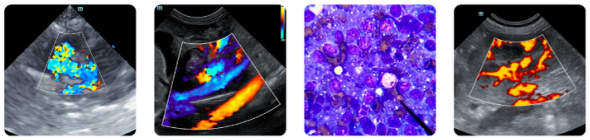


PATIENT

Peridot Clouser

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

6 years

WEIGHT

4.24

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Mario

HOSPITAL NAME

TLC Animal Hospital

REFERRING VET

Dr. Brenda Castorena

INVOICE

11316

DATE

2/13/2026

PRESENTING CLINICAL SIGNS

- Patient is a 6 yr old, Female spayed, Domestic shorthair. Patient diagnosed with Pancreatitis and Triaditis. Patient is icteric. Patient was hospitalized on IV fluids and was given convenia inj, cerenia, and pantoprazole. Patient appetite was not improving and was started on mirtazapine . Liver values slightly improved and patient was discharged from hospital. After 1 week we rechecked liver values and they had increased. Recommended starting patient on pradofloxacin. 1 week later values continued to go up. Recommended low does of prednisolone. Today Patient is doing better and is eating well but liver values are even higher. Recommended Full abdominal u/s to make sure nothing else going on in abdomen.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The wall is thin and smooth. The urine is predominantly anechoic with scant suspended echoes. The bladder neck and proximal urethra are unremarkable. No uroliths or ultrasonographic evidence of cystitis or mural mass are identified.

The left kidney measures 3.48×1.75cm in the sagittal plane. Cortical thickness is 0.26cm. The cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is normal and corticomedullary distinction is preserved. There is no pyelectasia, nephrolithiasis, or hydronephrosis.

The right kidney measures 3.67×1.69cm in the sagittal plane. Cortical thickness is 0.30cm. The cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is normal and corticomedullary distinction is preserved. There is no pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

Both adrenal glands have normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane:

- Left adrenal gland: 0.29cm (cranial pole) and 0.35cm (caudal pole).
- Right adrenal gland: 0.32cm (cranial pole) and 0.32cm (caudal pole).

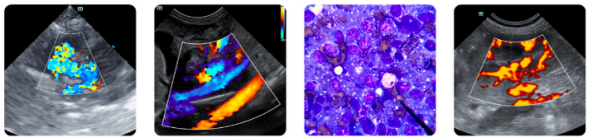
Spleen

Splenic thickness is 0.84cm. The parenchyma is homogeneous with normal echogenicity. The capsule is smooth.

Liver

The liver is subjectively normal in size, with sharp margins and regular contour. The parenchyma is homogeneous and isoechoic relative to the falciform fat, with normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder is poorly distended. The wall is thickened, measuring 1.64–2.48mm. The contents are predominantly anechoic with a few small choleliths.
The common bile duct (CBD) wall appears thickened (1.0–1.41mm). The CBD is mildly dilated, measuring 3.18–2.52mm along its course and 2.05–1.06mm near the duodenal papilla.



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In adult cats, the CBD diameter is typically ≤3–4mm. Measurements up to 5mm may be seen in some older cats without obstruction; however, in an icteric patient, dilation approaching or exceeding 3mm warrants clinical correlation.

Gastrointestinal

The stomach is distended with ingesta. Gastric wall thickness measures 0.80mm with preserved layering (within normal limits for a distended feline stomach).
Pylorus: 2.60mm.
Duodenum: 1.73mm.
Jejunum: 1.94mm.
Ileum: 1.22mm.
Ileocecal junction: 1.97mm.
Colon: 0.85mm.

All small intestinal wall thickness measurements fall within accepted feline reference ranges (generally <2.5–3.0mm depending on segment), and wall layering is preserved. No ultrasonographic evidence of obstructive or infiltrative disease is identified.

Pancreas

Pancreatic thickness measures 7.38–7.83mm. The margins are irregular. The pancreatic parenchyma is hypoechoic relative to adjacent mesenteric fat. The pancreatic duct measures 1.07mm. There is very mild hyperechogenicity of the surrounding peripancreatic fat.

In cats, pancreatic thickness up to approximately 6–8mm may be within normal variation; however, parenchymal hypoechogenicity and irregular margins are supportive of inflammation. A pancreatic duct diameter >1.0mm is considered mildly enlarged.

Free Abdomen

A small volume of free fluid is present within the rectovesical recess and hepatorenal recess. No mesenteric or ileocecal lymphadenopathy is identified. The iliac trifurcation region is unremarkable.

PRIMARY FINDINGS

- Gallbladder wall thickening with small choleliths.
- Mild common bile duct dilation (up to 3.18mm) with mural thickening.
- Pancreatic enlargement with hypoechogenicity and irregular margins and mild pancreatic duct enlargement.
- Mild peripancreatic fat hyperechogenicity.
- Small volume peritoneal effusion.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver parenchyma appears sonographically normal, which is important, as marked hepatic lipidosis typically produces increased echogenicity; however, a normal hepatic echotexture does not exclude inflammatory or cholestatic hepatopathy.

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The gallbladder wall thickening exceeds normal feline values (generally <1mm when distended) and supports inflammatory change. Small choleliths could contribute to intermittent obstruction or biliary irritation. The common bile duct maximal diameter measures up to 3.18mm, which is at the upper end of reported reference values for adult cats, with no evidence of clinically significant extrahepatic biliary obstruction. The gallbladder is not distended, and intrahepatic bile ducts are not dilated. In this context, the findings are more consistent with inflammatory cholangitis rather than mechanical obstruction.

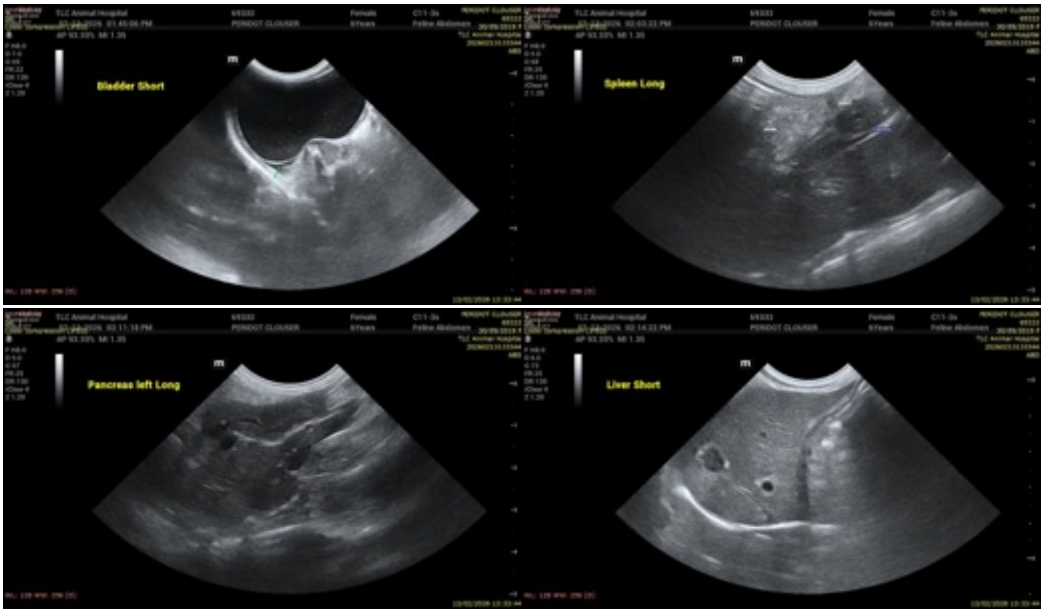
Pancreatic thickness hypoechogenicity, irregular margins, mild peripancreatic fat reaction, and a pancreatic duct diameter of 1.07mm collectively support active pancreatitis.

Overall, the ultrasonographic findings are most consistent with active pancreatitis associated with inflammatory cholangitis. There is no evidence of intestinal mural thickening or muscularis predominance to suggest concurrent infiltrative enteropathy at this time. The small volume of peritoneal effusion is likely reactive.

Ultrasound cannot definitively distinguish between neutrophilic and lymphocytic cholangitis. However, the constellation of findings strongly supports ongoing inflammatory pancreaticobiliary disease as the cause of worsening hyperbilirubinemia.

Recommendations

- Spec fPL.
- Continue supportive management for pancreatitis (analgesia, antiemetics, nutritional support).
- Repeat bilirubin and liver enzyme assessment to monitor progression.
- Consider bile sampling (cholecystocentesis) for cytology and culture if clinically stable.



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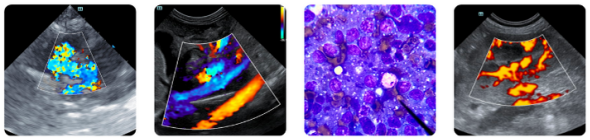

Clinical Sonography & Telecytology
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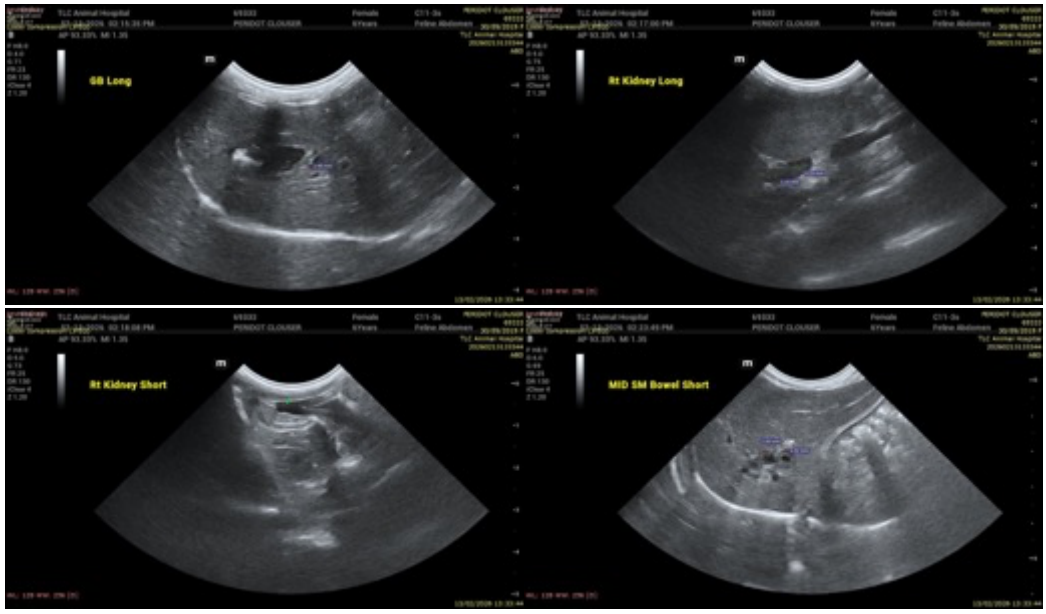

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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