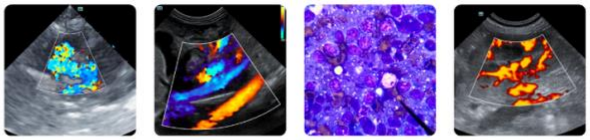


PATIENT

Jack Woodward

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

10 Years

WEIGHT

11 pounds

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Mark Schlimgen DVM

HOSPITAL NAME

Sherwood Family Pet Clinic

REFERRING VET

Dr. Michelle Janik

INVOICE

15203

DATE

04/17/26

PRESENTING CLINICAL SIGNS

Hyporexia, vomiting more often, and also is more vocal during mealtime, will often leave food unfinished when he used to eat all his food. Chews more on toys than previously, does not ingest the toys.
HX: Heart murmur, Seizures - currently well controlled on levetiracetam, Elevated liver values historically, Dental disease. Current meds: Maropitant, Levetiracetam, Gabapentin, Laxatone, Royal Canin renal canned

Abnormal PE/Chem/CBC/UA Results: ALT 163, ALP 67, Tbili 0.4, fPL 29.7 (0-4.4), Cardiopet proBNP 220 (0-100)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is moderately distended, and the wall appears thin and smooth. The urine is anechoic. The bladder neck and proximal urethra have a normal appearance. No calculi or evidence of inflammatory or neoplastic changes are identified.

The left kidney is normal in shape and size, measuring 3.23×2.22 cm, with a cortical thickness of 0.28 cm in the sagittal plane. The cortex is isoechoic compared to the hepatic parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

The right kidney is normal in shape and size, measuring 3.07×1.94 cm, with a cortical thickness of 0.32 cm in the sagittal plane. The cortex is isoechoic compared to the hepatic parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

Not confidently visualized.

Spleen

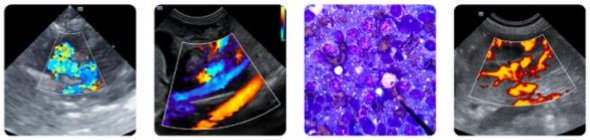
Splenic thickness is 0.51 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively increased in size, with markedly irregular margins that distort the normal architecture. The hepatic parenchyma is heterogeneous and contains multiple nodules of varying sizes. Most are small (<1 cm), hyperechoic, and relatively homogeneous, forming a multinodular pattern; however, larger nodules with variable echogenicity are also present, some forming mass-like lesions.

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

Gastrointestinal



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The stomach is empty and folded, with a mural thickness of 2.16 mm and preserved wall layering. The pylorus measures 4.19 mm. The duodenum measures 1.89 mm. The jejunum measures 1.98 mm, with mucosa 0.93 mm, submucosa 0.55 mm, and muscularis propria 0.33 mm. The ileum measures 2.34 mm, with mucosa 0.31 mm, submucosa 0.68 mm, and muscularis propria 0.53 mm; wall layering is preserved. The ileocecal junction measures 3.62 mm, with muscularis 1.78 mm.

The colon measures 0.93 mm and contains formed feces in the descending segment.

Pancreas

The evaluated pancreatic regions do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

No abdominal effusion or peritonitis is observed. Cranial mesenteric and ileocecal lymph nodes measure 2.01–2.80 mm, which is within normal limits, and the surrounding regions appear unremarkable. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Hepatomegaly with severely irregular margins and architectural distortion
- Diffuse heterogeneous hepatic parenchyma with multinodular pattern and multiple mass-like lesions of variable echogenicity

SECONDARY FINDINGS

- Mild biliary sludge.
- Focal increased muscularis thickness at the ileocecal junction (1.78 mm)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The dominant abnormality is severe, diffuse hepatic disease characterized by hepatomegaly, marked architectural distortion, and a multinodular to mass-like parenchymal pattern. The presence of nodules of varying size and echogenicity, including mass-like lesions, increases concern for a neoplastic process, although nodular hyperplasia within a chronically diseased liver remains a differential in cats. Ultrasound alone cannot reliably distinguish between these entities.
The mild ALT elevation (163) supports hepatocellular injury but does not allow assessment of hepatic function or differentiation between benign and malignant causes. The previously reported history of elevated liver enzymes further supports a chronic process. Definitive characterization requires cytology or histopathology.

Despite a markedly elevated fPL, the pancreatic areas recorded appears unremarkable on ultrasound. This discrepancy is well recognized in cats, as pancreatitis can be present without ultrasonographic abnormalities. Therefore, pancreatitis remains strongly supported clinically and biochemically despite the lack of imaging changes.

Gastrointestinal findings, including muscularis-to-mucosa ratios (jejunum ~0.35; ileum ~1.7 locally at the ileocecal junction), do not support diffuse inflammatory bowel disease or small cell lymphoma, although the focal muscularis prominence at the ileocecal junction is of uncertain significance.

Recommendations

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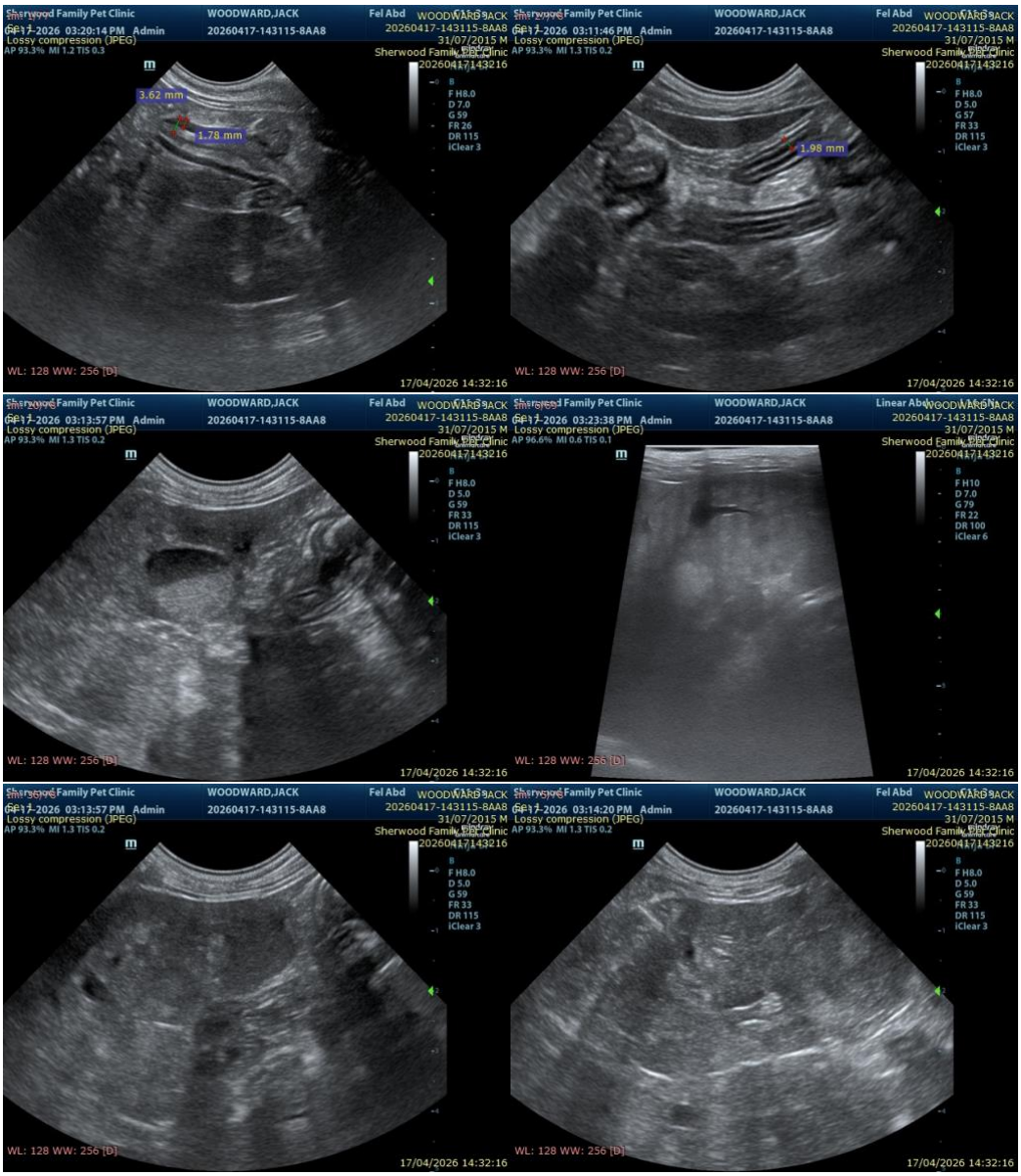
- Hepatic cytology is strongly recommended as a first step; if nondiagnostic, biopsy may be required for definitive diagnosis.
- Complete liver panel including bile acids or ammonia is recommended to assess hepatic function.
- Consider echocardiography in light of elevated proBNP, particularly prior to any anesthesia or invasive procedures.

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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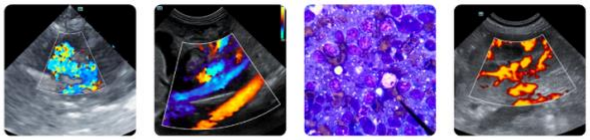

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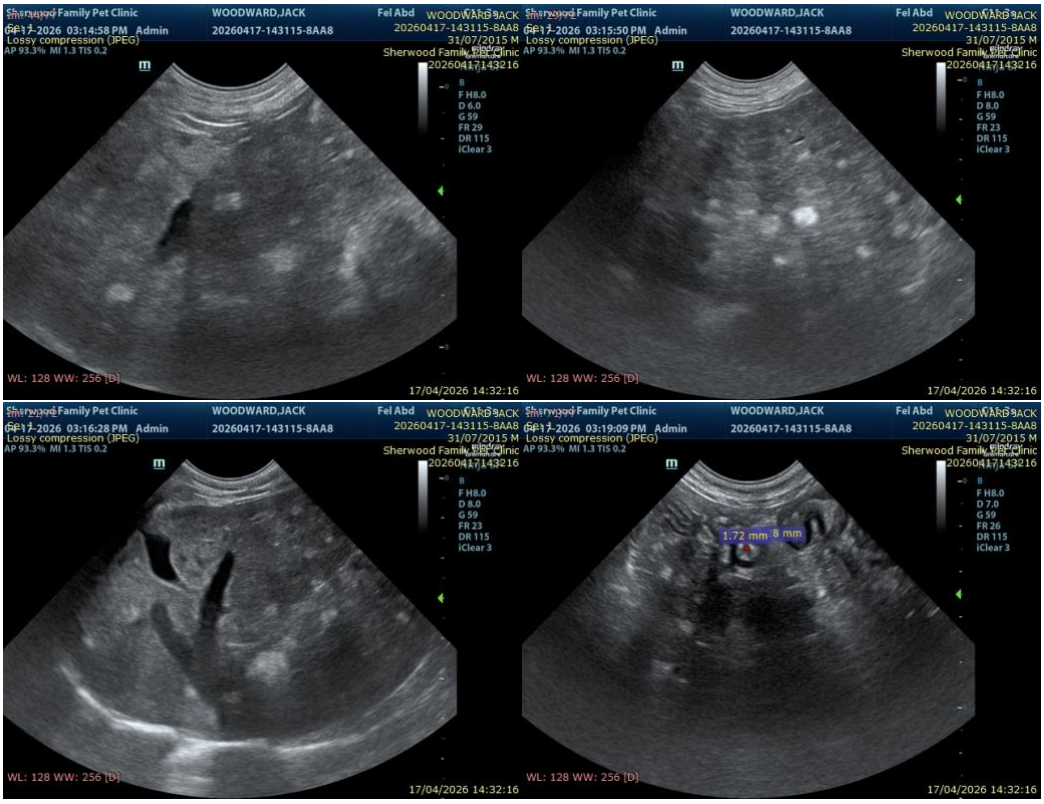

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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