

PATIENT

Niles Delollis

SPECIES

Feline

BREED

Domestic Medium Hair

SEX

Neutered male

AGE

14 years

WEIGHT

7.75 lbs

INTERPRETED BY

Eric Lindquist, DMV,
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

Ark AH

REFERRING VET

Dr. Parker

DATE

12/2/21

Invoice
94291

PRESENTING CLINICAL SIGNS

History: Weight loss and "picky eating" x 1 year. 3# weight loss over past year. No significant GI changes on PE. Note: P did need gabapentin to obtain blood sampling this year. Mild anemia 12/2020, rest of CBC/chem/T4 WNL. RBCs low normal 12/2021 but PrecisionPSL slightly elevated. Rest of CBC/chem WNL. UA - mild proteinuria, rest WNL. Radiographic Findings 12/2020 Abdominal rads indicated multiple non-specific/potential GI abnormalities

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 **left kidney** revealed a renal symphysis of two separate kidneys together with a combined measurement of 5.0 cm on the left. There were mild to moderate degenerative changes. Pinpoint mineralization was noted. The right kidney was not visualized. However, the left kidney appeared to be occupied by a symphysis.

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 0.37 cm. The right adrenal gland measured 0.32 cm.

Spleen

The **spleen** revealed slight irregular contour with an isoechoic nodule of 0.5 cm. Minor capsular expansion was noted. This may be positional irregularity and not necessarily pathological.

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



PATIENT *Gastrointestinal*

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Pancreas

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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. The colonic wall was thickened in this patient with loss of mural detail and measured up to 1.0 cm in wall thickness. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

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.

AGE

ULTRASONOGRAPHIC FINDINGS

Left renal symphysis.

No kidney in the right renal fossa.

Colonic thickening, suspect colonic neoplasia such as lymphoma, mast cell disease or carcinoma. There is a potential of chronic colitis.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

FNA of the colonic wall can be considered. The renal symphysis is a congenital issue that the patient has been living with its entire life and now has moderate degenerative changes. Colonic wall sampling through endoscopy or ultrasound-guided FNA would be appropriate.

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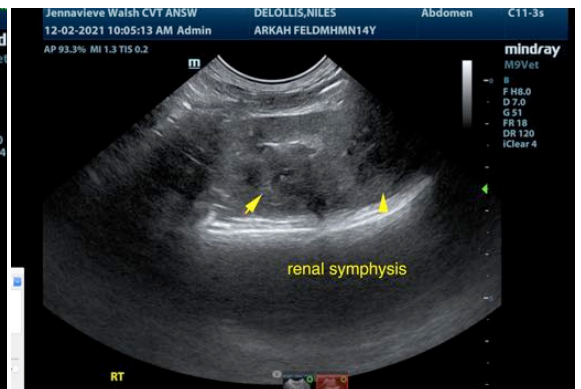
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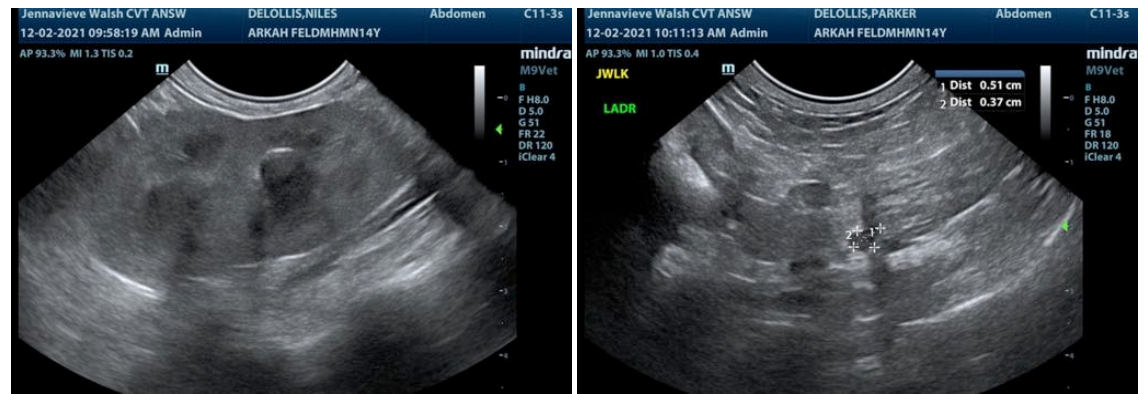
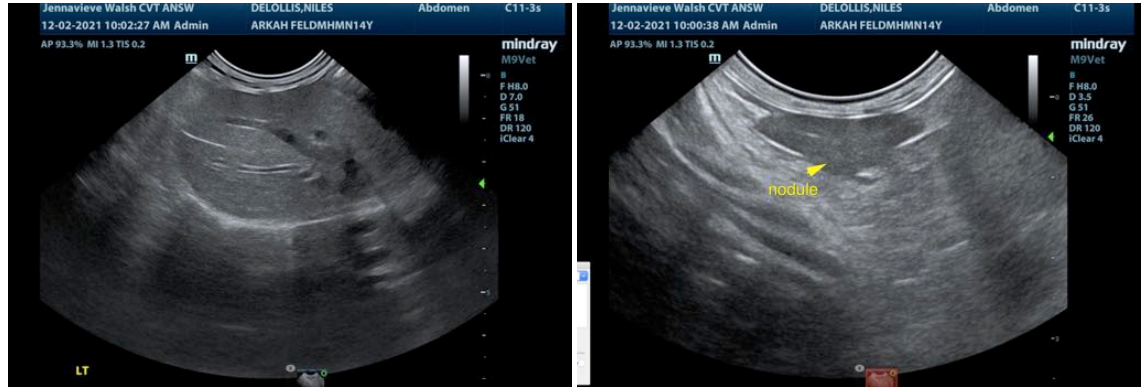
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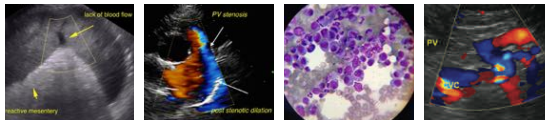


The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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Eric.Lindquist@SonoPath.com

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