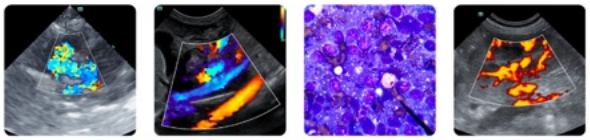


PATIENT

Echo Humphrey LeClair

SPECIES

Feline

BREED

Snowshoe

SEX

Neutered male

AGE

10 years

WEIGHT

6.5 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Warner

HOSPITAL NAME

VT NH Vet Clinic

REFERRING VET

Dr. Torzewski

INVOICE

70068

DATE

1/13/26

PRESENTING CLINICAL SIGNS

History: Echo presented for ultrasound due to bloodwork abnormalities noted on senior wellness bloodwork. No c/s/v/d reported, owner reported no concerns at that point (12/29/25). Pet is blind (myrdriasis OU). Severe dental disease present. Wt 7lbs that day. Echo has a history of triaditis, URI, and last year had several bloodwork abnormalities.
Abnormal PE/Chem/CBC/UA Results: 12/2024 leukocytosis/neutrophilia/Cr 1.5/hypoK 3.1/HyperGLOB 5.6 12/30/25 WBC 33.9K/uL (high 19), PMN 28.646 K/uL (high 15.17), monocytes 1.254 (high 0.467), ALT 618 (high 158), AST 263 (high 67), ALP 190 (high 59), GGT 7 (6 high)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the urinary bladder wall appears thin and smooth. The urine is predominantly anechoic with a small amount of suspended echogenic material. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no sonographic evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 3.59×1.98 cm, with a cortical thickness of 0.35 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.74×1.87 cm; cortical thickness could not be reliably measured in the provided sagittal images. In both kidneys, the renal cortex is increased in echogenicity, resulting in increased corticomedullary distinction. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified.

Adrenal Glands

The adrenal glands are not visualized.

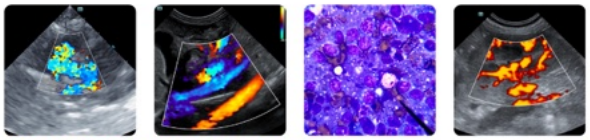
Spleen

Splenic thickness measures approximately 0.46 cm. The splenic parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size. The hepatic parenchyma appears homogeneous and isoechoic relative to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

A markedly enlarged gallbladder is identified, extending beyond the hepatic margins and displacing adjacent structures, including portions of the intestinal tract and the right kidney. The gallbladder lumen contains mixed anechoic fluid and aggregated echogenic material consistent with biliary sludge. The gallbladder wall is markedly thickened, measuring approximately 4 mm.



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The common bile duct is severely dilated along its visible course (6-9 mm). The distal portion of the common bile duct and its insertion into the duodenum cannot be followed due to mass effect and compression of adjacent structures. The duodenum is not visualized.

Gastrointestinal

The stomach is empty and folded, with a mural thickness of approximately 2.11 mm and preserved wall layering.

The duodenum is not visualized. Jejunal wall thickness measures approximately 2.68–2.76 mm, with mildly indistinct wall layering; measurements of individual layers are approximate due to partial loss of clear stratification. The ileal wall measures approximately 2.04 mm, with preserved wall layering.

All visualized intestinal segments are mildly fluid-filled and mildly dilated, with subjectively reduced peristalsis. The ileocecal junction is not visualized. The colonic wall measures approximately 0.69 mm, with formed fecal material present in the descending colon.

Pancreas

The pancreas is not visualized in this study due to acoustic artifact and mass effect from the markedly distended gallbladder.

Peritoneal Cavity

A small volume of anechoic abdominal effusion is identified within the rectovesical recess. Cranial mesenteric and ileocecal lymph nodes are not visualized; the surrounding regions appear unremarkable. The iliac trifurcation appears normal.

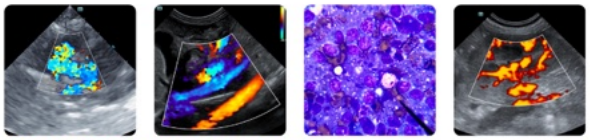
ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Severe gallbladder distension with mixed anechoic and echogenic contents consistent with biliary sludge.
- Marked gallbladder wall thickening (approximately 4 mm).
- Severe dilation of the common bile duct, consistent with biliary obstruction.
- Mild generalized small intestinal fluid distension with mildly decreased peristalsis.
- Small volume abdominal effusion within the rectovesical recess.

SECONDARY FINDINGS

- Increased renal cortical echogenicity bilaterally (likely chronic/incidental).



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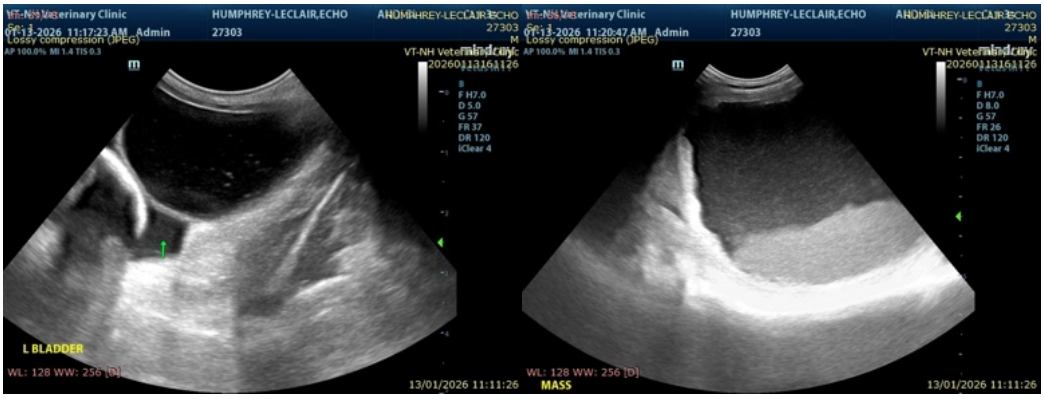
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominal ultrasonography reveals severe extrahepatic biliary obstruction characterized by marked gallbladder distension, significant gallbladder wall thickening, and severe dilation of the common bile duct. These findings are most consistent with severe extrahepatic biliary obstruction associated with marked inflammatory change. Given the patient's history of triaditis, marked leukocytosis with neutrophilia and monocytosis, and severe hepatobiliary enzyme elevations, an inflammatory etiology (such as cholecystitis and/or cholangitis with secondary biliary obstruction) is considered most likely. The degree of gallbladder wall thickening, biliary ductal dilation, and surrounding mass effect supports a severe inflammatory process. However, neoplastic obstruction cannot be entirely excluded, even in the absence of a discrete obstructing mass or regional lymphadenopathy.

The small intestinal loops subjectively appear diffusely thickened and mildly edematous on transverse imaging, consistent with generalized enteritis. In the context of severe hepatobiliary inflammation and a history of triaditis, these findings support concurrent inflammatory gastrointestinal involvement. While no specific ultrasonographic features of protein-losing enteropathy are identified, diffuse intestinal inflammation may contribute to systemic illness and should be considered in the overall clinical assessment.

Recommendations

- Sampling of the free abdominal fluid for cytologic evaluation and biochemical analysis (including comparison of fluid and serum bilirubin concentrations) is recommended to further characterize the effusion and exclude bile peritonitis.
- Hospitalization and supportive care (IV fluids, analgesia, antiemetics) are recommended. Broad-spectrum antimicrobial therapy should be considered.
- Surgical consultation is recommended to assess the need for biliary decompression or cholecystectomy.



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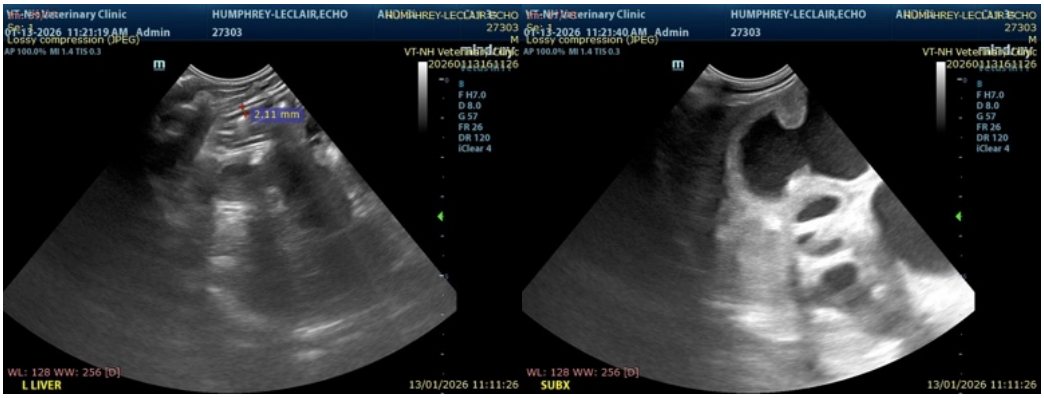

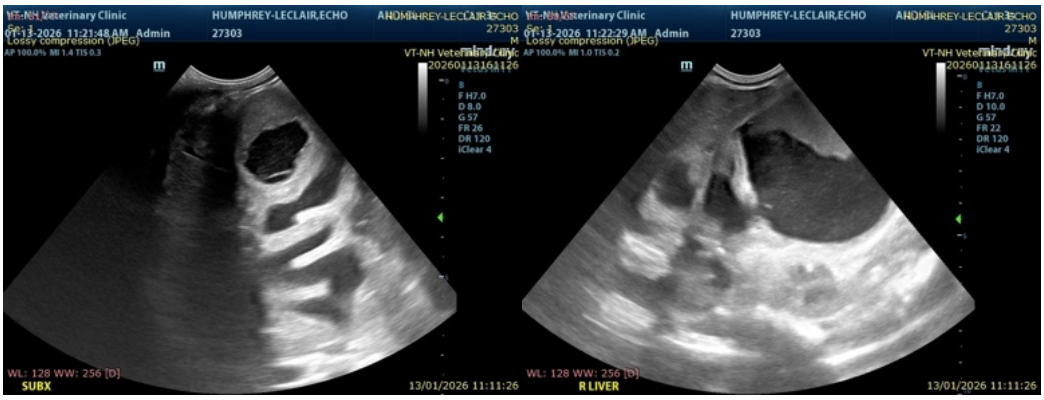

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

info@SonoPath.com