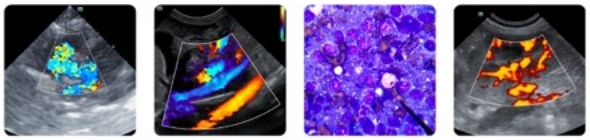


PATIENT

Tigger McDonald

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

9 years

WEIGHT

11.6 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Sreenivasa Maddineni

HOSPITAL NAME

West Babylon AH

REFERRING VET

Dr. Sreenivasa Maddineni

INVOICE

69828

DATE

1/5/26

PRESENTING CLINICAL SIGNS

History: Owner reports that patient has been lethargic, not wanting to eat, and vomited after drinking some water. Elevated liver enzymes, bloodwork attached.
Abnormal PE/Chem/CBC/UA Results: Blood work attached.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall appears thin and smooth. The urine is anechoic. The bladder neck and proximal urethra have a normal appearance. There is no evidence of urolithiasis, inflammatory changes, or neoplasia.

The left kidney is decreased in size (2.59×1.51 cm), with a cortical thickness of 0.34 cm (sagittal plane). Mild pyelectasia is present (renal pelvis measuring up to 1.13 mm). No nephroliths or hydronephrosis are identified.

The right kidney is normal in size and shape (4.27×2.63 cm), with a cortical thickness of 0.32 cm. The renal cortex is mildly increased in echogenicity with increased corticomedullary distinction. A medullary rim sign is present.

Adrenal Glands

Both adrenal glands are normal in shape and echogenicity. Left adrenal gland: 0.31 cm (cranial pole) and 0.30 cm (caudal pole). Right adrenal gland: 0.25 cm (cranial pole) and 0.26 cm (caudal pole).

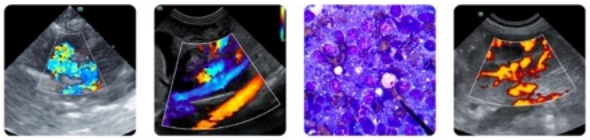
Spleen

Splenic thickness is 0.77 cm. The parenchyma is homogeneous with normal echogenicity. No focal splenic lesions are identified. The splenic capsule is smooth and regular.

Liver

The liver is subjectively enlarged, with rounded margins and a regular contour. The hepatic parenchyma is homogeneous and isoechoic relative to the falciform fat. No discrete hepatic masses are identified. No periportal lymphadenopathy is observed.

The gallbladder is markedly distended. The gallbladder wall is thickened (approximately 1.6–2.0 mm), as is the wall of the common bile duct. There is severe dilation of the cystic duct and common bile duct, measuring up to approximately 0.8–0.9 cm in diameter. Within the distal third of the common bile duct, there is a large intraluminal structure of intermediate, relatively homogeneous echogenicity measuring approximately 1.8×2.0 cm. Early dilation of intrahepatic bile ducts is also observed.



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Gastrointestinal

The stomach is distended with ingesta. Gastric wall thickness is within normal limits (1.48 mm) with preserved layering. The pylorus measures 2.10 mm.

Duodenum: 1.59 mm, jejunum: 1.90–2.58 mm, Ileum: 1.37 mm. Wall layering is preserved throughout the visualized small intestine. The ileocecal junction was not visualized. No evidence of obstruction, ileus, or foreign material is identified.

Colon wall thickness is 0.46 mm, with formed feces in the descending colon.

Pancreas

The pancreas measures approximately 7.04 mm (right limb) and 7.22 mm (left limb). Pancreatic parenchyma is mildly hypoechoic relative to adjacent omental fat. The pancreatic duct is mildly dilated (1.62–1.67 mm). No focal pancreatic masses or peripancreatic fluid are identified.

Peritoneal Cavity

No abdominal effusion or peritonitis is observed. Cranial mesenteric and ileocecal lymph nodes are not visualized; the surrounding mesentery appears unremarkable. The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

- Subjective hepatomegaly consistent with cholestasis.
- Severe dilation of the gallbladder, cystic duct, and common bile duct. Thickening of gallbladder and bile duct walls
- Large intraluminal structure within the distal common bile duct.
- Early intrahepatic bile duct dilation.
- Mild pancreatic duct dilation with subtle parenchymal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver appears subjectively enlarged with rounded margins; however, the hepatic parenchyma remains homogeneous, and no focal infiltrative or mass lesions are identified. The marked elevation in ALT reflects significant hepatocellular injury, which is expected in the setting of biliary obstruction due to bile acid–mediated hepatocyte damage and secondary inflammation.

There is marked dilation of the gallbladder, cystic duct, and common bile duct, with early dilation of intrahepatic bile ducts, indicating mechanical impairment of biliary outflow. Diffuse thickening of the gallbladder and common bile duct walls further supports an inflammatory component to the biliary disease, consistent with cholangitis and secondary biliary obstruction. The presence of a large intraluminal structure within the distal common bile duct strongly supports extrahepatic biliary obstruction, most likely due to organized biliary sludge or an impacted biliary plug. However, an

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intraductal biliary mass cannot be ruled out, as ultrasound cannot reliably differentiate among these entities.

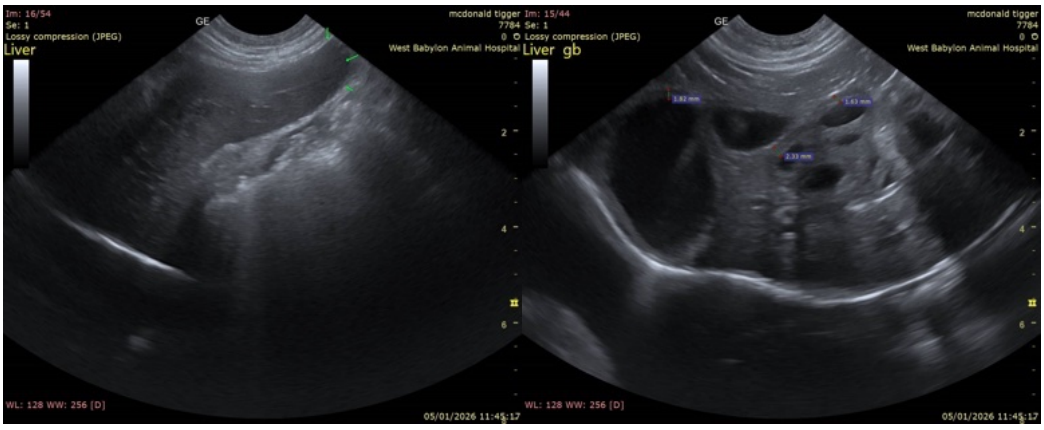
The concurrent elevation in ALP and GGT is particularly significant in cats and supports primary biliary tract involvement. The presence of only mild hyperbilirubinemia despite advanced ductal dilation may reflect partial or intermittent obstruction, early disease stage, or residual biliary patency, and does not exclude severe biliary disease.

Pancreatic changes may represent secondary chronic inflammation or age-related changes, rather than clinically significant pancreatitis. However, considering the limited sensitivity of pancreatic ultrasonography in cats, a feline-specific pancreatic lipase test could be considered to help further assess pancreatitis.

In the absence of significant azotemia or clinical signs attributable to renal dysfunction, renal findings are considered incidental to the primary hepatobiliary disease identified on this examination. However, they may be clinically relevant for overall patient management and anesthetic planning.

Recommendations

- Correlate the imaging findings with the patient's clinical status and hepatobiliary biochemical profile, recognizing that significant biliary obstruction may be present even in the absence of marked hyperbilirubinemia.
- Measurement of a feline-specific pancreatic lipase may be considered to further assess for concurrent pancreatic disease, recognizing the limitations of ultrasonography in detecting feline pancreatitis.
- Given the severity of extrahepatic biliary dilation and the presence of a distal common bile duct intraluminal structure, further diagnostic evaluation is strongly advised to determine the underlying cause of obstruction: Advanced imaging (contrast-enhanced CT or MRCP, if available) may help further characterize the distal common bile duct abnormality and assess surgical anatomy.



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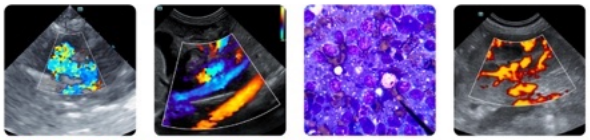

Clinical Sonography & Telecytology
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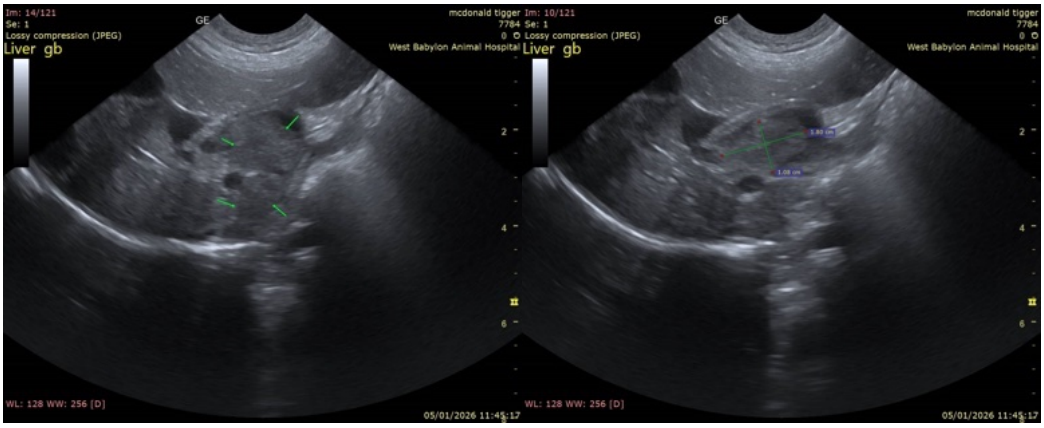

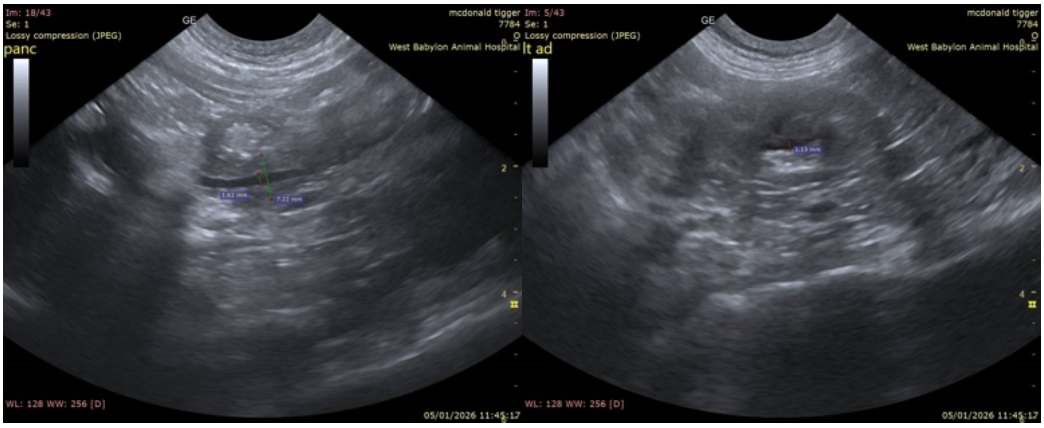

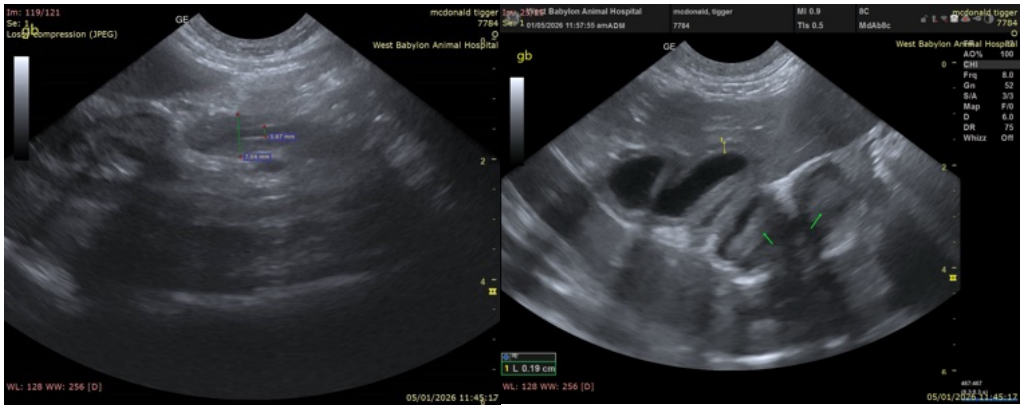

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@SonoPath.com