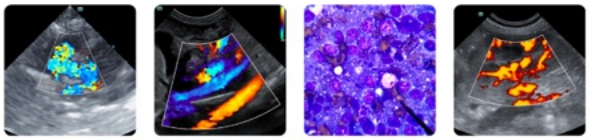


PATIENT

Latte Foam Gordon

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

9 years

WEIGHT

12.9 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Katie Kobyra

HOSPITAL NAME

Valley West & Elk Valley VH

REFERRING VET

Dr. Keith

INVOICE

71666

DATE

2/17/26

PRESENTING CLINICAL SIGNS

- Chronic history of elevated liver values and uroliths
- Recent weight loss with vomiting and muscle wasting; decreased appetite per owner with no change to diet
- treated with clavamox, flagyl, denamarin, mirtazepine and ondansetron with limited response to therapy - patient is difficult to medicate by mouth
- Feb 3 CBC: unremarkable; Chem: ALT 447(27-158) AST 132 (16-57) ALP 154 (12-59), TBili 0.6 (0-0.3), Bili 0.4 (0-0.2), UA: USG 1.007, pH 7.0, neg bilirubin Feb 17 - marked jaundice with 0.6lb w week weight loss 13.5lb on Jan 26, 12.9lb on 2/17

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The wall is thin and smooth. The urine is turbid with abundant suspended echogenic sediment. The bladder neck and proximal urethra appear normal. No uroliths are identified. No ultrasonographic evidence of mural inflammatory or neoplastic change is observed.

Left kidney: 4.16×2.82cm; cortical thickness 0.32cm (sagittal plane). Right kidney: 4.65×2.14cm; cortical thickness 0.35cm (sagittal plane). Renal length is within normal limits for a 12.9 lb cat. The renal cortices are mildly increased in echogenicity compared to the liver. Corticomedullary definition and corticomedullary ratio are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified.

Adrenal Glands

Left adrenal gland measures 0.29cm (cranial pole) and 0.28cm (caudal pole) in dorsoventral dimension. Right adrenal gland not reliably visualized.

Spleen

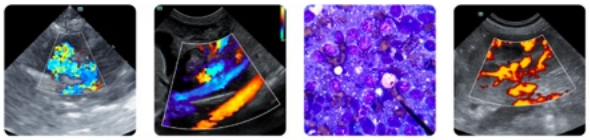
Splenic thickness 0.85cm. Parenchyma homogeneous, normal echogenicity. Capsule smooth. No focal lesions identified.

Liver

The liver is subjectively enlarged with rounded, mildly irregular margins and a diffusely coarse echotexture. The parenchyma is mildly hypoechoic relative to falciform fat, with increased conspicuity of portal walls, consistent with significant diffuse hepatopathy.

The gallbladder is normally distended. The wall is thickened (3mm). The lumen contains primarily anechoic bile with a small amount of dependent sludge.

The common bile duct measures: Proximal: 3.18mm. Mid: 2.53mm. Distal: 1.32mm



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In cats, the common bile duct is typically ≤3mm (may reach 3.5–4mm in older cats without obstruction). There is no abrupt cutoff or severe dilation identified.

Gastrointestinal

Stomach empty and folded; mural thickness 1.46mm; layering preserved. Pylorus 2.87mm with minimal luminal fluid. Duodenum 1.48mm (within normal range).

Jejunum 2.91mm total thickness:

- Mucosa 1.27mm, Submucosa 0.99mm, Muscularis 0.62mm

Ileum 2.78–3.01mm:

- Mucosa 0.98mm, Submucosa 0.89mm, Muscularis 1.12mm

Colon 0.91mm; formed feces present.

Pancreas

Visualized pancreatic regions appear normal in size and echogenicity. No peripancreatic fat inflammation or fluid.

Peritoneal Cavity

No abdominal effusion. No mesenteric or ileocecal lymphadenopathy identified. Iliac trifurcation normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Gallbladder wall thickening (3 mm). Mild proximal common bile duct dilation (3.18 mm).
- Mild ileal muscularis thickening (muscularis-to-mucosa ratio >1).

SECONDARY FINDINGS

- Mild renal cortical hyperechogenicity.
- Marked urinary sediment.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

In combination with progressive hyperbilirubinemia, marked ALT elevation, and gallbladder wall thickening, the hepatic findings strongly support active inflammatory hepatobiliary disease, most consistent with cholangitis or cholangiohepatitis.

The gallbladder wall thickening (3 mm) is abnormal in the feline patient and is consistent with cholecystitis. In conjunction with progressive hyperbilirubinemia, ultrasonographic diffuse

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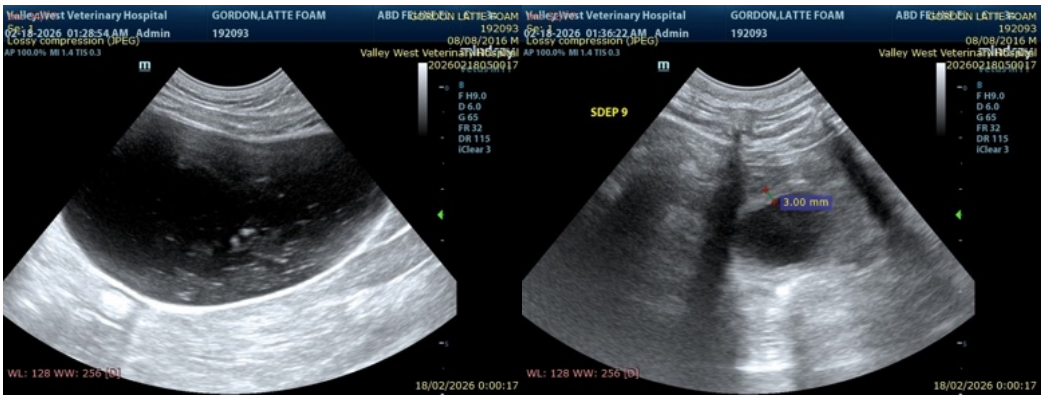
hepatopathy, and mild proximal common bile duct dilation, these findings support an active inflammatory hepatobiliary process, most consistent with a cholangitis–cholecystitis complex.

The common bile duct measures up to 3.18 mm proximally, which falls within the upper reference limits reported for adult cats. However, in the context of clinical jaundice and gallbladder wall thickening, this measurement raises concern for inflammatory cholestasis or partial/dynamic distal obstruction rather than fixed extrahepatic biliary obstruction. The progressive distal tapering and absence of marked dilation (>4–5 mm) further argue against established complete extrahepatic biliary obstruction at this time.

Mild ileal muscularis thickening is present. In cats, a muscularis layer equal to or thicker than the mucosa is considered abnormal and raises suspicion for chronic inflammatory enteropathy or early small cell lymphoma. The absence of mesenteric lymphadenopathy and preservation of wall layering reduce the likelihood of advanced infiltrative disease; however, significant ultrasonographic overlap between inflammatory bowel disease and small cell lymphoma is well recognized.

Recommendations

- Given the lack of response to prior antibiotic therapy and the chronicity of hepatic enzyme elevation, lymphocytic cholangitis should be strongly considered. Definitive differentiation between neutrophilic and lymphocytic cholangitis requires hepatic biopsy and histopathologic evaluation. Bile sampling for cytology and culture may also be considered if clinically appropriate.
- Evaluate coagulation profile prior to invasive sampling.
- Intestinal biopsy may also be beneficial. Although there is no current ultrasonographic evidence strongly suggestive of lymphoma, histopathology remains the only reliable method to definitively differentiate chronic inflammatory disease from early small cell lymphoma.
- If advanced diagnostics are declined, a carefully monitored therapeutic trial with corticosteroids may be reasonable.
- Monitor bile duct diameter on short-interval recheck ultrasound if jaundice progresses.
- Repeat full biochemistry including bilirubin and GGT to assess progression of cholestasis.
- Urinalysis with sediment exam due to marked bladder sediment and prior urolith history.



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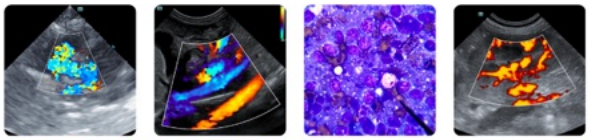

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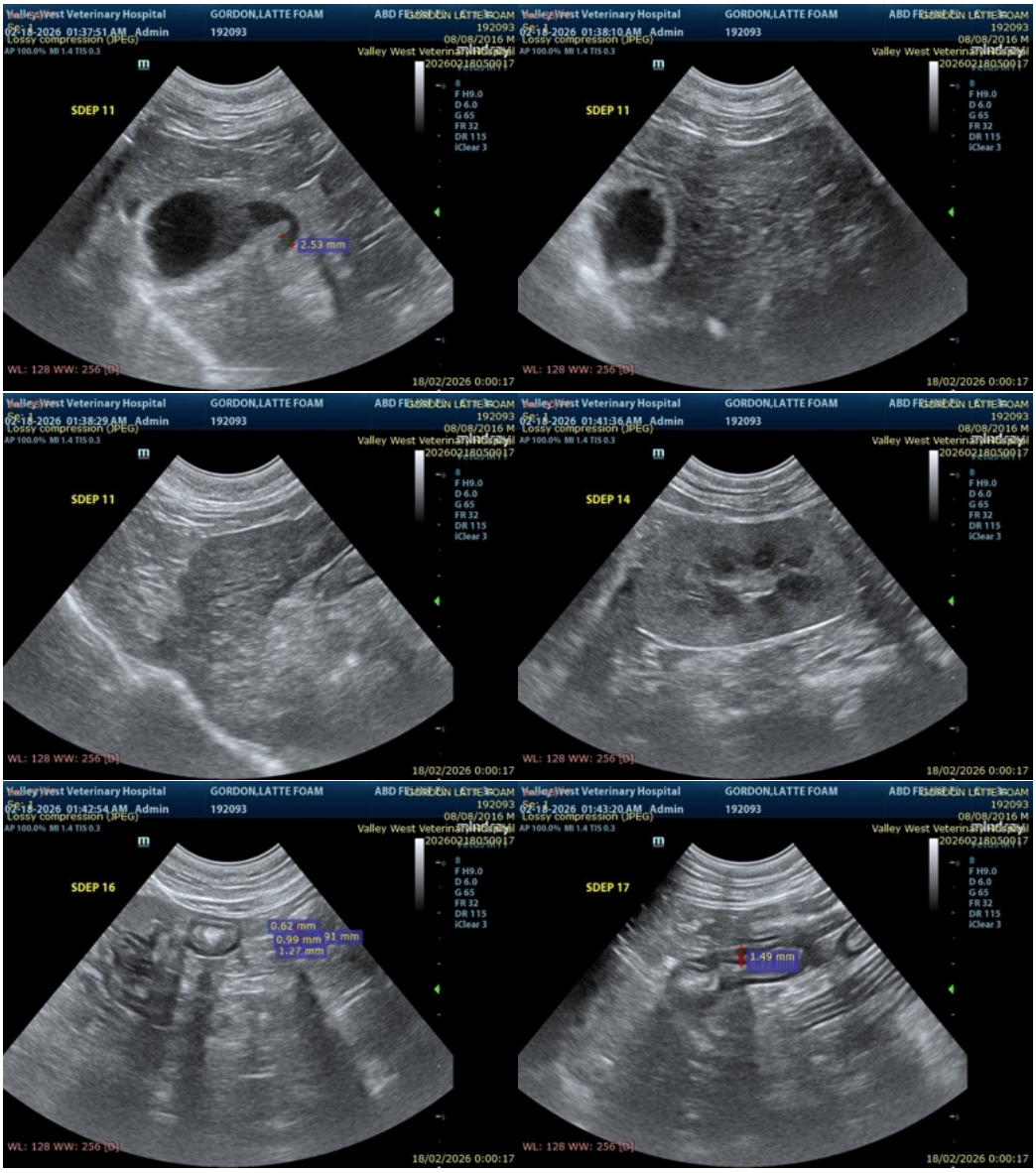

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@SonoPath.com