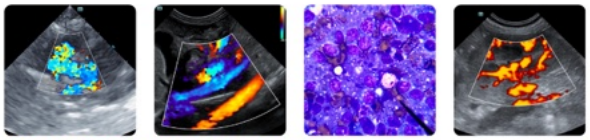


PATIENT

Dante Rennie

SPECIES

Feline

BREED

Bengal

SEX

Neutered male

AGE

14 years

WEIGHT

14.8 kg

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Chirstina Wagner

HOSPITAL NAME

Angeles CA

REFERRING VET

Dr. Wagner

INVOICE

71153

DATE

2/2/26

PRESENTING CLINICAL SIGNS

- Approx 1.4 lb weight loss over last 5 months. Unknown if any vomiting, is indoor/outdoor.
- Swelling on left lateral thigh where FeLV vaccine was given end of December. Missing many teeth due to hx FORLs. Heavy calculus remaining teeth. CBC - NSf Chem - ALT 305 T4 - pending fPL - pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The bladder wall is thin and smooth. Urine is predominantly anechoic with scant suspended echoes. 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 shape and size, measuring 4.74×2.80 cm, with a cortical thickness of 0.31 cm in the sagittal plane. The renal cortex is mildly increased in echogenicity, resulting in increased corticomedullary distinction. Two nephroliths are identified within the calyceal region, measuring 2.42 mm and 4.43 mm. Mild pyelectasia is present, measuring 3.13 mm. Color Doppler demonstrates a normal vascular pattern.

The right kidney is normal in shape and size, measuring 4.01×2.41 cm, with a cortical thickness of 0.33 cm in the sagittal plane. The renal cortex is mildly increased in echogenicity, with increased corticomedullary distinction. A small amount of fine echogenic material consistent with calyceal mineral sediment is present. No pyelectasia or hydronephrosis is observed. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

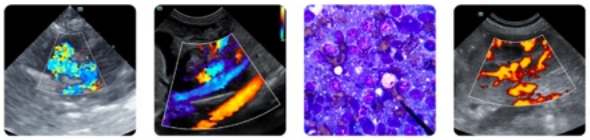
Both adrenal glands have normal shape and echogenicity. The left adrenal gland measures 0.35 cm at the cranial pole and 0.34 cm at the caudal pole. The right adrenal gland measures 0.26 cm at the cranial pole and 0.30 cm at the caudal pole.

Spleen

Splenic thickness is 0.86 cm. The splenic parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

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



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The gallbladder is moderately distended. The wall is thin. The lumen is primarily anechoic with a small amount of biliary sludge. At least two small non-shadowing choleliths are identified, measuring 1.87 mm and 1.98 mm. The common bile duct measures 3.98 mm proximally, tapering to 3.53 mm, 2.96 mm, and 2.45 mm distally.

Gastrointestinal

The stomach is nearly empty, containing only a small amount of ingesta. Gastric wall thickness measures 1.54 mm, with preserved wall layering. The duodenum measures 1.70 mm in wall thickness.
The jejunum measures 1.81 mm, with mural layers as follows:

- Mucosa: 0.84 mm, submucosa: 0.37 mm, muscularis propria: 0.57 mm

The ileum measures 2.11 mm, with mural layers as follows:

- Mucosa: 0.91 mm, submucosa: 0.74 mm, muscularis propria: 0.63 mm

Wall layering is preserved throughout. The ileocecal junction is not clearly visualized; the surrounding region appears mildly increased in echogenicity. No obstructive pattern is identified.

The colon wall measures 1.05 mm and contains formed fecal material within the descending colon.

Pancreas

The pancreas measures 7.82–10.1 mm in thickness. The pancreatic parenchyma is mildly hypoechoic relative to the adjacent omental fat. No hyperechogenicity of the peripancreatic fat are identified.

Peritoneal Cavity

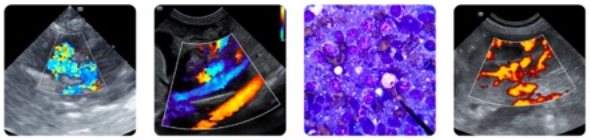
No abdominal effusion or ultrasonographic evidence of peritonitis is observed. Cranial mesenteric lymph nodes are identified, measuring 3.59–4.10 mm in thickness, with normal shape and echogenicity. Ileocecal lymph nodes are not visualized. A gastric (gastroesplenic) lymph node is identified, measuring 0.76×0.96 cm, and appears mildly hypoechoic.

A markedly tubular, anechoic structure measuring 7.73–8.48 mm in diameter is identified coursing transversely dorsal to the pancreas and extrahepatic portal vein. Color Doppler signal is not detected, likely due to an unfavorable insonation angle. Based on its appearance and anatomic location, this structure is most consistent with a dilated abdominal vein (splenic or gastroepiploic vein); however, its origin and termination cannot be fully delineated.

The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

- Mild bilateral renal cortical hyperechogenicity. Left renal nephrolithiasis with mild pyelectasia. Right renal calyceal mineral sediment.



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- Small choleliths and biliary sludge. Common bile duct diameter at the upper end of expected limits.
- Mild pancreatic enlargement and hypoechogenicity.
- Mildly enlarged, hypoechoic gastric lymph node .
- Dilated tubular abdominal structure consistent with a dilated vein (such as a splenic or gastroepiploic vein) but definitive vascular characterization cannot be confirmed on this examination.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Measured small intestinal wall thickness values are within accepted reference ranges for feline patients. Although the muscularis propria is mildly prominent relative to the mucosa in the jejunum and ileum, the muscularis-to-mucosal ratios remain below unity, wall layering is preserved, and no diffuse or focal mural disease is identified. This may support a functional change or early inflammatory enteropathy.

Renal findings include bilateral mild cortical hyperechogenicity, left-sided nephrolithiasis with mild pyelectasia, and right-sided calyceal mineral sediment. These changes are most consistent with chronic renal disease with ongoing mineral precipitation, with no current evidence of clinically significant obstruction.

Hepatobiliary findings include small choleliths and mild biliary sludge, with the common bile duct measuring at the upper end of expected limits and tapering distally. In the context of a significantly elevated ALT, these findings support hepatobiliary involvement, most consistent with inflammatory, metabolic, or functional hepatopathy. There is no ultrasonographic evidence of extrahepatic biliary obstruction. Pending thyroid and pancreatic results remain important for further clinical correlation.

Pancreatic changes suggest chronic pancreatitis, although ultrasonographic overlap with age-related changes is well recognized in cats. Correlation with clinical signs and pancreatic biomarkers is required.

Mild enlargement of a gastric lymph node with preserved morphology is most consistent with a reactive change, likely secondary to underlying hepatobiliary or pancreatic disease.

A dilated, tubular, fluid-filled structure is identified dorsal to the pancreas and extrahepatic portal vein. Although its appearance and location raise suspicion for a dilated abdominal vessel, definitive vascular characterization cannot be confirmed. Given the lack of associated clinical signs, mass effect, or secondary changes, this finding is considered most likely incidental and not felt to be a primary contributor to the patient's clinical presentation at this time.

Recommendations

- Further evaluation of hepatobiliary disease is recommended, including complete liver function assessment and correlation with pending T4 results, to investigate inflammatory, metabolic, or endocrine hepatopathies as the most likely contributors to the patient's weight loss and ALT elevation.
- Correlate pancreatic ultrasonographic findings with pending fPL.
- Monitor renal parameters and consider urinalysis.

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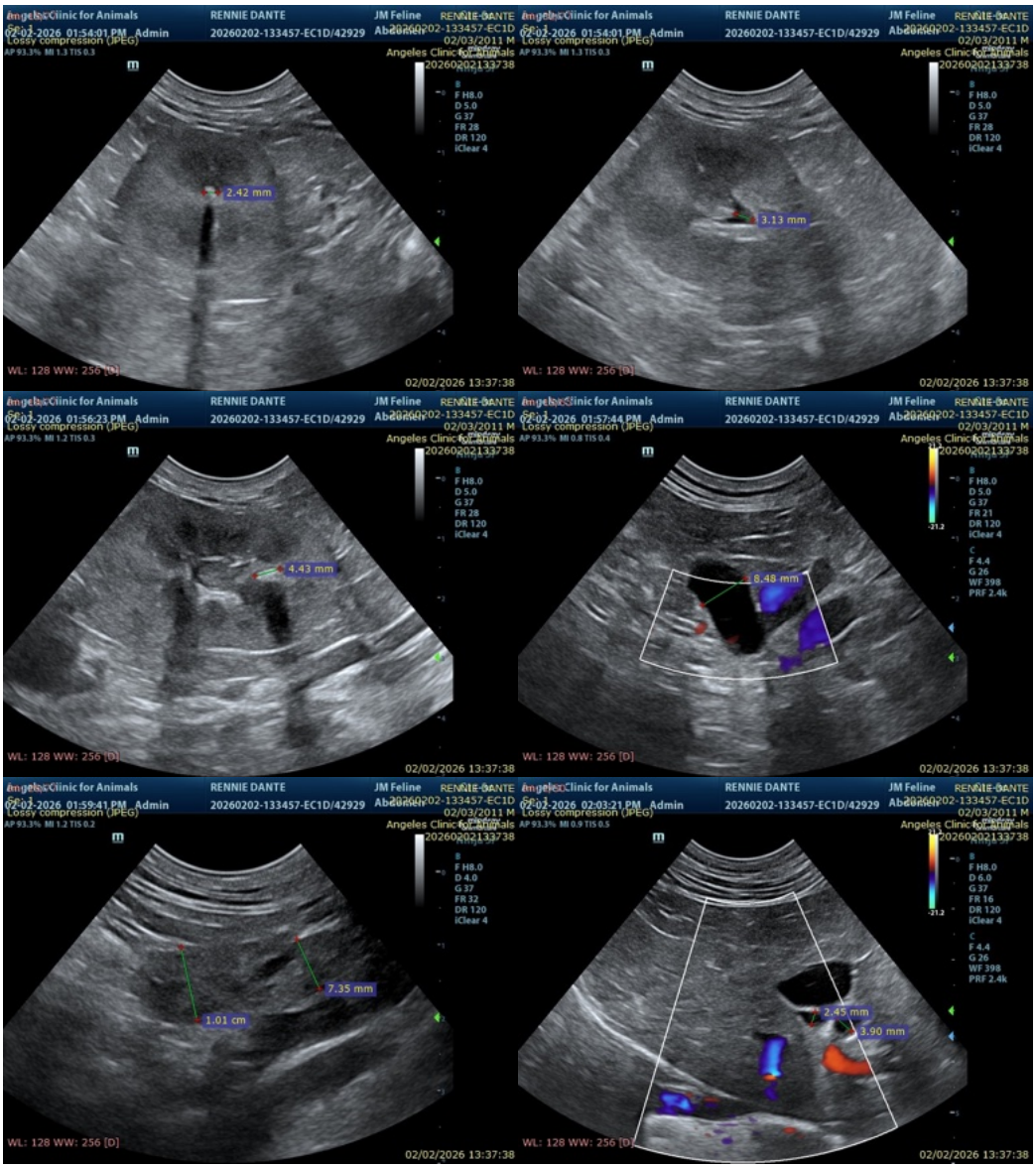
- Given the presence of a focal soft tissue swelling at the site of recent FeLV vaccination, further characterization of the left lateral thigh mass is recommended, including physical measurement and imaging (ultrasound) to assess size, depth, and tissue involvement. Depending on evolution and imaging findings, cytologic or histopathologic sampling may be warranted.



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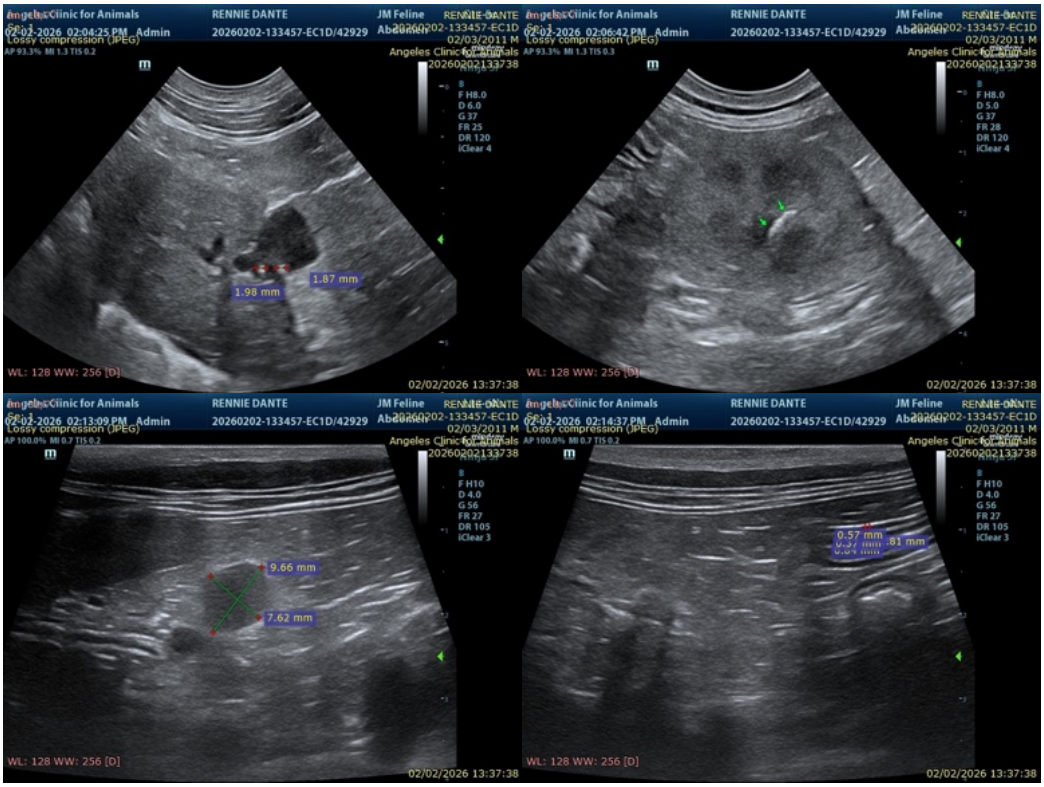

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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