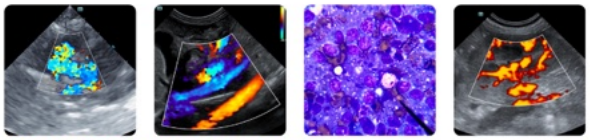


PATIENT

Gemma Jarvie

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

10 years

WEIGHT

6.2 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Hougentogler

HOSPITAL NAME

K-Vet AC

REFERRING VET

Dr. Hougentogler

INVOICE

73959

DATE

3/31/26

PRESENTING CLINICAL SIGNS

- Liver/GB; Pancreas
- Patient started vomiting and not eating about a week ago; not responding well to treatments; continues to decline. Lethargic; BCS 3/9; Icteric; possible organomegaly in cranial abdomen
- Weight 6.2 pounds. BodyScore9 4 - Ideal – 4. Temp 103.1, Pulse 180, Resp 40, Alert BAR
- Has been treated with Vitamin B; Fluids; Famotidine; Cerenia; Buprenorphine; Ursodiol; Penicillin; Clavamox; Depomedrol; Mirataz; Ondansetron - only a little bit of improvement; vomiting decreased; eating very little; continuing to decline
- Mono - 0.01; PLT - 55; PCT - 0.09%; TP - 8.3; Glob - 5.5; ALT - 832, ALP - 242; GGT - 15; TBil - 6.0; Precision PSL - 101

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended with a thin, smooth wall. The urine is anechoic. The bladder neck and proximal urethra appear unremarkable. No calculi are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic change.

The left kidney is normal in shape and size, measuring 3.18×1.97 cm with cortical thickness of 0.34 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 3.49×2.15 cm with cortical thickness of 0.40 cm in the sagittal plane.

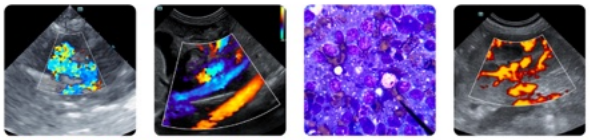
Both cortices are normally echogenic with preserved corticomedullary definition and normal ratios. Color Doppler demonstrates normal vascular pattern. No pyelectasia, nephroliths, or hydronephrosis is evident.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.29 cm at the cranial pole and 0.29 cm at the caudal pole. The right adrenal gland measures 0.30 cm at the cranial pole and 0.31 cm at the caudal pole.

Spleen

Splenic thickness is 0.65 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.



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Liver

The liver is subjectively enlarged with sharp margins and regular contour. The parenchyma appears diffusely heterogeneous with patchy variation in echogenicity and coarse echotexture but no discrete nodules or masses. No hepatic lymphadenopathy is identified.

The gallbladder lumen is normally distended with a thin wall. Contents are primarily anechoic with minimal biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and folded with mural thickness of 1.83 mm and preserved wall layering. Duodenum measures 2.11 mm with mild corrugation. Jejunum measures 2.71 mm (mucosa 1.42 mm, submucosa 0.97 mm, muscularis propria 0.73 mm). Ileum measures 2.02 mm (mucosa 0.73 mm, submucosa 0.61 mm, muscularis propria 0.28 mm).

Wall layering is preserved throughout. The ileocecocolic junction was not visualized. No evidence of inflammation, ileus, or foreign material.

Colon measures 0.75 mm with scant soft fecal material in the descending segment.

Pancreas

Pancreatic thickness measures 7.42–10.6 mm with irregular margins. The parenchyma is markedly hypoechoic relative to adjacent omental fat. The pancreatic duct measures 1.48 mm. Peripancreatic fat demonstrates evidence of active inflammation.

Free Abdomen

Mild to moderate abdominal effusion is present. No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation appears normal.

PRIMARY FINDINGS

- Severe pancreatic enlargement (7.42-10.6 mm), hypoechogenicity, irregular margins, duct prominence (1.48 mm), peripancreatic fat inflammation.
- Hepatomegaly with diffuse heterogeneous parenchyma and coarse echotexture.
- Mild-moderate abdominal effusion.

SECONDARY FINDINGS

- Mild jejunal mural thickening
- Duodenal corrugation.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver demonstrates hepatomegaly with diffuse parenchymal heterogeneity, patchy variation in echogenicity, and coarse echotexture—findings most consistent with chronic feline cholangiohepatitis that has undergone acute exacerbation, given the clinical icterus, markedly elevated ALT 832, ALP 242, TBil 6.0, and poor response to ursodiol and antibiotics. The disproportionate ALT elevation with relatively modest GGT increase favors a chronic lymphocytic/plasmacytic process over acute neutrophilic cholangitis. The absence of biliary distension or marked gallbladder wall changes does not exclude FCH, which frequently appears subtle on ultrasound in cats.

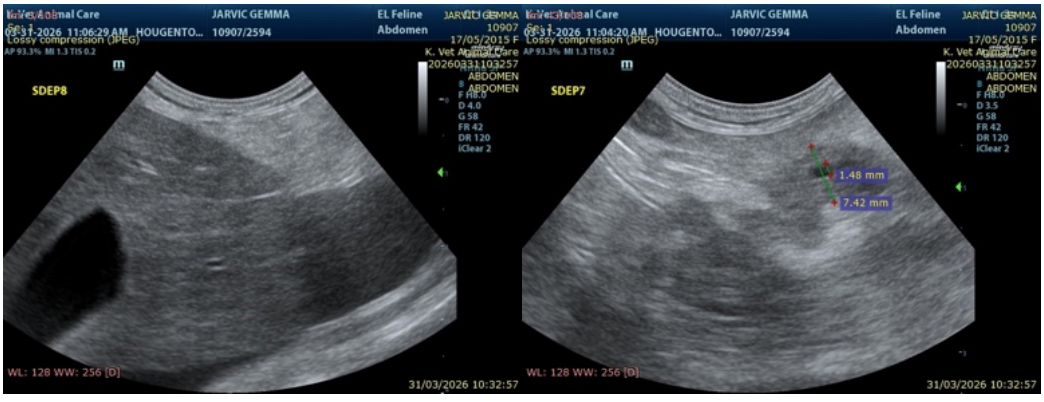
The pancreas shows severe acute pancreatitis, correlating with Precision PSL 101 and representing the likely acute trigger exacerbating the underlying chronic hepatobiliary disease.

Intestinal measurements reveal mild jejunal thickening with muscularis-to-mucosa ratio of 0.51, within normal feline reference ranges. Duodenal corrugation represents reactive duodenitis commonly associated with adjacent severe acute pancreatitis, rather than primary inflammatory bowel disease.

Abdominal effusion with thrombocytopenia raises concern for portal hypertension, coagulopathy, or systemic inflammatory response secondary to acute pancreatitis/hepatopathy.

Recommendations
Aggressive pancreatitis treatment first (IV fluids, esophagostomy tube feeding, analgesia, Cerenia). Once stabilized, initiate hepatic support with SAMe- silymarin, ursodiol (via tube), and consider prednisolone. Cobalamin SQ weekly. No FNA/biopsy due to thrombocytopenia. Monitor liver values.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.



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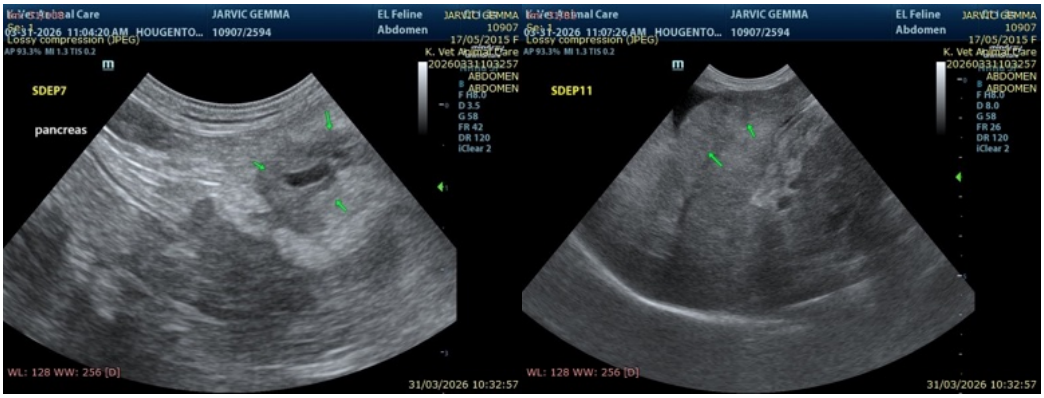

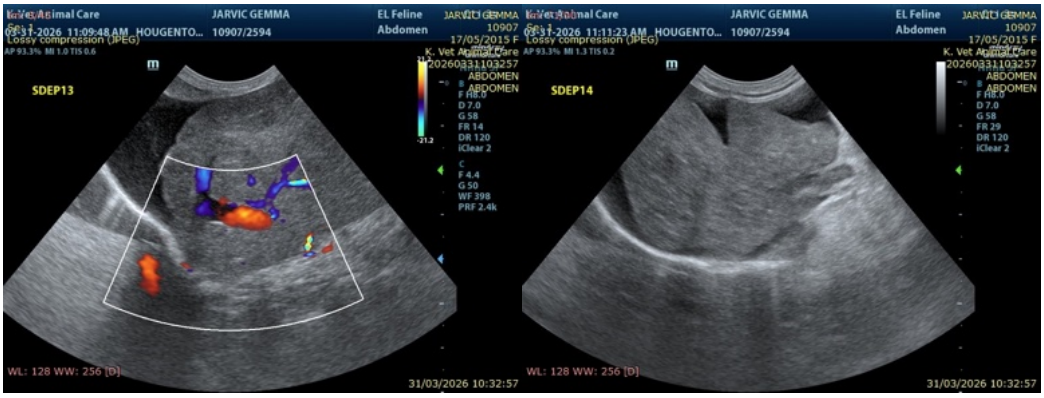

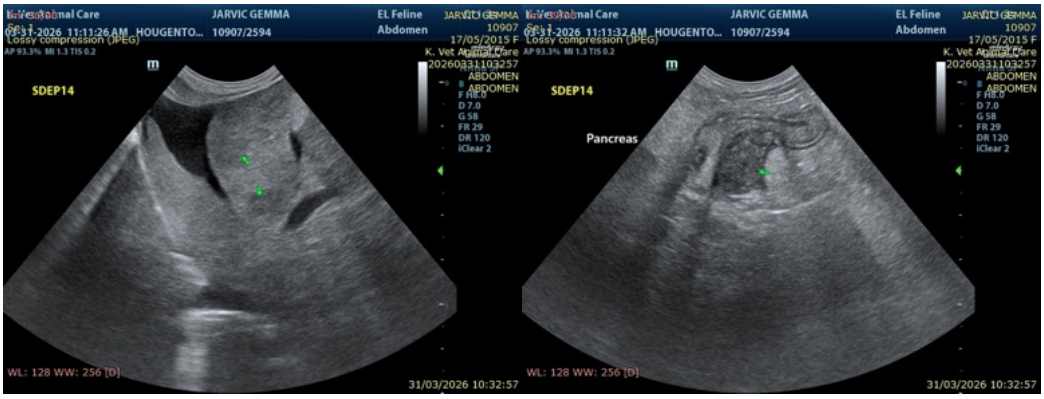

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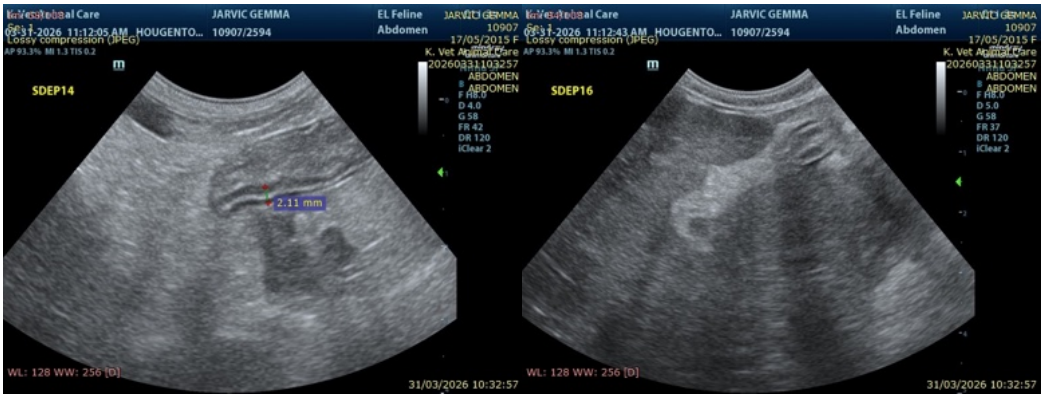

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com