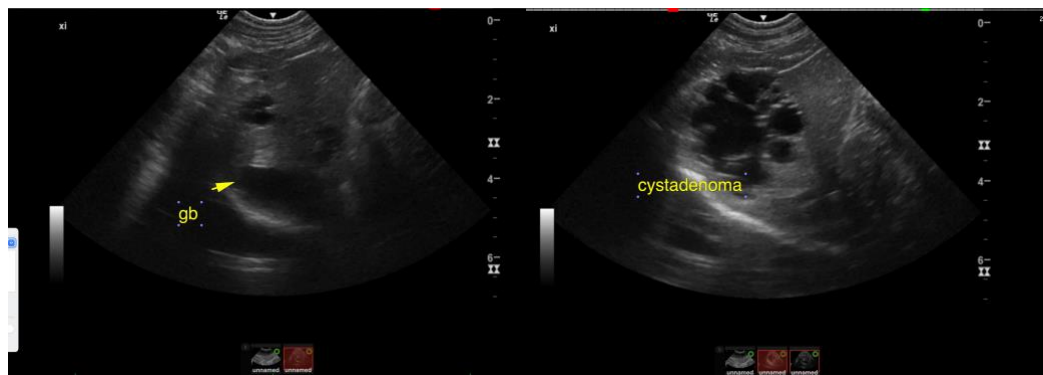
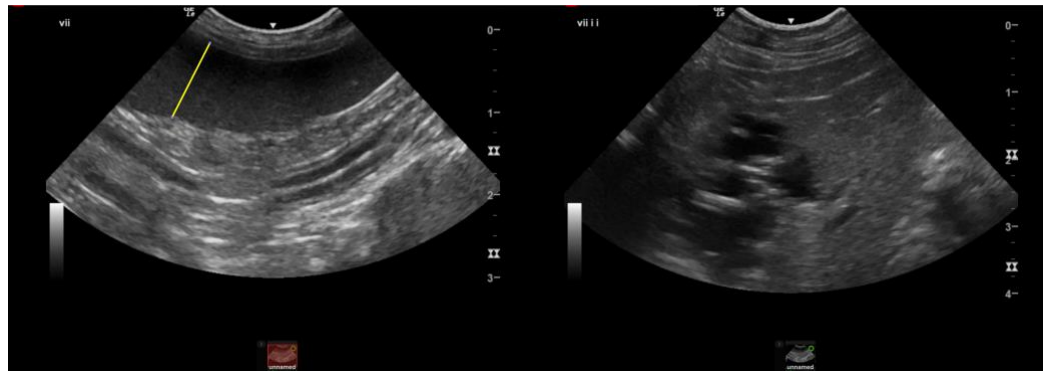
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.



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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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