



## PATIENT

Mikey Jolin

## SPECIES

Feline

## BREED

Domestic Shorthair

## SEX

Neutered male

## AGE

17 years

## WEIGHT

15.75 lbs

## INTERPRETED BY

Dr. Alicia Angosto  
Guerrero

## IMAGING PERFORMED BY

Dr. Cronin

## HOSPITAL NAME

Ark Animal Homecare

## REFERRING VET

Dr. Cronin

## INVOICE

68915

## DATE

11/20/25

## PRESENTING CLINICAL SIGNS

**History:** History of progressively elevating ALP. Has been eating less recently, losing weight. Started phenobarbital for seizures a few months ago but ALP was mildly elevated prior to that, and has increased. History of possible cranial abdominal mass on radiographs March 2025 (r/o mass vs. intestinal bunching).

**Abnormal PE/Chem/CBC/UA Results:** CBC/chem/t4 11/6/25: SDMA 15, Calcium 13.2, Chloride 112, ALP 206 Has lost 2 lbs since October

## 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: 4.11 x 2.42 cm, and the thickness of the cortex is 0.38 cm, in the sagittal plane. The cortical is isoechogenic compared to liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths or hydronephrosis.

The right kidney is normal in shape and size: 3.93 x 2.28 cm, and the thickness of the cortex is 0.30 cm, in the sagittal plane. The cortical is isoechogenic compared to liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths or hydronephrosis.

### *Adrenal Glands*

The adrenal glands were not visualized.

### *Spleen*

Splenic thickness is 0.99 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 isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is almost completely empty. The wall is thick (1.97 mm), hyperechoic. No evident dilation of the cystic duct or common bile duct is observed.



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## *Gastrointestinal*

The stomach contains food, with mural thickness (1.59 mm) and preserved wall layering. Duodenum: 2.14 mm. Jejunum: 1.98 mm. Ileum: 1.63 mm. Normal wall layering. The ileocecal junction wall measures 2.90 mm, muscularis 0.62 mm. No signs of inflammation, ileus, or foreign material are identified. Colon: 0.77 mm, with formed feces in the descending segment.

## *Pancreas*

The pancreas measured 1.02–1.27 cm. The parenchyma of the pancreas is hypoechoic to the adjacent omental fat. The diameter of the pancreatic duct is 1 mm. At least three cysts are observed between the body of the pancreas and the left pancreatic lobe: a 2.26×2.72 cm cyst, a 0.9×1 cm cyst adjacent to the first one, and another more separate cyst measuring 0.89×0.94 cm. No signs of active inflammation of the peripancreatic fat are evident.

## *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

- Empty, thickened, hyperechoic gallbladder wall (1.97 mm). No cystic or common bile duct dilation.
- Pancreatic parenchyma hypoechoic relative to adjacent omental fat. Multiple pancreatic cysts. No peripancreatic fat inflammation.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pancreas is diffusely hypoechoic, which can be seen with chronic pancreatic changes or chronic smoldering pancreatitis. It contains multiple cystic lesions of varying size, all of which demonstrate smooth, thin walls and marked distal acoustic enhancement, features that strongly support true pancreatic cysts or pancreatic pseudocysts rather than solid or infiltrative masses. One of the larger cysts shows minimal internal echogenicity or very mild wall irregularity, but the overall appearance remains far more consistent with benign cystic change than with neoplastic disease.

The patient had radiographic concern for a possible cranial abdominal mass several months ago (March). Given the amount of time that has passed, if this had represented a pancreatic or hepatic tumor, significant progression, mass effect, invasion, or the development of regional lymphadenopathy would be expected by now. None of these are present. The pancreas does not show any solid masses, the cystic structures do not have mural nodules, and the surrounding tissues remain uninvolved. There is also no lymph node enlargement, which further decreases the likelihood of malignancy.



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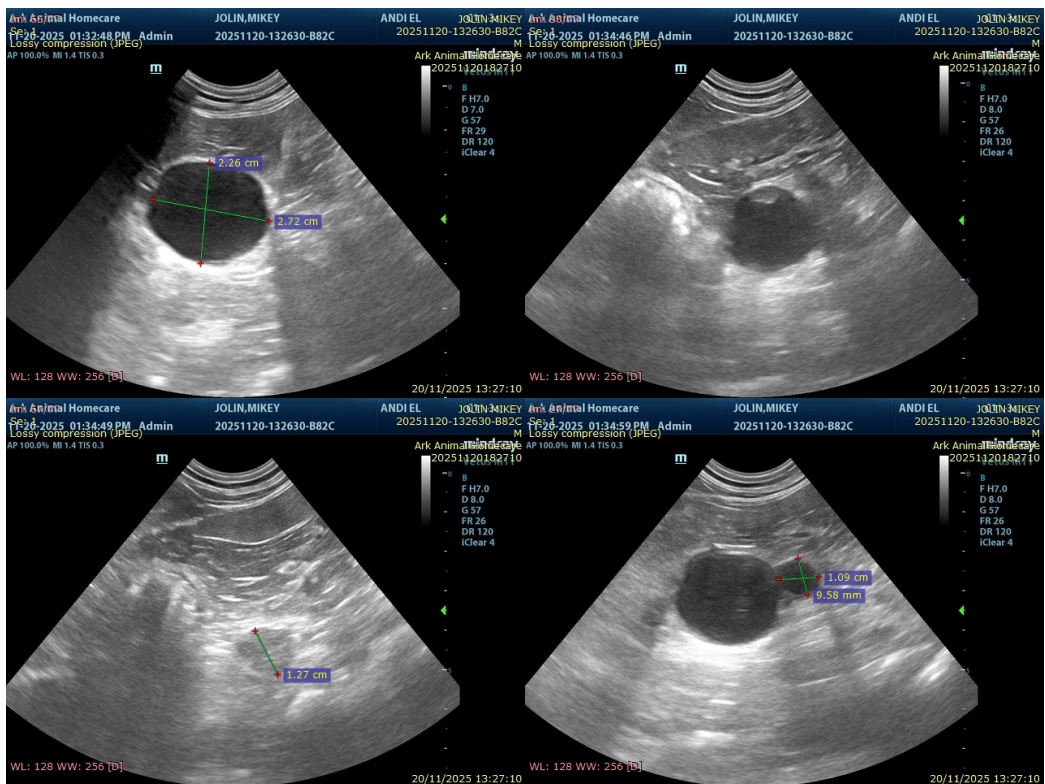
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The liver appears normal despite the patient’s progressively increasing ALP. This does not rule out hepatopathy, as vacuolar hepatopathy or phenobarbital-associated hepatopathy may exist before any ultrasonographic changes become evident. A chronically thickened or fibrotically remodeled gallbladder wall may fail to adequately distend, even in appropriate fasting conditions. Chronic cholecystopathy, chronic hepatobiliary inflammation, or vacuolar hepatopathy—particularly in the context of long-term phenobarbital use—can all produce this appearance.

**Recommendations**

- Perform Spec fPL to assess pancreatitis.
- Monitor liver enzymes (ALP, ALT, GGT) serially.
- Monitor the gallbladder and pancreatic cysts with repeat abdominal ultrasounds for changes in cyst size, wall characteristics, gallbladder distension, or progression of mural thickening.
- Consider abdominal CT if cystic pancreatic lesions progress or if neoplasia becomes a stronger differential.





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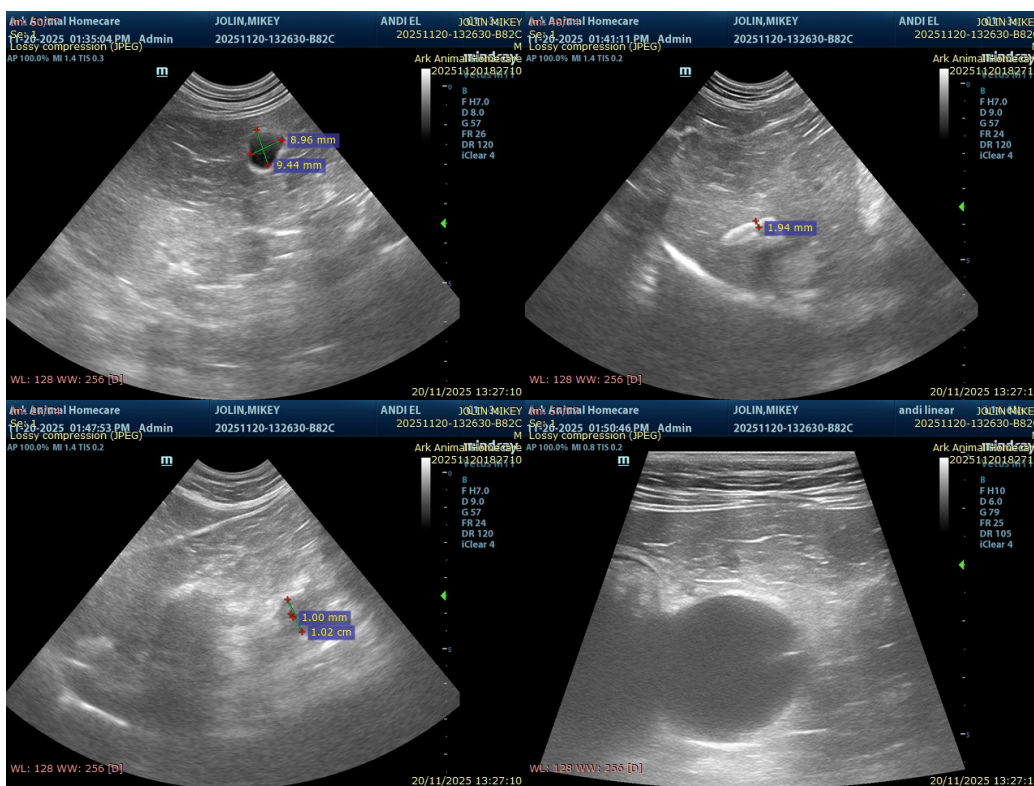
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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