



PATIENT

Trickster C2770
Animals in Distress

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

11 years

WEIGHT

19 lbs

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Renee Ziegler Post

HOSPITAL NAME

For Cats Only VC

REFERRING VET

Dr. Ziegler Post

INVOICE

71087

DATE

1/29/26

PRESENTING CLINICAL SIGNS

- Fever of 106.4, lethargy, not eating
- Elevated WBC

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended. The urinary bladder wall is thin and smooth. The urine is markedly turbid, containing abundant suspended echogenic sediment. The bladder neck and proximal urethra have a normal appearance. No uroliths are identified, and there is no ultrasonographic evidence of mural inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 4.35×2.99 cm, with a cortical thickness of 0.48 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. No pyelectasia, nephroliths, or hydronephrosis are identified. Doppler evaluation demonstrates a normal perfusion pattern.

The right kidney is normal in shape and size, measuring 4.88×3.02 cm, with a cortical thickness of 0.50 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. No pyelectasia, nephroliths, or hydronephrosis are identified. Doppler evaluation demonstrates a normal perfusion pattern.

Adrenal Glands

Not visualized.

Spleen

Splenic thickness measures 0.63 cm. The splenic parenchyma has 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, with sharp margins and a regular contour. Hepatic parenchyma is homogeneous and isoechoic relative to falciform fat, with a normal echotexture. No hepatic lymphadenopathy is identified.

The gallbladder lumen is normally distended. The gallbladder wall is thin. The contents consist of a moderate to marked amount of organized biliary sludge. No dilation of the cystic duct or common bile duct is identified.



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Gastrointestinal

The stomach is semi-empty and contains small amounts of ingesta. Gastric wall thickness measures 2.19 mm, with preserved wall layering. The pylorus measures 2.88 mm.

Duodenal wall thickness measures 2.14 mm. Jejunal wall thickness ranges from 1.91–2.07 mm. Ileal wall thickness measures 1.09 mm. The ileocecal junction measures 2.32 mm, with a muscularis thickness of 0.57 mm. Wall layering is preserved throughout. No ultrasonographic evidence of mural inflammation, ileus, or foreign material is identified.

The colonic wall measures 0.66 mm, with formed fecal material present within the descending colon.

Pancreas

The evaluated portions of the pancreas do not show ultrasonographic evidence of overt inflammation.

Peritoneal Cavity

No abdominal effusion or ultrasonographic evidence of peritonitis is observed. Cranial mesenteric and ileocecal lymph nodes are not visualized, and the surrounding regions appear unremarkable. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

- Markedly turbid urine with abundant suspended sediment
- Moderate amount of organized biliary sludge.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Markedly turbid urine with abundant suspended sediment is noted and may represent crystalluria, inflammatory debris, or bacteriuria. While no ultrasonographic evidence of cystitis is identified, this finding warrants correlation with urinalysis and urine culture, particularly in the context of systemic illness and leukocytosis, as urinary tract infection cannot be excluded based on ultrasonography alone.

The remaining abdominal organs, including the liver, spleen, kidneys, gastrointestinal tract, pancreas, and adrenal glands, appear structurally unremarkable, with preserved architecture and no evidence of focal inflammatory, infectious, or neoplastic disease. The absence of abdominal effusion, lymphadenopathy, or organ enlargement argues against peritonitis, overt abdominal abscessation, or advanced intra-abdominal neoplasia at this time. The presence of organized biliary sludge may be favored by reduced food intake and biliary stasis and is considered incidental in this clinical context.

Overall, the lack of significant abdominal ultrasonographic abnormalities suggests that the patient's severe fever and leukocytosis are more likely related to an extra-abdominal infectious, inflammatory, or immune-mediated process, or to early-stage disease not yet associated with overt structural change.



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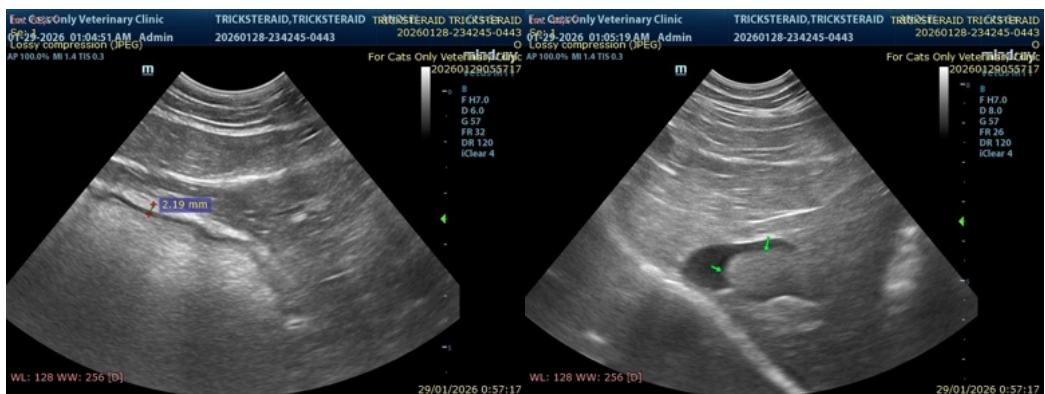
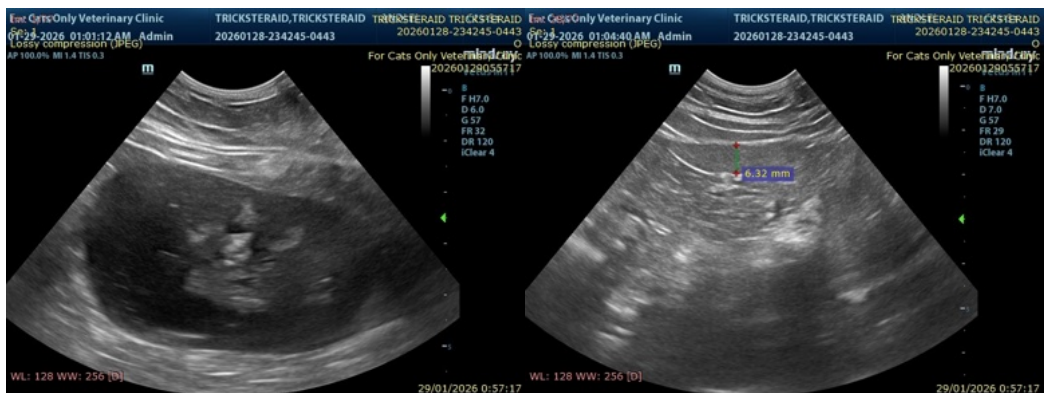
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Recommendations

- Complete urinalysis and urine culture: Strongly recommended to further evaluate the markedly turbid urine and exclude urinary tract infection as a potential contributor to systemic illness.
- Given the largely unremarkable abdominal ultrasound, further diagnostic workup should prioritize extra-abdominal causes if the urinary infection is ruled out.
- Ongoing monitoring of temperature, hydration status, and clinical response to therapy is essential. Repeat imaging may be considered if clinical status deteriorates or new signs localize to the abdomen.





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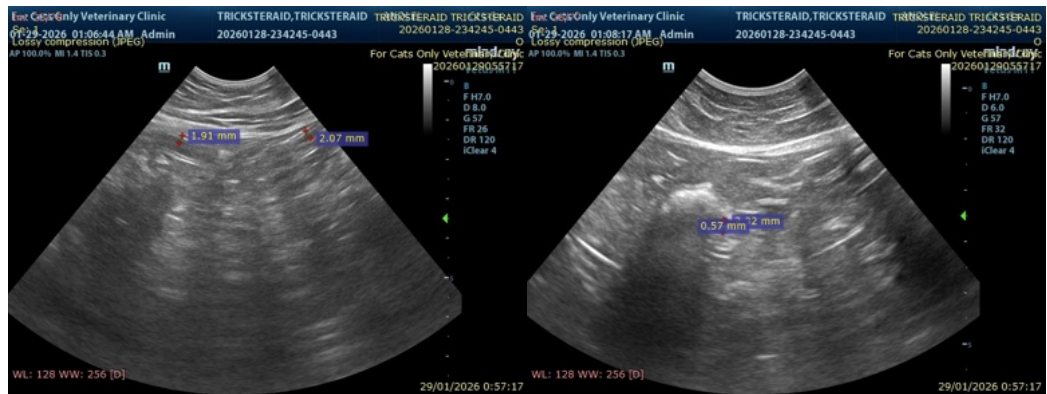
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

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