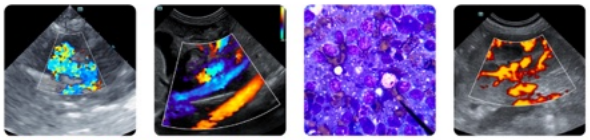


PATIENT

Mitz Stygles

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

14 years

WEIGHT

11.8 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Lexi Naylor

HOSPITAL NAME

Malletts Bay VH

REFERRING VET

Dr. Naylor

INVOICE

74491

DATE

4/15/26

PRESENTING CLINICAL SIGNS

History: lethargic/anorexic/reclusive for 3d. dehydrated on PE, pyrexic (104.2), slightly jaundiced yesterday but markedly jaundiced today. did not eat despite symptomatic care yesterday (SQF, cerenia, clavamox, gabapentin, metacam inj). very quiet today, did not need sedation for AUS
Abnormal PE/Chem/CBC/UA Results: BW: Low normal HCT (32%), Neutropenia, Lymphocytosis, Mild low K+, mild hyperglycemia (192, poss stress), Mild high Bili (1.1, plasma was icteric), Mild high SDMA (15) qPL=4.2 (normal) FeLV/FIV/HW=Neg UA (cysto)-USPG=1.050, Pro-500, Bili-6, Urobili-12, Cocci++ XRAYS: sternal lymphadenopathy, prominent kidneys

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the wall appears thin and smooth. The urine is turbid, with suspended echogenic material. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic changes.

The left kidney is slightly increased is size, measuring 4.26×2.98 cm in the sagittal plane, with a cortical thickness of 0.42 cm. The renal cortex hyperechoic compared to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. No pyelectasia, nephroliths, or hydronephrosis are observed.

The right kidney could not be confidently visualized in any of the submitted video clips.

Adrenal Glands

Not confidently visualized.

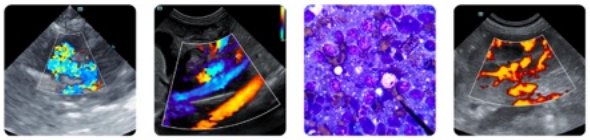
Spleen

Splenic thickness is 0.94 cm. The parenchyma demonstrates normal echogenicity and 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 parenchyma is homogeneous and isoechoic relative to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder is normally distended, with a thin wall. The contents are predominantly anechoic. No dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach is empty and folded, with a mural thickness of 1.37 mm and preserved wall layering. The pylorus measures 3.05 mm. Duodenum: 1.33 mm. Jejunum: 2.12 mm (mucosa 1.14 mm; submucosa 0.49 mm; muscularis propria 0.19 mm). Ileum: 1.94 mm (mucosa 0.98 mm; submucosa 0.66 mm; muscularis propria 0.68 mm), with preserved wall layering. The ileocecal junction was not visualized. No ultrasonographic evidence of inflammation, ileus, or foreign material is identified. Colon: 1.06 mm, containing a small amount of soft fecal material.

Pancreas

The pancreas measures 7.62 mm in thickness. The parenchyma is mildly hypoechoic relative to the adjacent omental fat. The pancreatic duct measures 1.03 mm in diameter. No peripancreatic fat changes are observed.

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Mild pancreatic enlargement (7.62 mm) with slight hypoechogenicity.
- Pancreatic duct measuring 1.03 mm

SECONDARY FINDINGS

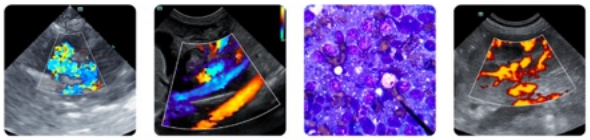
- Turbid urine with suspended echogenic material.
- Mild diffuse renal cortical hyperechogenicity.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Despite the patient's marked and rapidly progressive jaundice, there is no ultrasonographic evidence of extrahepatic biliary obstruction, with normal appearance of the gallbladder and biliary tract and an unremarkable hepatic parenchyma. In this context, the findings support a non-obstructive hepatobiliary process.

Given the clinical presentation (fever, neutropenia, acute deterioration, and hyperbilirubinemia), the leading consideration is acute inflammatory or infectious hepatobiliary disease, particularly neutrophilic cholangitis, with possible contribution from sepsis-associated cholestasis. In cats, these conditions may be present despite a normal ultrasonographic appearance, especially when inflammation is confined to microscopic bile ducts or is diffuse without causing structural changes.

The pancreatic changes are nonspecific and may reflect chronic or age-related changes. The normal feline pancreatic lipase concentration reduces the likelihood of clinically relevant pancreatitis; however, mild or chronic pancreatic inflammation cannot be entirely excluded, as fPLI has limited sensitivity in



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these settings.

Intestinal findings are within normal limits, with preserved wall layering and no evidence of obstruction, ileus, or clinically relevant enteropathy.

The presence of turbid urine with suspended echogenic material is consistent with the urinalysis findings, supporting the presence of significant urinary sediment. No ultrasonographic evidence of cystitis is identified.

The left kidney is 4.26 cm; upper end to mildly above typical feline reference range (~3.0–4.5 cm), with increased cortical echogenicity relative to the liver, while maintaining normal corticomedullary definition and architecture. This combination of findings is most consistent with mild renal parenchymal disease, although the preserved architecture suggests no advanced structural remodeling at this time.

Recommendations

- Further hepatobiliary evaluation:
  - Liver ± gallbladder sampling (FNA or biopsy, depending on stability).
  - Bile cytology and culture if feasible.

- Continue/adjust broad-spectrum antimicrobial therapy pending diagnostic results.
- Monitor bilirubin, liver enzymes, and clinical status closely over the next 24–48 hours.
- Supportive care (IV fluids, antiemetics, nutritional support) is indicated.

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

***PLEASE NOTE

The gastric wall layering is preserved, and although the submucosal layer appears subjectively somewhat prominent, the overall gastric wall thickness remains within normal limits for a cat. As such, this finding is considered of uncertain clinical significance and does not support a definitive diagnosis of gastric pathology. The pancreaticoduodenal lymph node is visualized and is within normal limits in size and echogenicity, as well as the other LN. In addition: I may be mistaken, but I was unable to confidently identify the right kidney in the submitted clips. It is possible that both kidneys are present but not labeled; however, the images appear most consistent with different views of the left kidney. Please let me know if additional clips are available. Thank you

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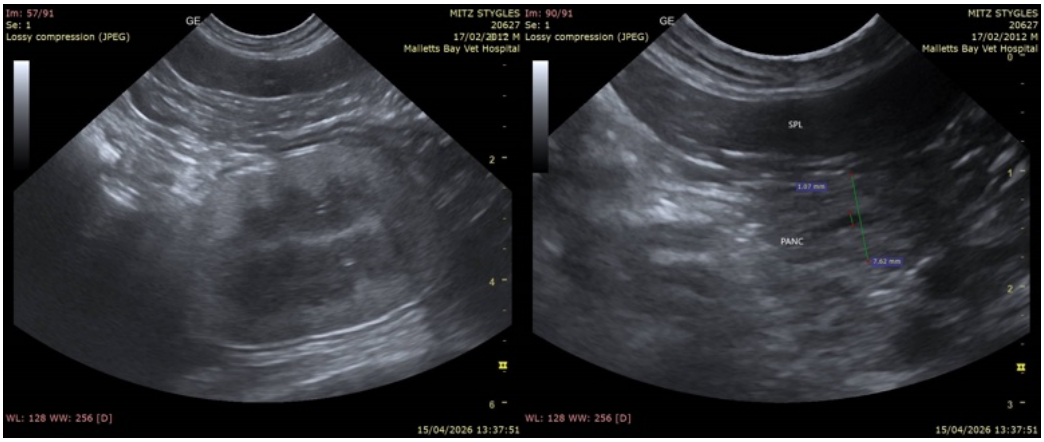

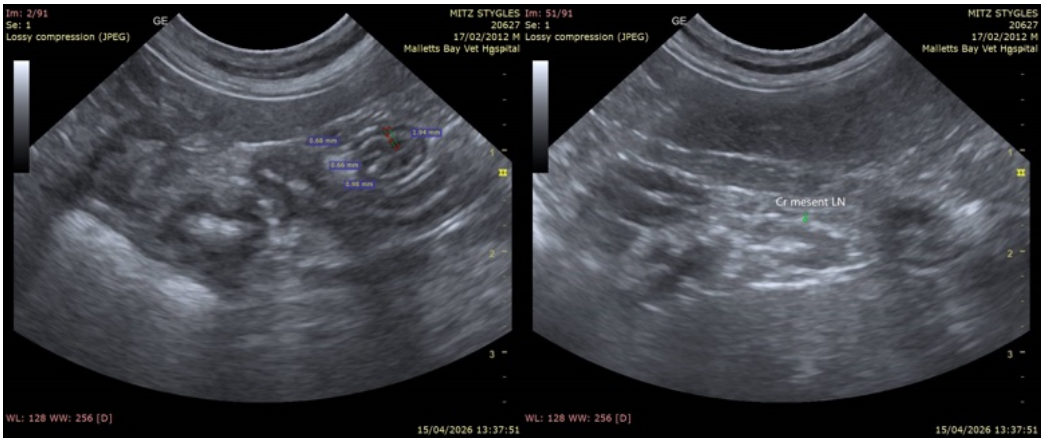

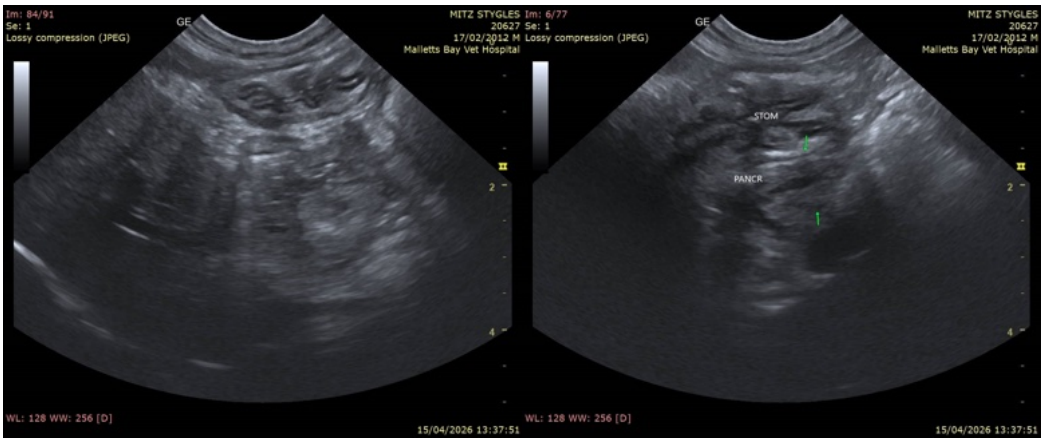

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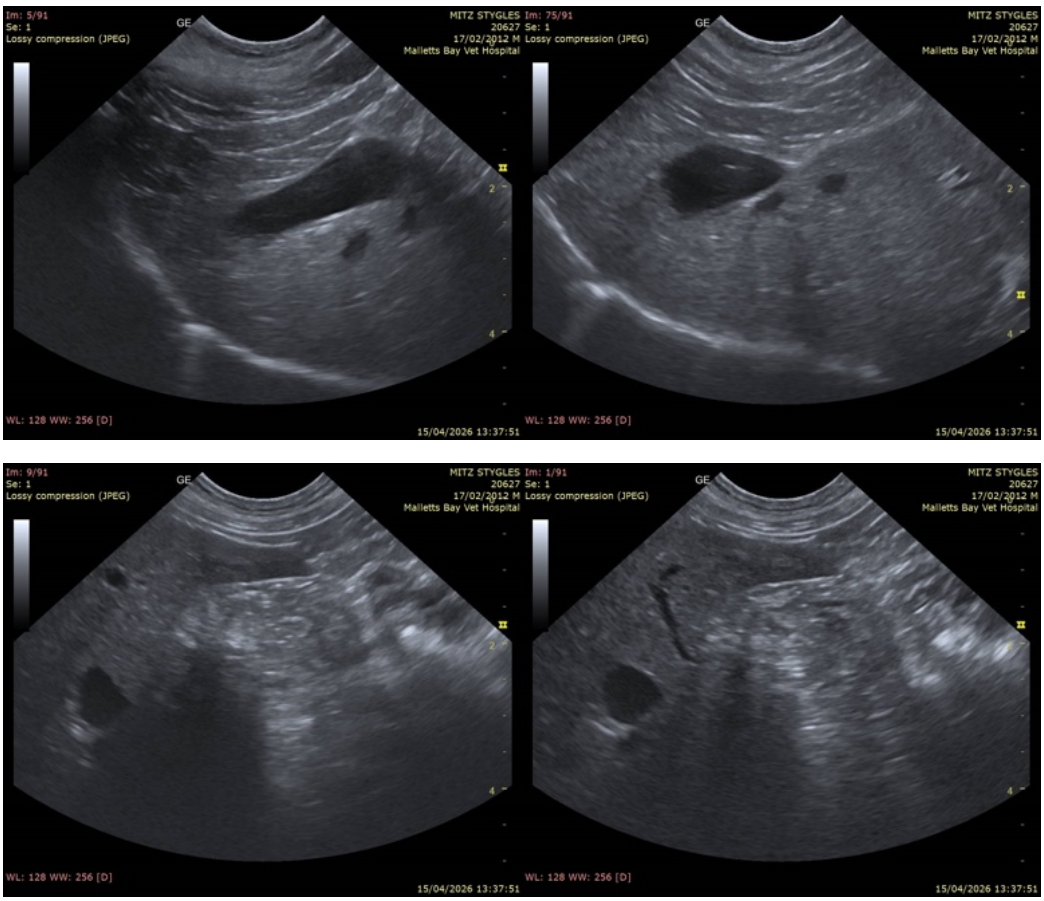

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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