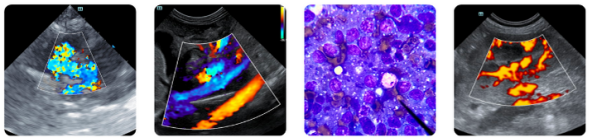


PATIENT

Luna Westcott

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

16 years

WEIGHT

10.4 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Ryan Bergner, LVT

HOSPITAL NAME

Waterville VC

REFERRING VET

James Gilchrist, DVM

INVOICE

74874

DATE

4/27/26

PRESENTING CLINICAL SIGNS

History: Presented today for acute vomiting and anorexia. Ate her dinner last night, at approximately 3:00 AM this morning, she vomited the entirety of her dinner. Since then, she has had multiple episodes of vomiting bile and has been vocalizing more than usual. She has refused to eat all day until just prior to the appointment, when she consumed a small amount of a liquid treat.
History of diabetes mellitus. She received her insulin last night but did not receive it this morning because she was not eating.
Physical exam findings include dehydration, bilateral cataracts, and being edentulous.
Abnormal PE/Chem/CBC/UA Results: CBC: Increased Lymph - 7.71 Chem: Glu 403, ALT 1853 after dilution, ALP 178, GGT 6, Bili 1.1 UA: SG 1.018, Glu 56 Radiology report conclusions: Severe extensive biliary tract mineralization and large calculi suspect affecting large parts of the common bile duct. Suspect spleno-systemic collateral circulation.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is poorly distended, limiting wall evaluation. The urine is anechoic. The bladder neck and proximal urethra appear normal. There are no calculi and no ultrasonographic evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 4.12×1.84 cm, with a cortical thickness of 0.37 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 4.01×1.87 cm, with a cortical thickness of 0.30 cm in the sagittal plane. In both kidneys, the cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio is within normal limits and corticomedullary definition is preserved. There is dilation of the renal pelvis measuring 8.57 mm in the left kidney and 4.08 mm in the right kidney.

Adrenal Glands

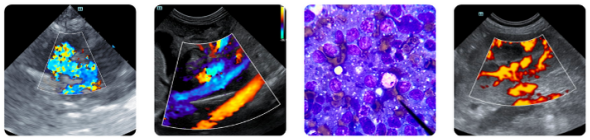
Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.29 cm at the cranial pole and 0.28 cm at the caudal pole. The right adrenal gland measures 0.27 cm at the cranial pole and 0.26 cm at the caudal pole.

Spleen

Splenic thickness is 0.62 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 edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.



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The gallbladder is normally distended. The wall measures 0.91 mm and appears hyperechoic. The lumen contains a moderate amount of choleliths. The common bile duct measures 3.98–3.51–3.28–2.54–2.09 mm from proximal to distal. The wall thickness measures 0.74 mm. The intrahepatic bile ducts are diffusely filled with hyperechoic structures producing distal acoustic shadowing, consistent with mineral material (cholelithiasis/choledocholithiasis).

Gastrointestinal

The stomach is empty and folded, with a mural thickness of 1.06 mm and preserved wall layering. The pylorus measures 2.99 mm. Duodenum: 1.19 mm. Jejunum: 1.21 mm (mucosa 0.64 mm, submucosa 0.37 mm; muscularis not reliably measured). Ileum: 1.80 mm (mucosa 0.70 mm, submucosa 0.76 mm, muscularis propria 0.30 mm). Wall layering is preserved throughout. The ileocecal junction was not visualized. No ultrasonographic evidence of obstruction, ileus, or foreign material is identified. Colon: 0.81 mm, containing a small amount of formed fecal material.

Pancreas

The pancreas was not clearly visualized on the available images; however, the evaluated pancreatic regions do not show evidence of significant ultrasonographic abnormalities.

Free Abdomen

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

PRIMARY FINDINGS

- Diffuse cholelithiasis and choledocholithiasis involving gallbladder, common bile duct, and intrahepatic bile ducts.
- Mild to moderate common bile duct dilation.
- Bilateral pyelectasia-
- No spleno-systemic collateral vessels were identified on the provided clips.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is extensive mineral material (cholelithiasis/choledocholithiasis) involving the gallbladder, common bile duct, and intrahepatic bile ducts. The distribution and quantity of mineralization are highly unusual in cats and strongly support a chronic underlying biliary disorder, most consistent with cholangitis/cholangiohepatopathy associated with long-standing biliary stasis.
The marked elevation in ALT indicates severe hepatocellular injury, which in this context is most likely secondary to the underlying biliary disease, including inflammation and impaired bile flow.

The common bile duct measures up to 3.98 mm. While this does not confirm complete obstruction in a cat of this age, the presence of mineral material within the ductal system is clinically significant and

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supports impaired bile flow, most consistent with partial or intermittent obstruction rather than a fixed, complete obstruction at this time. The absence of marked ductal dilation, gallbladder overdistension, or abdominal effusion further supports a dynamic process, where bile flow is variably compromised. This type of condition can progress, and clinical deterioration or evolution to complete obstruction remains a concern if not appropriately managed.

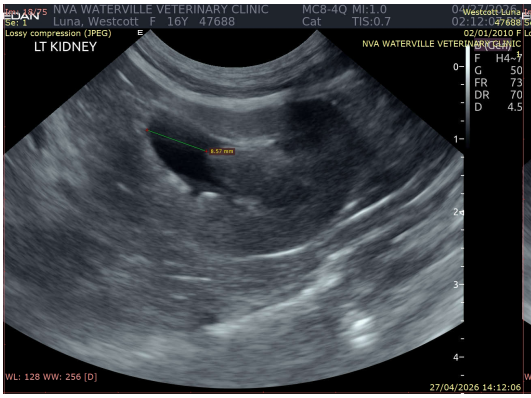
The pancreatic regions do not show overt ultrasonographic abnormalities; however, given the known limitations of ultrasound in feline patients, concurrent pancreatitis cannot be excluded.

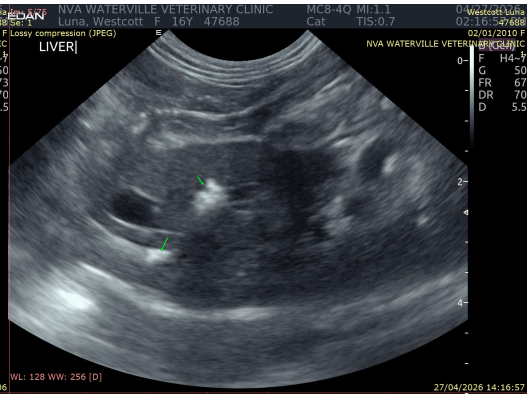
Renal pelvic dilation, particularly on the left (8.57 mm), is noted and is most likely functional or secondary (hydration status or diabetic diuresis) in the absence of ureteral dilation or evidence of obstruction. While not considered the primary concern, monitoring renal function and confirming normal urination is recommended.

Recommendations

- Initiate active medical management, with hospitalization if clinically warranted (fluids, monitoring, supportive care), antiemetics and analgesia as needed.
- Consider start antibiotic therapy (amoxicillin-clavulanate ± metronidazole).
- Hepatobiliary support and cobalamin supplementation.
- Ensure close glucose monitoring and diabetes management.
- Monitor liver values (ALT, bilirubin) and reassess clinically.
- Monitoring renal function.

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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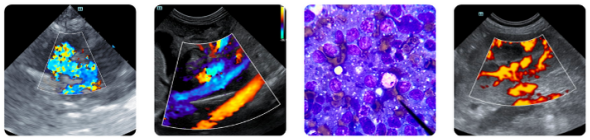

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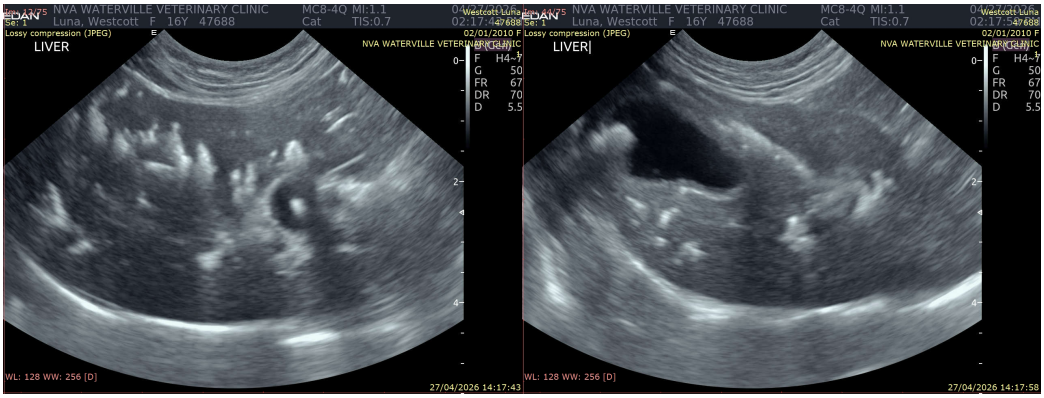

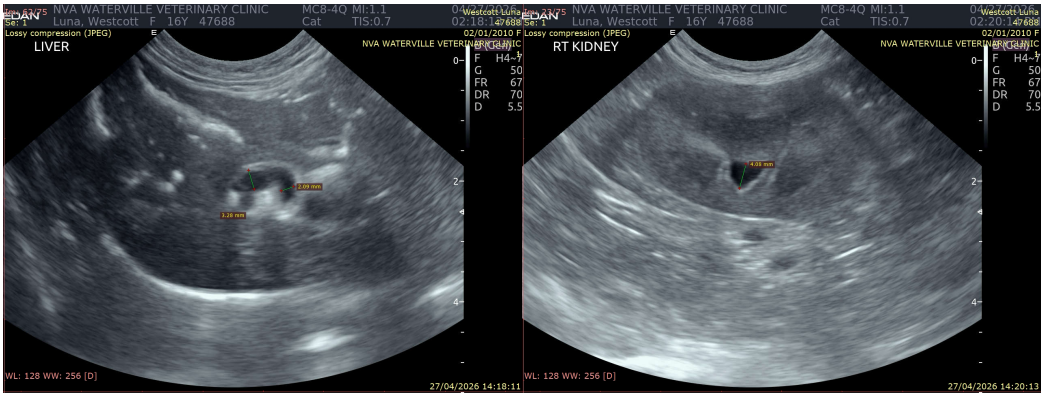

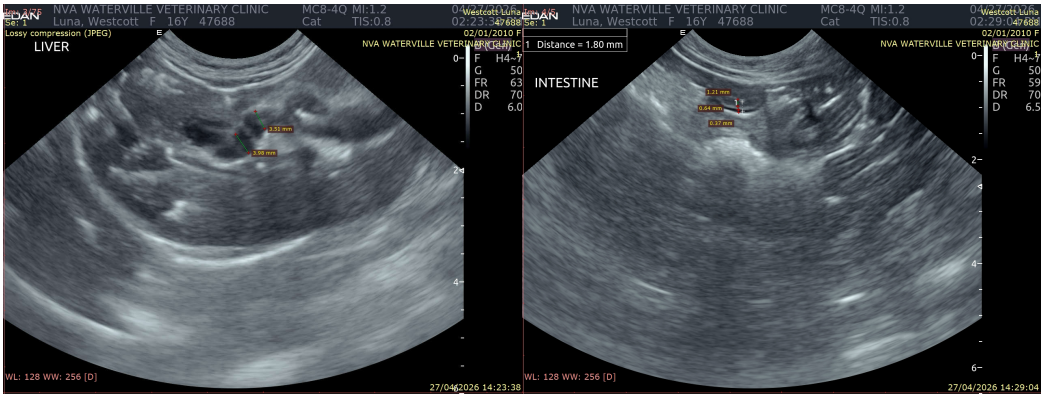

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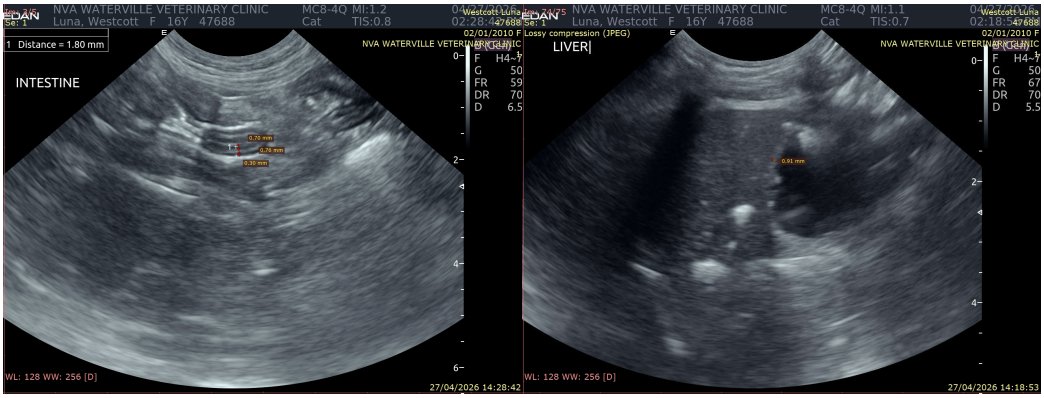

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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