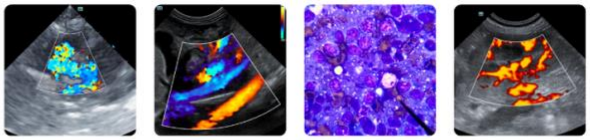

PATIENT

Sally Thompson

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

6 Years

WEIGHT

5.02 kg

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Cassie Jackson

HOSPITAL NAME

Huntsville Animal Hospital

REFERRING VET

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12420

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PRESENTING CLINICAL SIGNS

Presented for intermittent inappetance progressing to anorexia - O has tried many food options, Sally refuses almost all food - No vomiting/diarrhea/coughing/sneezing - Energy level seems normal - Indoors only - Has been known to chew pieces of rope off cat climber - No improvement on trial of Cerenia

Abnormal PE/Chem/CBC/UA Results: ALT 136 (high end normal 130) - M1 neutropenia Rest NSF

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: 3.68x1.98 cm, and the thickness of the cortex is 0.35 cm, in the sagittal plane.

The right kidney is normal in shape and size: 3.16x2.12 cm, and the thickness of the cortex is 0.31 cm, in the sagittal plane.

The cortical echogenicity is normal. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths or hydronephrosis.

Adrenal Glands

The left adrenal gland 0.25 cm at the cranial pole y 0.27 cm at the caudal pole. The right adrenal gland measures 0.30 cm at the cranial pole and 0.31 cm at the caudal pole.

Spleen

Splenic thickness is 0.80 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

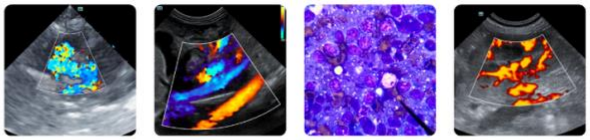
Liver

The liver is subjectively increased in size, with mildly rounded edges and a regular contour. The liver parenchyma appears uniform and very hyperechoic compared to the falciform fat, with a very fine echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic, with a mild to moderate amount of biliary sludge. The common bile duct is 2.35 mm.

Gastrointestinal

The stomach is empty and folded, with a small amount of fluid in the gastric body and pylorus; mural thickness is 2.27 mm with preserved wall layering.
The pylorus measures 3.39–4.26 mm.
Duodenum: 1.51 mm.
Jejunum: 2.07–2.25 mm; mucosa: 1.58 mm; submucosa: 0.59 mm; muscularis propria: 0.27 mm.
Ileum: 1.73–1.89 mm; mucosa: 0.77 mm; submucosa: 0.61 mm; muscularis propria: 0.41 mm.



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Wall layering is normal.
The ileocecal junction measures 2.69 mm; muscularis 1.11 mm.
No signs of obstruction, ileus, or foreign material are identified.

Colon: transverse 0.92 mm, empty; descending segment 0.74 mm, with normal feces.

Pancreas

4.93 mm. The right limb, body, and left limb appear normal. The parenchyma of the pancreas is isoechoic to the adjacent omental fat. The diameter of the pancreatic duct is 0.62 mm. No signs of active inflammation or neoplastic disease are evident.

Free Abdomen

No abdominal effusion or peritonitis is observed. Ileocecal lymph nodes measure 1.93–2.19 mm, elongated and very hypoechoic. Cranial mesenteric lymph nodes are not visualized, but the surrounding regions appear unremarkable. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Hepatomegaly with markedly hyperechoic liver parenchyma.
- Mild–moderate biliary sludge in the gallbladder.
- Ileocecal lymph nodes mildly enlarged (1.93–2.19 mm), normal shape and very hypoechoic.
- Pyloric thickening, though layering preserved.
- Mild gastric fluid retention.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The diffuse hepatic hyperechogenicity accompanied by subjective hepatomegaly and fine echotexture, which is highly suggestive of:

- Hepatic lipidosis (most likely due to anorexia).
- Other endocrine/metabolic hepatopathy.

The presence of mild to moderate biliary sludge is common and can be incidental, but in the context of anorexia and elevated liver enzymes, mild cholestasis is suspected. The common bile duct diameter of 2.35 mm is within normal limits for a cat, making biliary obstruction unlikely at this time.

The ileo-cecal lymph nodes are mildly enlarged and very hypoechoic, which could represent reactive lymphadenopathy secondary to GI inflammation, chronic enteropathy, or early infectious/inflammatory disease. Their shape remains elongated, which is reassuring and less suggestive of neoplastic infiltration.

Although all intestinal segments, including the ileocecal valve and its muscularis layer, fall within published normal thickness ranges for cats and the mucosal–muscularis ratios remain appropriate, early inflammatory bowel disease cannot be fully excluded, particularly given the mild pyloric thickening and the ileo-cecal lymph nodes. Early IBD may present with completely preserved layering and measurements that remain within normal limits, and clinical correlation remains essential.

The pancreas appears normal with a normal pancreatic duct, and no ultrasonographic evidence of pancreatitis is identified.

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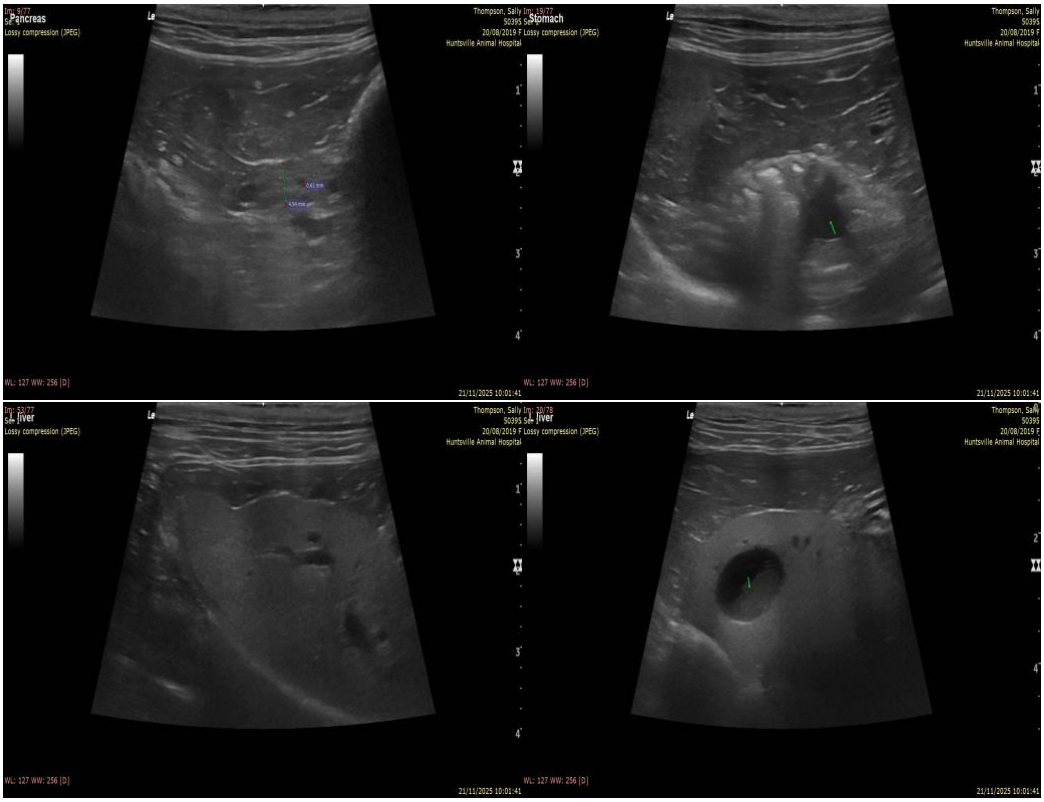
Recommendations

- Pursue a comprehensive gastrointestinal panel to evaluate for early inflammatory bowel disease, SIBO/dysbiosis, and subtle pancreatic disease.
- Cobalamin supplementation (empirical): Even if levels are not yet available, a large proportion of cats with chronic GI signs have functional cobalamin deficiency. It is safe, inexpensive, and could improve appetite and GI motility.
- Mirtazapine or capromorelin: If appetite stimulants fail → consider temporary assisted feeding (NG tube) to avoid worsening hepatopathy.
- Anti-nausea and GI support: Given the pyloric thickening, omeprazole + sucralfate can be considered.
- Consider a trial of prednisolone if the cat appetite remains poor, or GI panel suggests malabsorption. Prednisolone is especially reasonable if everything else has failed, as untreated anorexia will worsen hepatic lipidosis.
- Recheck ALT, AST, ALP, tBili 7 days.



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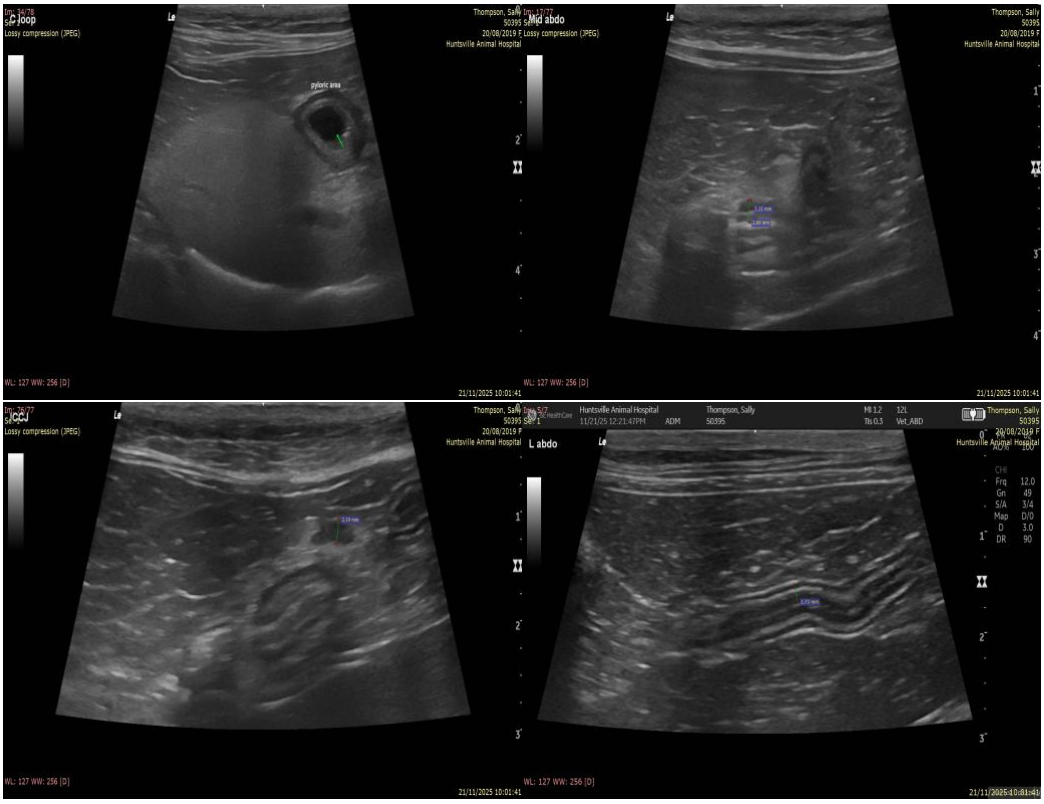

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com