



PATIENT

Gus Kinner

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

7 years

WEIGHT

9.5 lbs

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Anshu Gupta

HOSPITAL NAME

Liverpool Village AH

REFERRING VET

Dr. Gupta

INVOICE

68584

DATE

11/11/25

PRESENTING CLINICAL SIGNS

History: Weight loss, chronic vomiting and decreased appetite. Unknown true age (rescue). No significant improvement with symptomatic therapy (ondansetron, SQ fluids)
Mildly dehydrated on examination Mildly elevated ALP (70), otherwise normal bloodwork

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. Normal appearance of the proximal urethra and vesicoureteral junction. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.94x2.23 cm, and the thickness of the cortex is 0.34 cm, in the sagittal plane. The renal cortex is normal in echogenicity. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths or hydronephrosis. Doppler color shows normal pattern.

The right kidney is normal in shape and size: 4.17x2.32 cm, and the thickness of the cortex is 0.36 cm, in the sagittal plane. The renal cortex is normal in echogenicity. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths or hydronephrosis. Doppler color shows normal pattern.

Adrenal Glands

Not clearly visualized.

Spleen

Splenic thickness is 0.41 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma looks uniform and hyperechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and folded, with mural thickness of 1.42 mm and preserved wall layering. The pylorus was not clearly measured.



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The jejunum measures 1.52 mm (mucosa 1.14 mm, submucosa 0.48 mm, muscularis 0.28 mm). The ileum measures 1.16 mm (mucosa 0.38 mm, submucosa 0.51 mm, muscularis 0.20 mm). The ileocecal junction was not visualized.

The colon contains a small amount of formed feces and appears within normal limits. Normal wall layering is maintained throughout. No signs of obstruction, ileus, or foreign material are present.

Pancreas

Although no specific pancreatic images were provided, the portions of the pancreas that were visualized show no evident signs of peripancreatic fat inflammation, ductal dilation, or nodules.

Peritoneal Cavity

No abdominal effusion or peritonitis is observed. Cranial mesenteric lymph nodes and ileocecal lymph nodes are not visualized, but the surrounding regions appeared unremarkable. The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

- Mild hepatic hyperechogenicity.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The abdominal ultrasound reveals mildly increased hepatic echogenicity. This finding is most consistent with mild hepatic lipidosis secondary to chronic inappetence.

Early vacuolar hepatopathy (vacuolar change of endocrine origin or corticosteroid influence) is less likely in this case, but also possible. The absence of biliary tract abnormalities, hepatic lymphadenopathy, or focal lesions argues against a neoplastic or severe inflammatory process.

The gastrointestinal tract demonstrates normal wall thickness and preserved layering throughout. However, mild chronic intermittent gastritis or mild enteropathy cannot be fully ruled out.

Recommendations

- Evaluate serum fPLI to rule out concurrent chronic pancreatitis (given chronic vomiting).
- Measure total T4 if not recently performed.
- Repeat liver enzymes in 3–4 weeks after nutritional and symptomatic support to monitor resolution or progression.
- Symptomatic management with antiemetics and highly digestible or moderate-fat diet.



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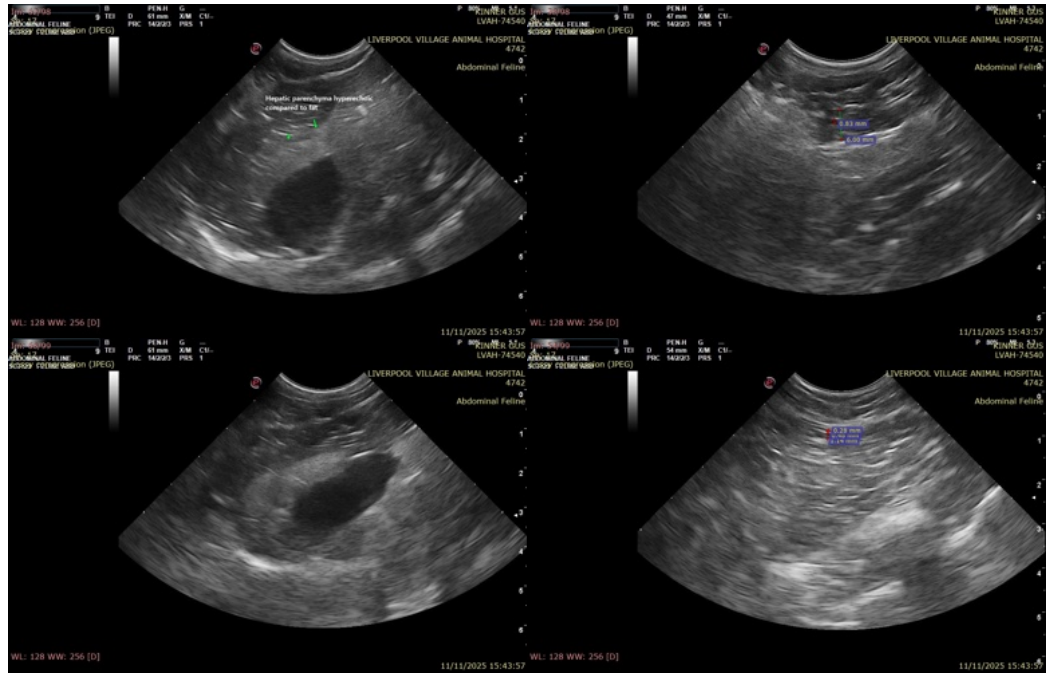
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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