

**PATIENT**

Sergie Amaral

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Neutered male

**AGE**

15

**WEIGHT**

10.7 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Pamela Harrigan, RDMS

**HOSPITAL NAME**

Norfolk County VS

**REFERRING VET**

Dr. Richards

**INVOICE**

75962

**DATE**

7/6/23

**PRESENTING CLINICAL SIGNS**

History: Grade II/VI heart murmur. Hypertensive, hyperthyroid, uncontrolled. Weight loss, increased vomiting. BP: 195, 201, 216 mmHg. \*Sedated with Torb/Alfaxan for study. \*Having bi-cavity ultrasound exams.

**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 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 and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The right kidney measured 4.14 cm. The left kidney measured 3.6 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 0.36 cm.

**Spleen**

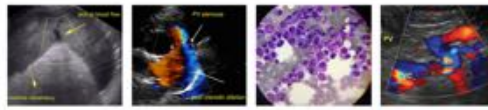
The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

**Liver**

The **liver** revealed minor, heterogenous, hypoechoic nodular changes measuring up to 0.4 cm and was non-disruptive, yet generalized hepatomegaly was noted. A bifid gallbladder was noted. This is a normal variant. Minor hepatic vein dilation was noted.

**Gastrointestinal**

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



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demonstrated normal luminal chyme and stool consistency respectively. There was soft stool noted in the colon. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

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**Pancreas**

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct dilation was noted along with slight tortuosity, yet there was no evidence of active inflammation. No overt evidence of active inflammatory or neoplastic disease was noted.

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**ULTRASONOGRAPHIC FINDINGS**

Subtle hepatic nodules and mild hepatomegaly. Minor passive congestion pattern. Minor pancreatic duct dilation was noted.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Thoracic assessment for cause of the passive congestion is indicated. The cause for weight loss is not evident in the abdomen; however, I cannot rule out an emerging neoplastic event in the liver. However, given the age of the patient the liver presentation is likely benign hyperplasia. The remainder of the abdominal changes are expected for the patient's age.

**WEIGHT**

10.7 lbs

Malnutrition panel, three view chest radiographs and full CNS examination is recommended to examine for occult disease that could be responsible for the weight loss. Evaluation for competitive eating environments should also be considered.

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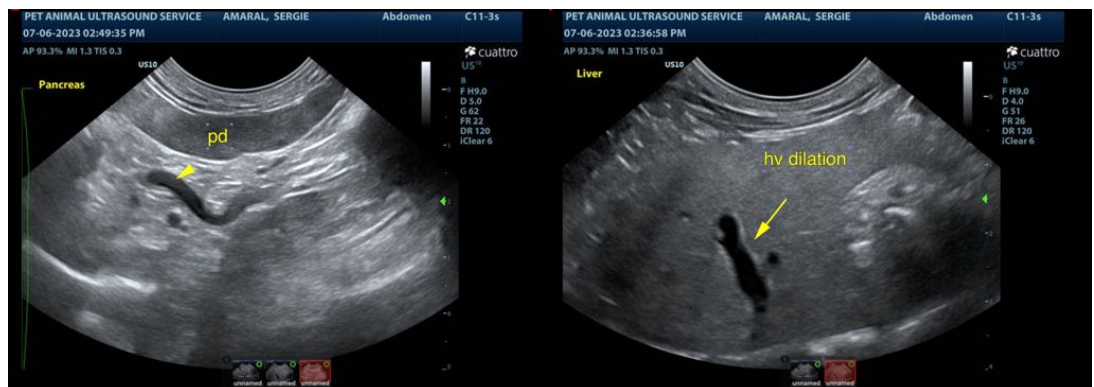
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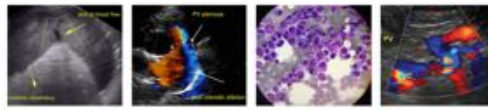
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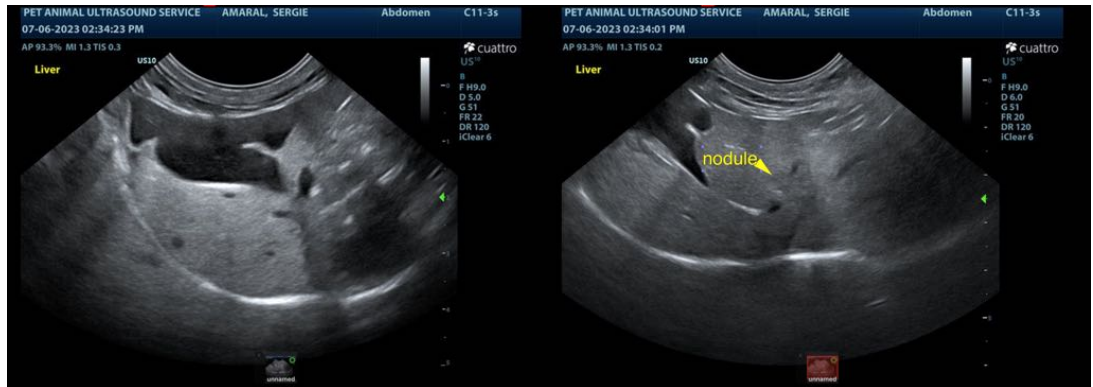
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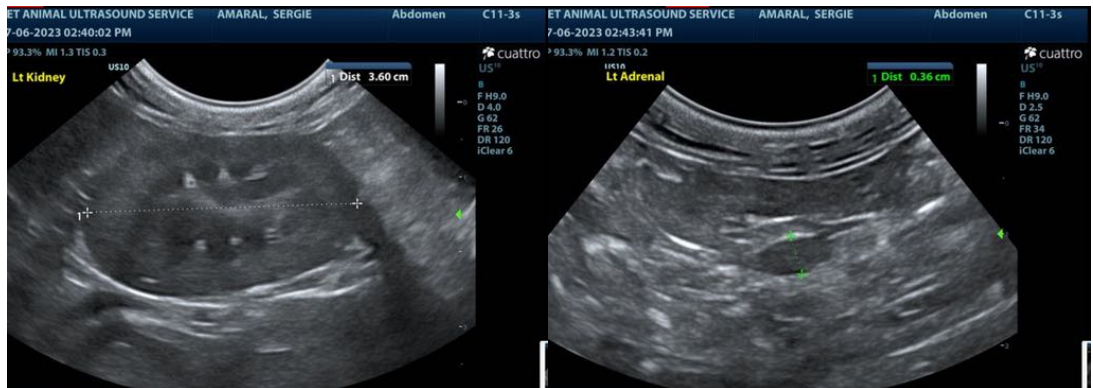
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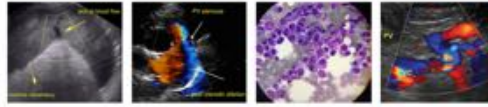
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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