

PATIENT

Hennigan Kitty

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

14 years

WEIGHT

8.3 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Griffin

HOSPITAL NAME

Northside VC

REFERRING VET

Dr. Griffin

INVOICE

91301

DATE

8/17/21

PRESENTING CLINICAL SIGNS

History: ADR, lethargic for 3 days
Abnormal PE/Chem/CBC/UA Results: CBC: WNL FPL: Abnormal SDMA: 17 CHEM: Phos 2.9 mg/dL, Chol 54 mg/dL, NA 166 mmol Rads: Diffuse mineral opacities in lungs, irregular liver margin, subjectively thickened intestines

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 and no evidence of pelvic dilation was present. The kidneys each measured 3.5 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.

Spleen

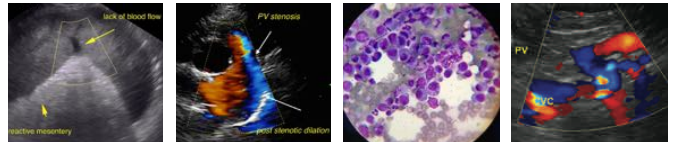
The **spleen** was mildly enlarged, uniform and hypoechoic measuring 1.26 cm with enhanced surrounding mesentery and scalloping contour. Micronodular changes were present.

Liver

The **liver** was coarse in architecture and was mildly swollen. Mildly increased portal markings were noted. The gallbladder and common bile duct were unremarkable. Pleural effusion was noted through the diaphragm.

Gastrointestinal

The **gastrointestinal** presentation revealed mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall with slight disruption of the normal 1:3 muscularis/mucosal ratio. The intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease. No concerning lymphadenopathy was visible. No evidence of obstruction was present. Chronic inflammatory bowel disease is likely with a low possibility of an early neoplastic event such as



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lymphoma. 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 out this possibility.

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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.

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ULTRASONOGRAPHIC FINDINGS

Mild, diffuse intestinal thickening.

AGE

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Age related renal changes.

Splenic enlargement.

Minor, heterogenous hepatic changes.

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Pleural effusion.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

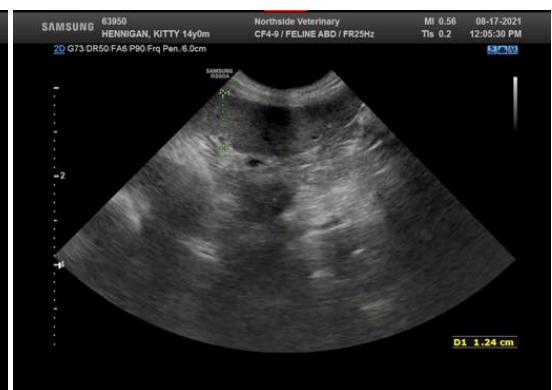
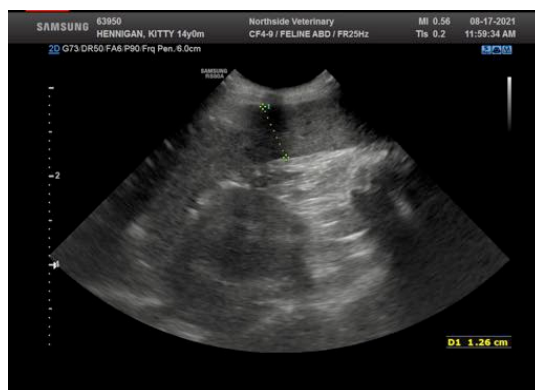
An echocardiogram is warranted to assess for cardiogenic versus non-cardiogenic causes of pleural effusion. I am concerned for emerging round cell neoplasia versus reactive spleen. Guarded prognosis depending on cytology results. There is a potential for low-grade pancreatitis, yet the changes are minor.

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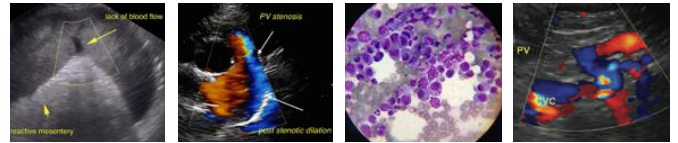
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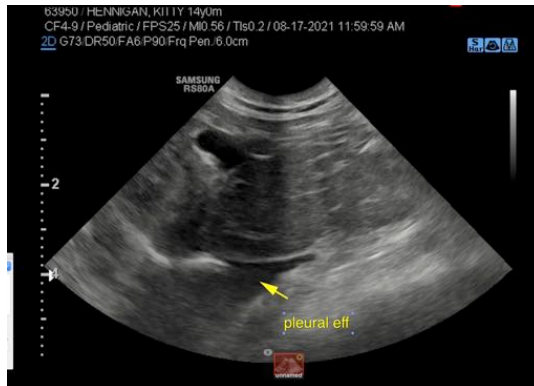
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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