



PATIENT

Blackjack France

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

12 years

WEIGHT

21.2 lbs

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Shannon Matthies,
DVM

HOSPITAL NAME

Saugerties AH

REFERRING VET

Dr. Matthies

INVOICE

69495

DATE

12/22/25

PRESENTING CLINICAL SIGNS

History: Intermittent vomiting for the past week.
PE - WNL CBC/Chem - elevated ALT (204, n 10-100) and AST (102, n 1-100), elevated PSL (41, n 8-26)
AXR - concerned about possible gallstones

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended with a thin, smooth wall. Urine is anechoic. The bladder neck and proximal urethra appear normal. No uroliths or ultrasonographic evidence of inflammatory or neoplastic disease are identified.

The left kidney is normal in size and shape (3.99×2.14 cm), with a cortical thickness of 0.33 cm. The right kidney is normal in size and shape (4.24×2.40 cm), with a cortical thickness of 0.37 cm. In both kidneys, cortical echogenicity is within normal limits, the corticomedullary ratio is normal, and corticomedullary definition is preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is observed.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. The left adrenal gland measures 0.28 cm at the cranial pole and 0.26 cm at the caudal pole. The right adrenal gland measures 0.27 cm at the cranial pole and 0.26 cm at the caudal pole.

Spleen

The spleen measures 1.0 cm in thickness. The parenchyma is homogeneous with normal echogenicity. The capsule is smooth and regular. No focal lesions are identified.

Liver

The liver is subjectively normal in size, with sharp margins and a regular contour. The parenchyma is diffusely and mildly hyperechoic relative to falciform fat, with a fine, uniform echotexture. No focal hepatic lesions or hepatic lymphadenopathy are identified.

The gallbladder is moderately distended with a thin wall. Multiple echogenic intraluminal choleliths are present, measuring up to approximately 4.6 mm and 6.4 mm, with distal acoustic shadowing. The common bile duct measures approximately 4.24 mm proximally, tapering to 3.42 mm and 2.59 mm distally. A small amount of mineral sediment is also noted within some intrahepatic bile ducts. No complete biliary obstruction is identified.

Gastrointestinal

The stomach is empty and folded, with normal wall thickness (2.12 mm) and preserved layering. The pylorus measures 3.66 mm. The duodenum (1.70 mm), jejunum (1.90 mm), and ileum (1.88 mm)



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demonstrate normal wall thickness and preserved layering. The ileocecal junction measures 2.90 mm, with a muscularis thickness of 0.91 mm. No evidence of obstruction, ileus, or foreign material is identified. The colon measures approximately 0.70 mm and contains formed feces.

Pancreas

The pancreas measures approximately 4.75 mm in thickness. Parenchymal echogenicity is isoechoic to adjacent omental fat. The pancreatic duct measures 0.75 mm. No ultrasonographic evidence of pancreatitis or pancreatic mass lesions is observed.

Peritoneal Cavity

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

ULTRASONOGRAPHIC FINDINGS

- Multiple choleliths within the gallbladder, measuring up to approximately 6.4 mm.
- Mild dilation of the proximal common bile duct, with distal tapering.
- Minimal mineral sediment within intrahepatic bile ducts.
- Diffusely hyperechoic liver parenchyma relative to falciform fat, with preserved architecture.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The primary ultrasonographic abnormality is cholelithiasis, with multiple gallstones and mild associated biliary mineral sediment extending into some intrahepatic bile ducts. The common bile duct is mildly prominent proximally but tapers distally, with no evidence of complete extrahepatic biliary obstruction at the time of examination.

The liver shows mild, diffuse hyperechogenicity, which is most consistent with a metabolic or hepatocellular change (vacuolar hepatopathy like lipidosis or reactive hepatopathy), and correlates well with the patient's elevated ALT and AST. No focal hepatic disease or secondary changes suggestive of advanced cholestasis are identified.

The pancreas appears within normal limits sonographically; however, given the elevated pancreatic lipase, early or mild pancreatitis cannot be excluded, as ultrasonographic changes may be absent in subclinical or early disease.

Overall, the findings support a hepatobiliary process dominated by cholelithiasis with mild biliary stasis, with possible concurrent low-grade pancreatitis contributing to the patient's intermittent vomiting.

Recommendations

- Correlation with laboratory findings is strongly recommended, particularly liver enzymes, bilirubin, and pancreatic markers, to assess the clinical significance of the cholelithiasis and biliary duct changes.



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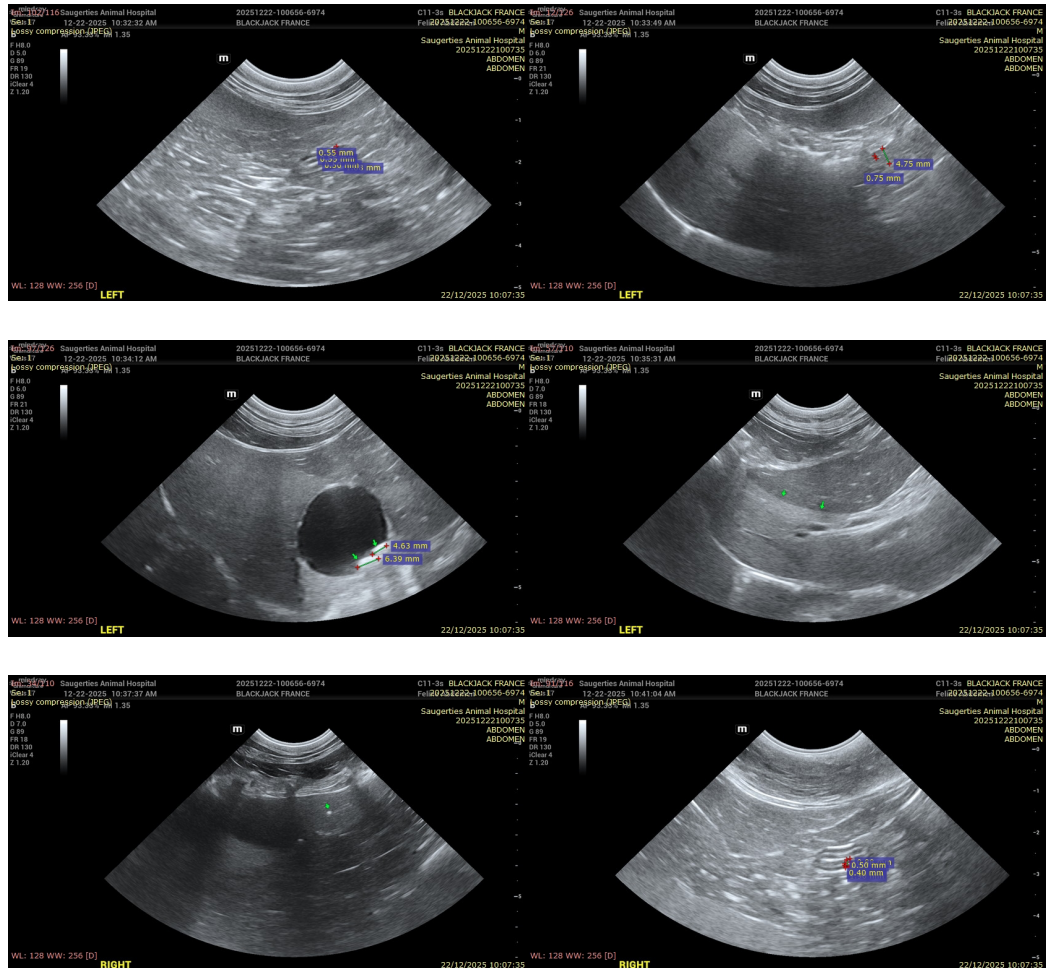
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- Given the presence of gallstones and mild biliary duct dilation, medical management and close clinical monitoring are reasonable initial approaches in a clinically stable patient.
- Surgical intervention (cholecystectomy) should be considered only if clinical signs persist or worsen, if there is progression of biliary obstruction, or if laboratory values indicate evolving cholestasis or biliary compromise.



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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