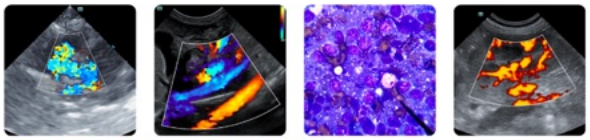


PATIENT

Finn Cairns

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

10 years

WEIGHT

9.14 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Brian Klug

HOSPITAL NAME

Sondel Family VC

REFERRING VET

Dr. Mortensen

INVOICE

74098

DATE

74098

PRESENTING CLINICAL SIGNS

- Significant weight loss over last two months
- T. Bili - 12.7 ALT - 812 ALP -215 Albumin and gobulins unable to read Icteric Ua - bilirubin crystals present

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is predominantly anechoic with scant suspended echoes. Normal appearance of the bladder neck and proximal urethra. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 3.86×2.36 cm in the sagittal plane. Cortical thickness is 0.38 cm. The cortex is isoechoic compared to the hepatic parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

The right kidney is normal in shape and size, measuring 4.01×2.26 cm in the sagittal plane. Cortical thickness is 0.30 cm. The cortex is isoechoic compared to the hepatic parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.27 cm at the cranial pole and 0.29 cm at the caudal pole. The right adrenal gland measures 0.26 cm at the cranial pole and 0.26 cm at the caudal pole.

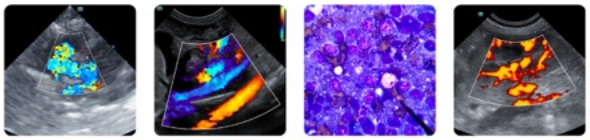
Spleen

Splenic thickness is 1.38 cm. The parenchyma demonstrates mildly decreased 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 hepatic parenchyma is homogeneous and isoechoic relative to the falciform fat, with a normal echotexture. No focal lesions or hepatic lymphadenopathy are identified.

The gallbladder is normally distended. The wall is thin and regular. The luminal contents are predominantly anechoic with a small amount of biliary sludge. The common bile duct measures 3.51 mm proximally, tapering to 2.87 mm, 1.84 mm, and 1.71 mm distally.



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Gastrointestinal

The stomach is empty and folded, with a wall thickness of 1.71 mm and preserved layering. The pylorus measures 4.14 mm. Duodenum: 2.11 mm. Jejunum: 1.89 mm, with mucosa 1.00 mm, submucosa 0.47 mm, and muscularis propria 0.17 mm. Ileum: 2.06 mm, with mucosa 0.59 mm, submucosa 0.65 mm, and muscularis propria 0.93 mm. Wall layering is preserved. The ileocecal junction measures 3.15 mm, with muscularis thickness of 1.47 mm. Colon: ascending colon 0.83 mm; descending colon 0.60 mm, containing small amounts of formed feces.

Pancreas

Pancreatic thickness ranges from 4.04–5.01 mm. Pancreatic parenchyma is mildly hypoechoic relative to the adjacent omental fat. The pancreatic duct measures 1.03–1.60 mm in diameter. No hyperechoic change of the surrounding peripancreatic fat is identified.

Free Abdomen

No abdominal effusion or signs of peritonitis are present. Cranial mesenteric lymph nodes measure 2.93–2.58 mm and ileocecal lymph nodes 1.39–1.54 mm; both are within normal limits in size and maintain normal shape and echogenicity. Mild hyperechogenicity of the surrounding perinodal fat is present. The iliac trifurcation appears normal.

PRIMARY FINDINGS

- Marked ileal and ileocecal muscularis thickening.
- Small amount of biliary sludge. Mild proximal common bile duct dilation
- Mild pancreatic enlargement and hypoechogenicity. Pancreatic duct dilation.

SECONDARY FINDINGS

- Mild perinodal fat hyperechogenicity.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although the liver appears structurally unremarkable on ultrasound, the marked hyperbilirubinemia and hepatocellular enzyme elevation support a clinically significant diffuse hepatobiliary disorder. In this context, the hepatic component may reflect cholestatic hepatopathy secondary to biliary disease, inflammatory hepatopathy associated with feline triaditis. Diffuse infiltrative disease not detectable sonographically is considered unlikely.

Mild pancreatic enlargement, hypoechogenicity, and pancreatic duct dilation support pancreatopathy, compatible with chronic or low-grade pancreatitis in a feline patient. There is a marked muscularis thickening in the ileum and especially at the ileocecal junction. This pattern supports chronic enteropathy, including both inflammatory bowel disease and low-grade lymphoma.

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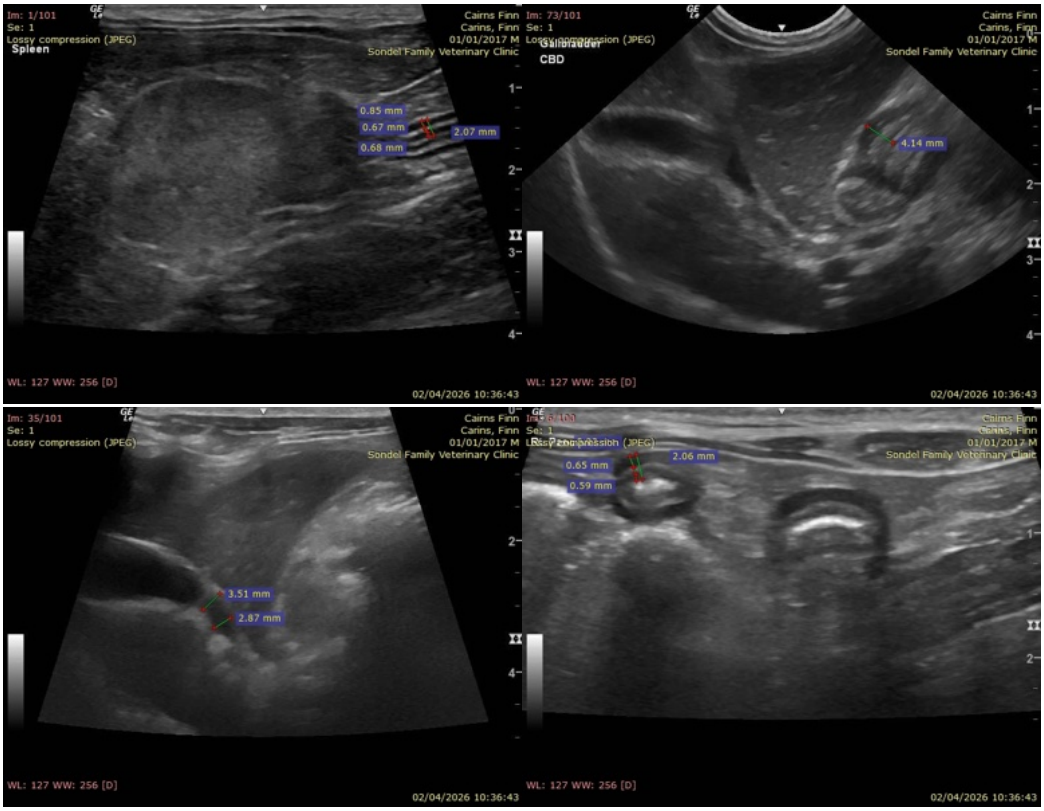
Normal lymph node size and preserved layering do not exclude either entity. The mild perinodal fat hyperechogenicity supports a low-grade regional inflammatory component.

Overall, the findings are most consistent with a triaditis-type process with concurrent enteric, pancreatic, and biliary involvement.

Recommendations

- Further characterization of the hepatobiliary process is recommended, including correlation with pancreatic lipase testing if not already available and close clinical/laboratory monitoring of bilirubin and liver enzymes.
- Empirical treatment for a pancreatobiliary inflammatory process is reasonable, together with supportive care and nutritional management.
- Chronic enteropathy remains strongly suspected; GI panel and cobalamin assessment are recommended if not already performed.
- If clinical response is poor or if bilirubin fails to improve, further diagnostics should be considered, including sampling of the liver and/or intestine as clinically appropriate, as ultrasound alone cannot definitively distinguish inflammatory from infiltrative disease here.

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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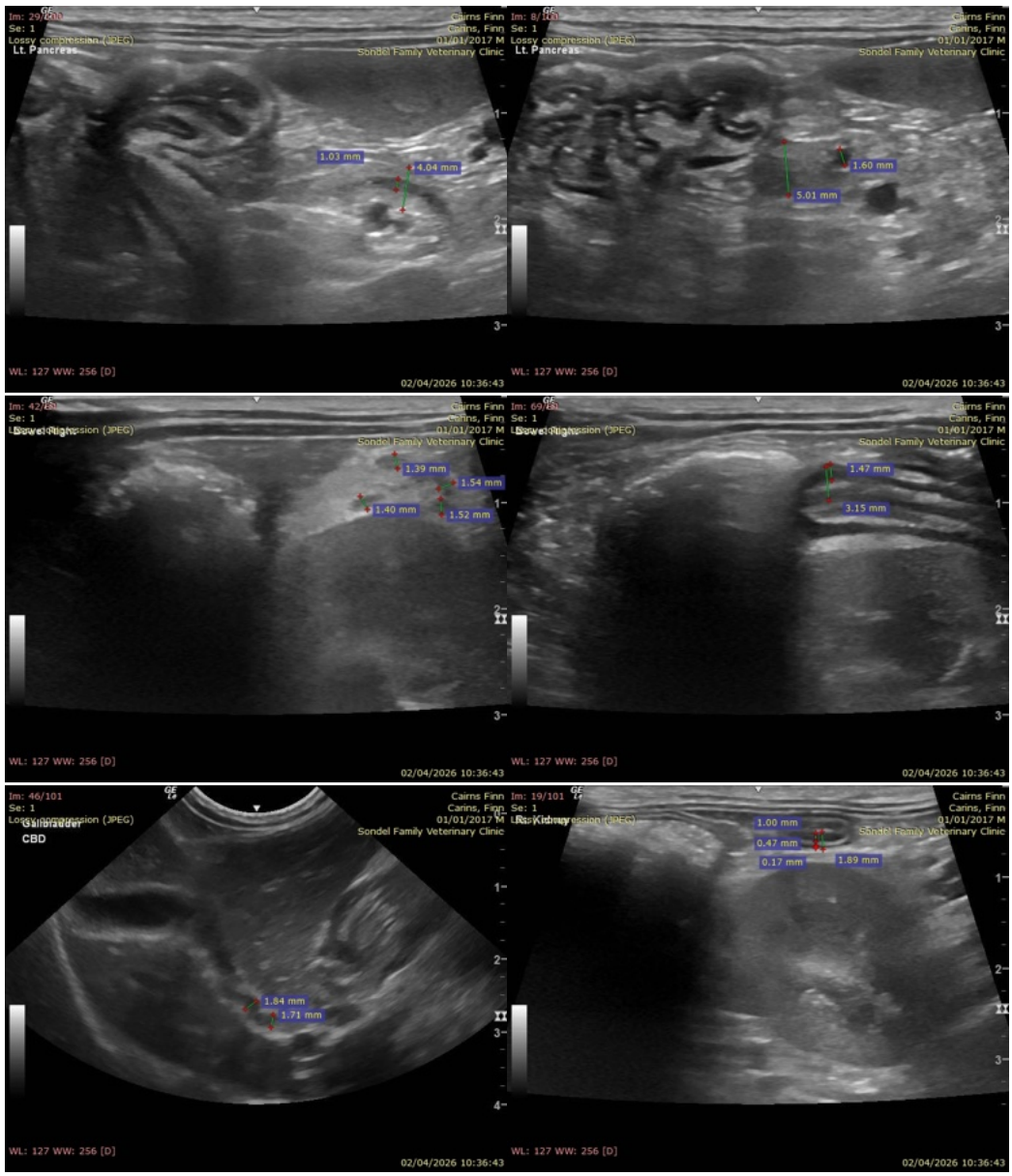

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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