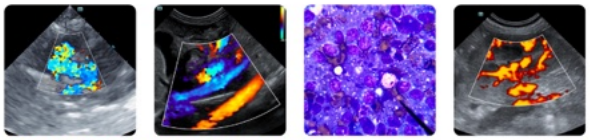

PATIENT

Molly Abulencia

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

11 years

WEIGHT

3.72 kg

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Patrick Hennigan, DVM

HOSPITAL NAME

Mattydale AH

REFERRING VET

Karen Leshkivich, DVM

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PRESENTING CLINICAL SIGNS

History: p presented 4/1/26 for difficulty defecating, small bowel movements. PE mm tacky, palpated small hard stool in colon. Plan: CBC/Chem/T4, subQ fluids, enema. Rx lactulose, miralax. 4/14/26 recheck, no stools in 2 days, n/e in am. radiograph showed poor detail to abdomen. Abnormal PE/Chem/CBC/UA Results: Alk Phos 120 (6-102), Lymphocytes 335 (1200-8000). Remaining WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended, with a thin and smooth wall. The urine is anechoic. The bladder neck and proximal urethra appear normal. No uroliths or ultrasonographic evidence of inflammatory or neoplastic changes are identified.

The left kidney is normal in shape and size, measuring 3.50×1.99cm, with a cortical thickness of 0.30cm. The right kidney measures 3.70×1.92cm. In both kidneys, the cortex has normal echogenicity. The corticomedullary ratio is within normal limits and corticomedullary definition is preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified.

Adrenal Glands

Not confidently visualized.

Spleen

Splenic thickness is 1.07 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

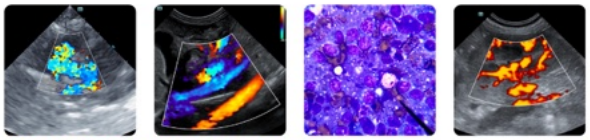
Liver

The liver is subjectively increased in size, with rounded edges and a regular contour. The liver parenchyma looks uniform and hyperechoic compared to the falciform fat, with a fine echotexture. No hepatic lymphadenopathy is observed.

The gallbladder is normally distended, with a thin wall and a moderate amount of biliary sludge. The common bile duct measures 2.39–1.31mm, within normal limits for a cat.

Gastrointestinal

The stomach is empty and folded, with a wall thickness of 1.34mm and preserved layering. The pylorus measures 3.96mm, with a muscularis thickness of 1.82mm. The duodenum measures 1.30mm. The jejunum measures 1.81mm (mucosa 1.05mm, submucosa 0.43mm, muscularis propria 0.24mm), with preserved layering. The ileum measures 1.62mm (mucosa 0.96mm, submucosa 0.76mm, muscularis



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propria 0.51mm), with preserved layering. The ileocecal junction measures 3.29mm, with a muscularis thickness of 1.30mm. No evidence of ileus, obstructive pattern, or intraluminal foreign material is identified. The colon measures: Ascending: 0.74mm, Transverse: 0.97mm, Descending: 0.82mm. There is a mild amount of formed fecal material, without evidence of impaction or marked distension.

Pancreas

The pancreatic parenchyma is not confidently identified; however, the evaluated regions do not show evidence of overt inflammation or focal lesions.

Free Abdomen

Moderate anechoic abdominal effusion is present. No lymphadenomegaly is identified. The iliac trifurcation region is normal.

PRIMARY FINDINGS

- Moderate abdominal effusion
- Mild disproportionate muscularis thickening:
  - Pylorus (muscularis 1.82mm).
  - Ileocecal junction (muscularis 1.30mm).

SECONDARY FINDINGS

- Mild hepatomegaly with diffuse hyperechogenicity.
- Biliary sludge.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver is mildly enlarged and diffusely hyperechoic, with a homogeneous echotexture, findings most consistent with hepatic lipidosis, likely secondary to decreased intake or systemic disease rather than a primary hepatic disorder. A moderate amount of biliary sludge is present within the gallbladder. In cats, this finding is commonly associated with biliary stasis secondary to anorexia or decreased gastrointestinal motility, and is considered clinically secondary in this context, without evidence of biliary obstruction.

The colon is not distended and does not contain impacted fecal material, indicating that the previously reported constipation or obstipation is not currently a primary structural issue.

Mild segmental muscularis prominence (notably at the pylorus and ileocecal region) is noted, with preserved wall layering. These changes are mild and nonspecific and may reflect early or low-grade chronic enteropathy.
The pancreas is not confidently visualized; therefore, pancreatitis cannot be excluded, although no secondary ultrasonographic signs are identified.

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Importantly, the presence of moderate abdominal effusion without a clear cardiac or ultrasonographic source raises concern for an underlying systemic or intra-abdominal disease process. Differential considerations include:

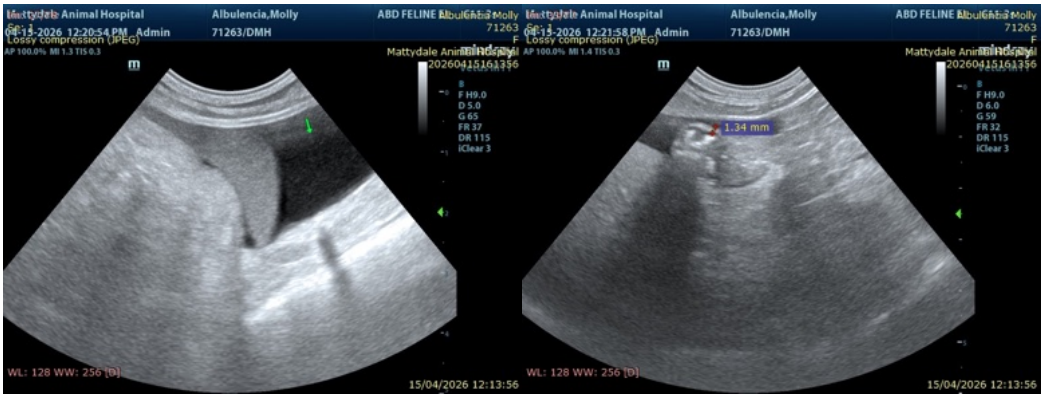
- Inflammatory or infectious peritonitis.
- Neoplastic disease (particularly early or infiltrative processes such as lymphoma or carcinomatosis).
- Effusion secondary to hypoalbuminemia.

Feline infectious peritonitis remains a differential diagnosis; however, based on the available clinical and laboratory data, it is not specifically supported nor excluded.

Recommendations

- Abdominocentesis and fluid analysis:
  - Cytology and total protein concentration.
  - Consider Rivalta test and additional testing (PCR) as clinically indicated
- Correlate with serum albumin and globulin concentrations.
- Assessment of pancreatic-specific lipase may be considered, particularly given the limited pancreatic evaluation and clinical signs.
- Adequate hydration, which may help improve biliary flow and reduce sludge formation, as well as help to prevent constipation.

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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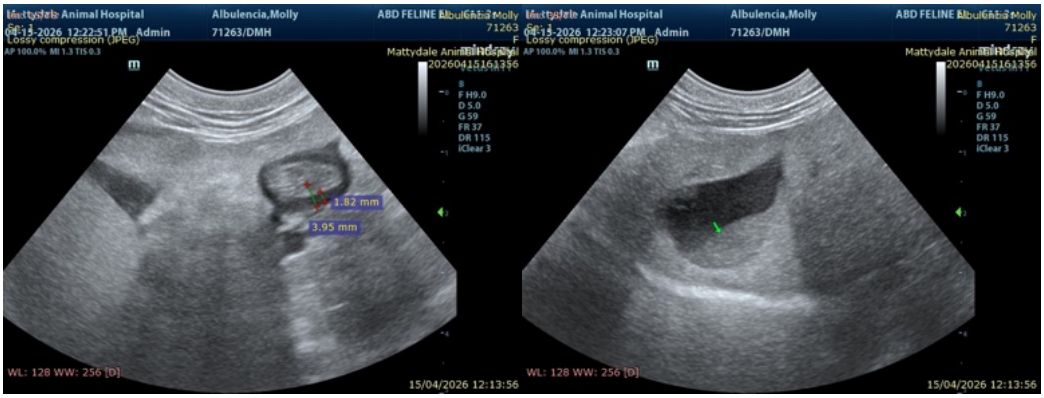

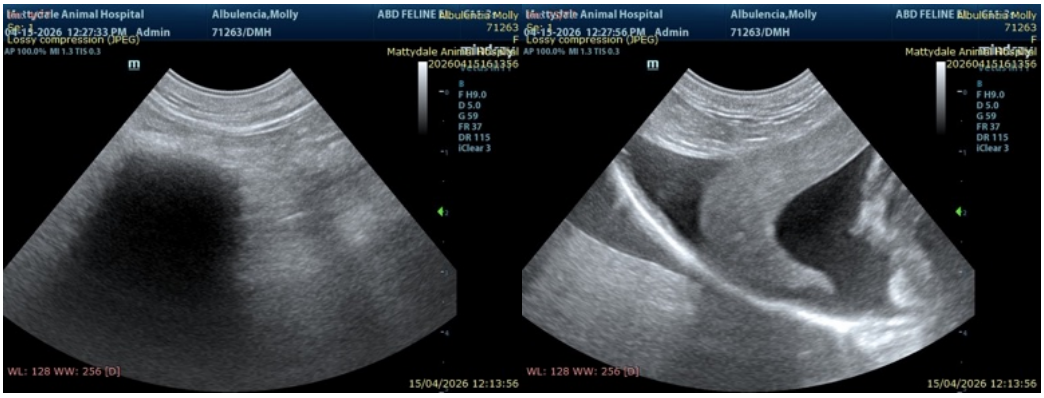

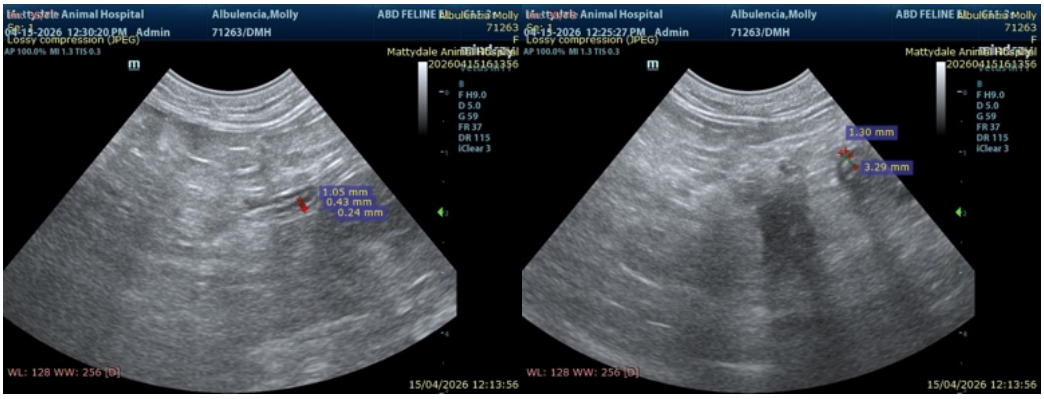

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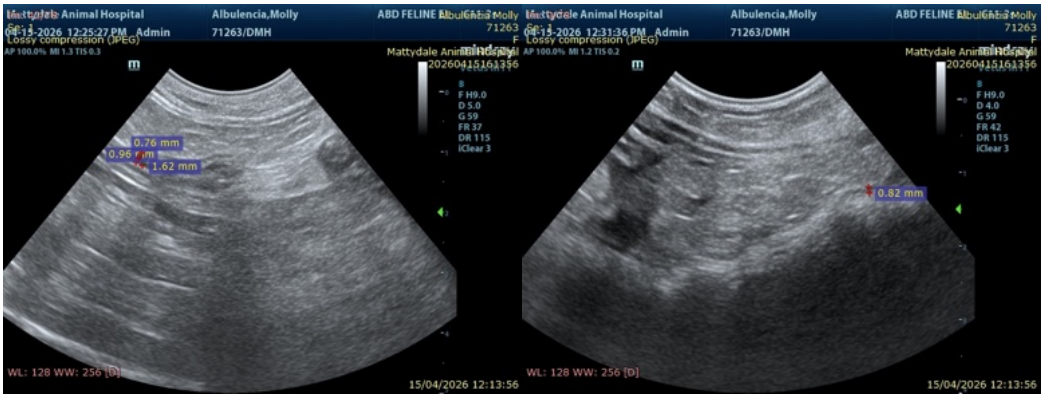

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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