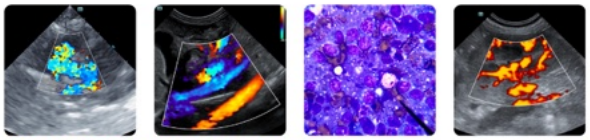


PATIENT

Susu Zwikelmaler

SPECIES

Feline

BREED

Siamese

SEX

Neutered male

AGE

11 years

WEIGHT

7.8 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Stranzl

HOSPITAL NAME

Dakota VC

REFERRING VET

Dr. Stranzl

INVOICE

69325

DATE

12/16/25

PRESENTING CLINICAL SIGNS

History: Went to the ER for not eating and vomiting multiple times (3-4 TIMES)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the bladder wall appears thin and smooth. The urine is predominantly anechoic with scant suspended echoes. The bladder neck and proximal urethra have a normal appearance. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is small, measuring 2.40 × 1.62 cm, with a cortical thickness of 0.31 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 4.47 × 2.70 cm, with a cortical thickness of 0.49 cm in the sagittal plane. In both kidneys, the renal cortex is increased in echogenicity, resulting in increased corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler demonstrates a normal perfusion pattern.

Adrenal Glands

The left adrenal gland was not visualized. The right adrenal measures 0.23 cm at the cranial pole and 0.27 cm at the caudal pole.

Spleen

Splenic thickness is 0.59 cm. The parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture, with small hyperechoic foci measuring approximately 1.66×1.96 mm. The splenic capsule is smooth and regular.

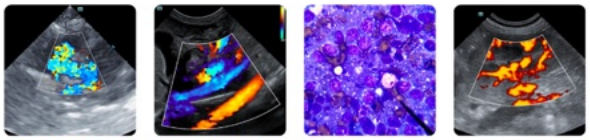
Liver

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

The gallbladder lumen is markedly distended. The wall is thin, and the contents are primarily anechoic. The common bile duct is markedly dilated and tortuous, measuring approximately 7.2 mm. No intraluminal sludge, choleliths, or mass are identified that would clearly account for the dilation. The extrahepatic bile duct could not be visualized at its insertion into the duodenal papilla; therefore, the most distal portion of the biliary tract could not be evaluated.

Gastrointestinal

The stomach is empty and folded, with a gas pattern. Gastric mural thickness measures 2.18 mm, with preserved wall layering. The pylorus measures 3.55 mm and contains a small amount of fluid.



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The duodenum could not be measured.
The jejunum measures 1.69 mm, with the following wall layer measurements: mucosa 0.61 mm, submucosa 0.28 mm, and muscularis propria 0.11 mm.

The ileum measures 1.12 mm, with mucosa 0.36 mm, submucosa 0.48 mm, and muscularis propria 0.23 mm. Wall layering is preserved.

The ileocecal junction measures 2.27 mm, with a muscularis thickness of 0.66 mm. No signs of obstruction, ileus, or foreign material are identified.

The colon wall thickness measures 0.76 mm, with a small amount of fecal material present in the descending segment.

Pancreas

The pancreas could not be clearly visualized in any of the provided images; however, no evidence of steatitis or inflammatory changes of the surrounding fat is observed.

Peritoneal Cavity

No abdominal effusion or evidence of peritonitis is observed. Cranial mesenteric and ileocecal lymph nodes appear normal. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Markedly distended gallbladder. With marked dilation and tortuosity of the common bile duct.
- Asymmetric renal size with a small left kidney. Increased renal cortical echogenicity bilaterally.

SECONDARY FINDINGS

- Small hyperechoic splenic foci.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The marked dilation and tortuosity of the common bile duct, in conjunction with a markedly distended gallbladder, are highly suggestive of extrahepatic biliary obstruction or severe functional cholestasis. No intraluminal biliary sludge or choleliths are identified within the gallbladder or proximal bile duct. However, the most distal portion of the extrahepatic bile duct could not be evaluated at its insertion into the duodenal papilla, and therefore a distal obstructive process cannot be excluded. Potential differentials include inflammatory obstruction at the level of the duodenal papilla, pancreatitis-associated biliary compression, biliary tract stricture, or neoplastic obstruction.

The pancreas was not adequately visualized, and although there is no sonographic evidence of peripancreatic fat inflammation, pancreatic disease cannot be ruled out. Given the intimate anatomical

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relationship between the pancreas and the distal bile duct in cats, pancreatitis remains an important differential in the presence of marked biliary dilation and acute vomiting.

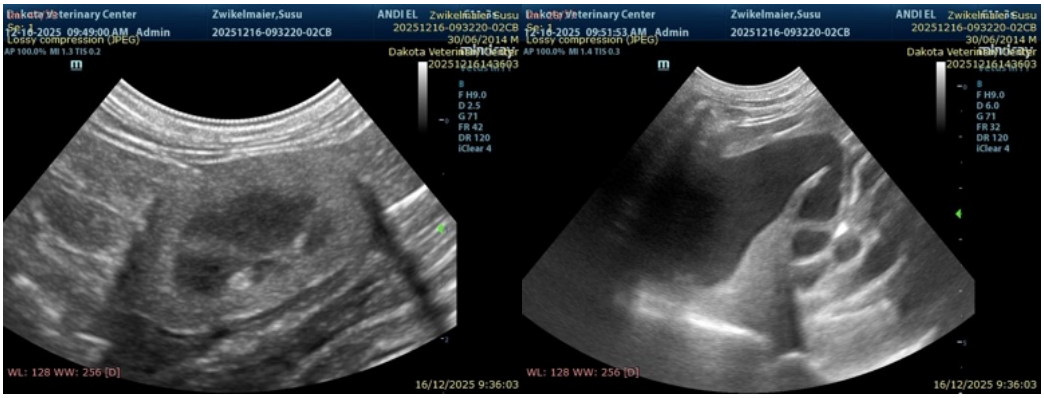
The markedly small left kidney, together with bilateral increased renal cortical echogenicity, is most consistent with chronic renal parenchymal disease, likely longstanding and incidental to the current acute presentation. The right kidney appears within expected size limits and does not demonstrate clear compensatory hypertrophy, suggesting that the left kidney may be chronically small rather than the right kidney being enlarged.

The small hyperechoic splenic foci are most consistent with benign splenic changes, such as myelolipomas or siderotic nodules, and are considered incidental.

No sonographic evidence of mechanical gastrointestinal obstruction is identified. The intestinal wall thickness and layering are preserved throughout.

Recommendations

- Prompt clinical correlation is recommended, including hepatic and biliary biochemical evaluation (ALT, ALP, bilirubin) if not already performed.
- Pancreatic lipase testing (feline-specific) is recommended given the concern for pancreatobiliary disease.
- Further evaluation of the distal bile duct and duodenal papilla may be warranted, potentially including repeat ultrasonography, advanced imaging, or referral, depending on clinical progression.
- Further evaluation of renal function is recommended, including UPC, SDMA, serum creatinine, and repeat urinalysis, to better characterize the extent of renal involvement.
- Systemic blood pressure measurement is also advised.



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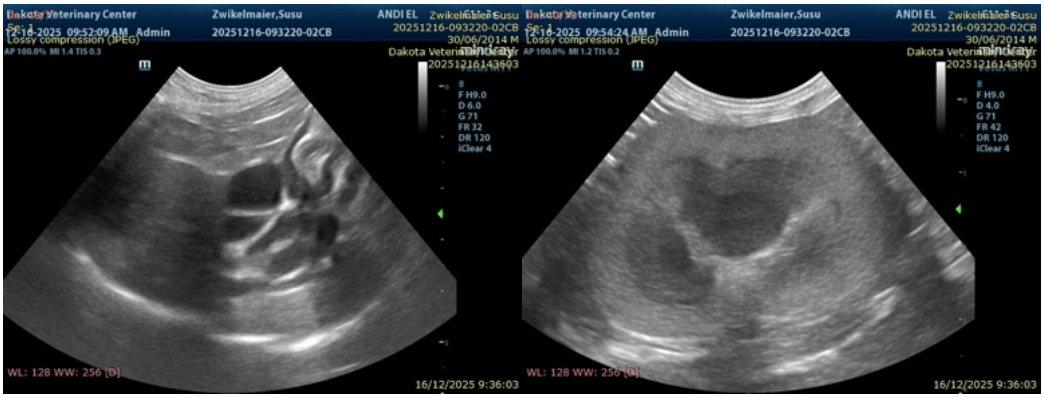

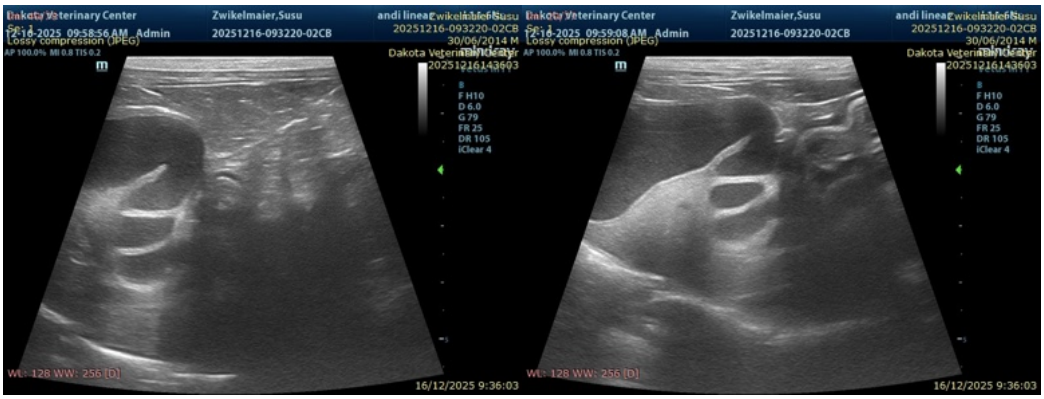

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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