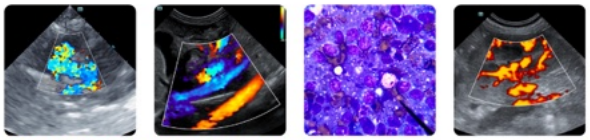


PATIENT

Oliver Demb

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

13 years

WEIGHT

13.8 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Melinda Persson

HOSPITAL NAME

At Home Veterinary

REFERRING VET

Dr. Persson

INVOICE

74973

DATE

4/29/26

PRESENTING CLINICAL SIGNS

History: *Acute-onset inappetence, lethargy
*Fever of 104
*Mild elevations in ALT, AST and bilirubin, bilirubinuria
*Neutropenia, lymphopenia
*Cranial abdominal mass effect
Abnormal PE/Chem/CBC/UA Results: ALT 122 (10-100) AST 127 (10-100) Bilirubin 0.5 (0.1-0.4) Neutrophils 2132 (2500-8500) Lymphocytes 338 (1200-8000)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is thin and smooth. The urine is predominantly anechoic with a small amount of sediment. The bladder neck and proximal urethra have a normal appearance. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 4.09×2.34 cm, with a cortical thickness of 0.30 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 4.32×2.30 cm, with a cortical thickness of 0.29 cm in the sagittal plane. In both kidneys, cortical echogenicity is normal. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

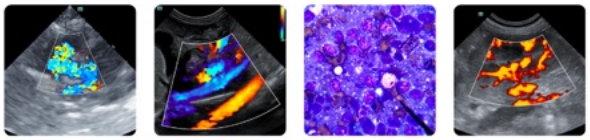
Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.29 cm at the cranial pole and 0.28 cm at the caudal pole. The right adrenal gland measures 0.32 cm at the cranial pole and 0.35 cm at the caudal pole.

Spleen

Splenic thickness is 1.30 cm, with a mild irregular contour. The parenchyma demonstrates decreased 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 margins and prominent lobes. The hepatic parenchyma is diffusely hypoechoic relative to falciform fat, with increased conspicuity of portal vessel walls. A rounded hypoechoic structure measuring 1.54×2.21 cm is identified immediately dorsal to the extrahepatic portal vein in the perihilar region, with a hyperechoic center, compatible with an enlarged hepatic lymph node.



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The gallbladder is normally distended. The wall is thickened, measuring up to 3.56 mm (normal feline gallbladder wall typically <1–2 mm), and the contents are predominantly anechoic with a small amount of biliary sludge. There is no evident dilation of the cystic duct or common bile duct.

Gastrointestinal

The stomach is empty and folded, with a mural thickness of 1.75 mm and preserved wall layering. The pylorus measures 2.57 mm. Duodenum: 1.91 mm. The duodenal papilla measures 3.29×4.02 mm. Jejunum: 3.23 mm (mucosa 1.53 mm, submucosa 0.64 mm, muscularis propria 0.93 mm). Ileum: 1.51 mm (mucosa 0.48 mm, submucosa 0.52 mm, muscularis propria 0.46 mm). Wall layering is preserved. Ileocecal junction: 2.49 mm, with muscularis measuring 0.98 mm. Colon: 0.86 mm, with formed fecal material in the descending segment.

Pancreas

The pancreas measures 8.08–8.71 mm in thickness (mildly increased; normal feline pancreas typically ~4–7 mm depending on region). Parenchyma is isoechoic relative to adjacent omental fat. The pancreatic duct measures 1.57–1.98 mm (mildly dilated; typically ≤1 mm in most cats, though can increase with age). Mild hyperechogenicity of the surrounding peripancreatic fat is present.

Free Abdomen

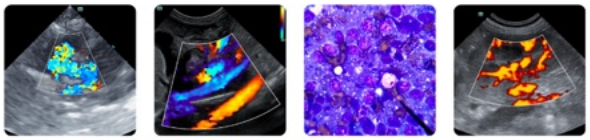
A minimal amount of abdominal effusion is present adjacent to the liver. The peritoneum appears reactive in the hepatic hilum and right duodenal/pancreatic region.
Cranial mesenteric and ileocecal lymph nodes are not visualized; the surrounding regions appear unremarkable. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Hepatomegaly with diffuse hepatic hypoechogenicity
- Marked gallbladder wall thickening (up to 3.56 mm)
- Enlarged hepatic (perihilar) lymph node (1.54×2.21 cm)
- Pancreatic enlargement with mild peripancreatic fat inflammation and pancreatic duct dilation
- Mild peritoneal reactivity with minimal effusion

SECONDARY FINDINGS

- Mild splenomegaly with splenic hypoechogenicity
- Small intestinal muscularis thickening (jejunum and ileocecal region)



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The combination of marked hepatomegaly with diffuse hypoechogenicity, significant gallbladder wall thickening, perihilar lymphadenopathy, mild peritoneal effusion with regional reactivity, and concurrent pancreatic enlargement with mild peripancreatic inflammation and ductal dilation (up to ~2 mm) is most consistent with hepatobiliary inflammation with concurrent pancreatitis, within the spectrum of feline triaditis. The clinical findings (fever, neutropenia, lymphopenia, and hyperbilirubinemia) further support a clinically significant inflammatory process, with infectious (potentially septic) cholangitis/cholecystitis representing a primary concern.

The previously described cranial abdominal mass effect is best explained by the combination of hepatomegaly and an enlarged hepatic lymph node, rather than a primary mass lesion.
The hepatic lymph node (1.54×2.21 cm) is markedly enlarged. Its morphology (hypoechoic with a preserved echogenic hilus) is compatible with reactive lymphadenopathy, particularly given the severity of adjacent hepatobiliary disease. However, the degree of enlargement is greater than typically expected for mild to moderate reactive change. Therefore, while a reactive process is favored, neoplastic infiltration (particularly lymphoma) cannot be excluded based on ultrasonographic appearance alone, especially in an older cat.

Mild splenomegaly with diffuse splenic hypoechogenicity likely reflects reactive or systemic inflammatory change, consistent with the hematologic abnormalities.

Mild muscularis thickening within the jejunum and ileocecal region (ratios approximately 0.61 and 0.66, respectively) is noted. While these values overlap with those described in inflammatory or infiltrative enteropathies, in this context they are more associated with the adjacent pancreatobiliary inflammation.

Recommendations

- Fine-needle aspiration of the liver.
- Fine-needle aspiration of the enlarged hepatic lymph node.
- If clinically feasible, consider bile sampling for cytology and culture (aerobic/anaerobic), as infectious cholangitis/cholecystitis is a significant concern in this case.
- Evaluate coagulation status prior to invasive procedures.
- Initiate or continue supportive and empiric therapy for hepatobiliary and pancreatic inflammation, including consideration of broad-spectrum antimicrobial coverage pending results, given the suspicion of a septic component.
- Correlation with fPLI.
- Close clinical monitoring.

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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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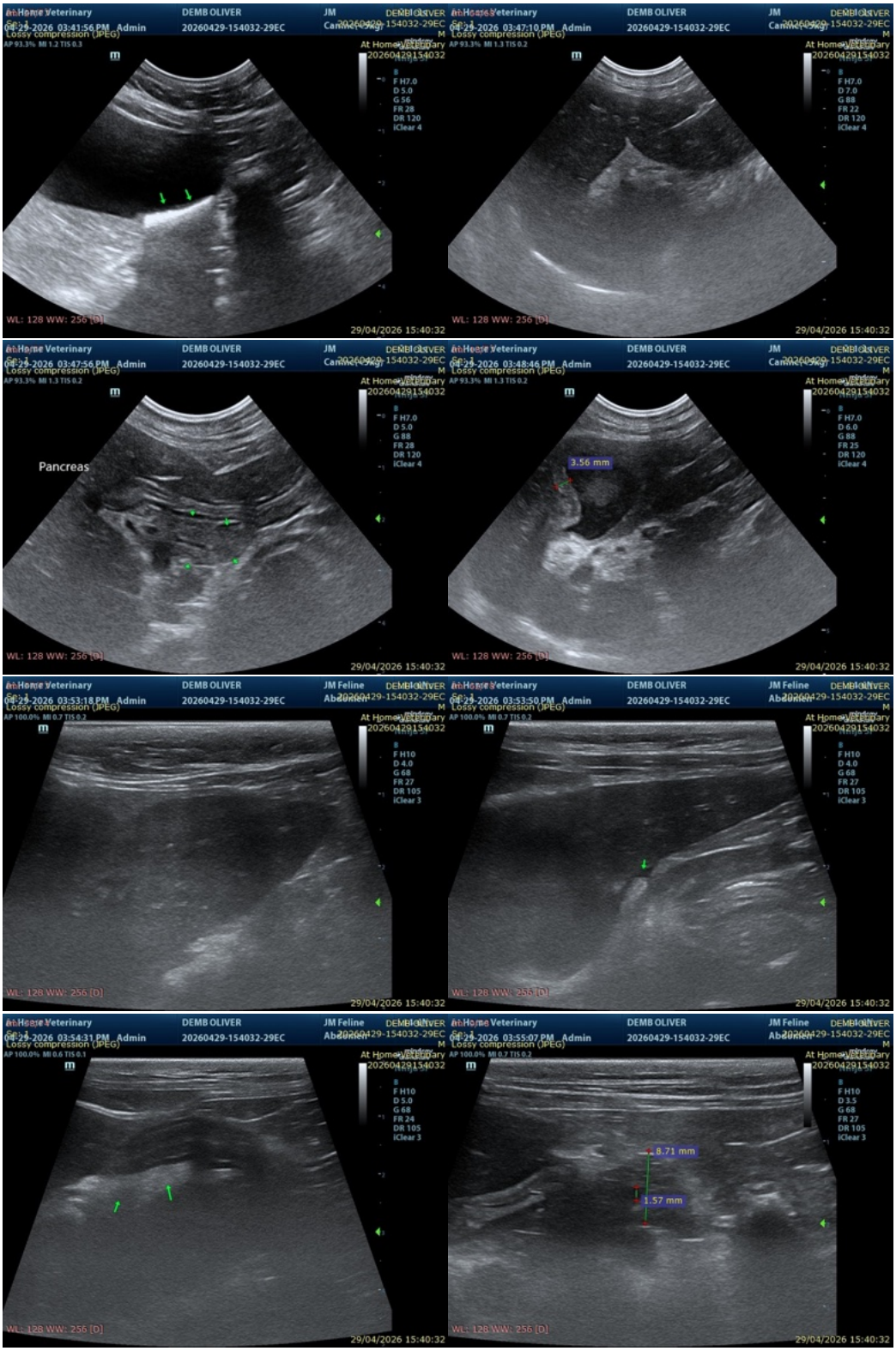

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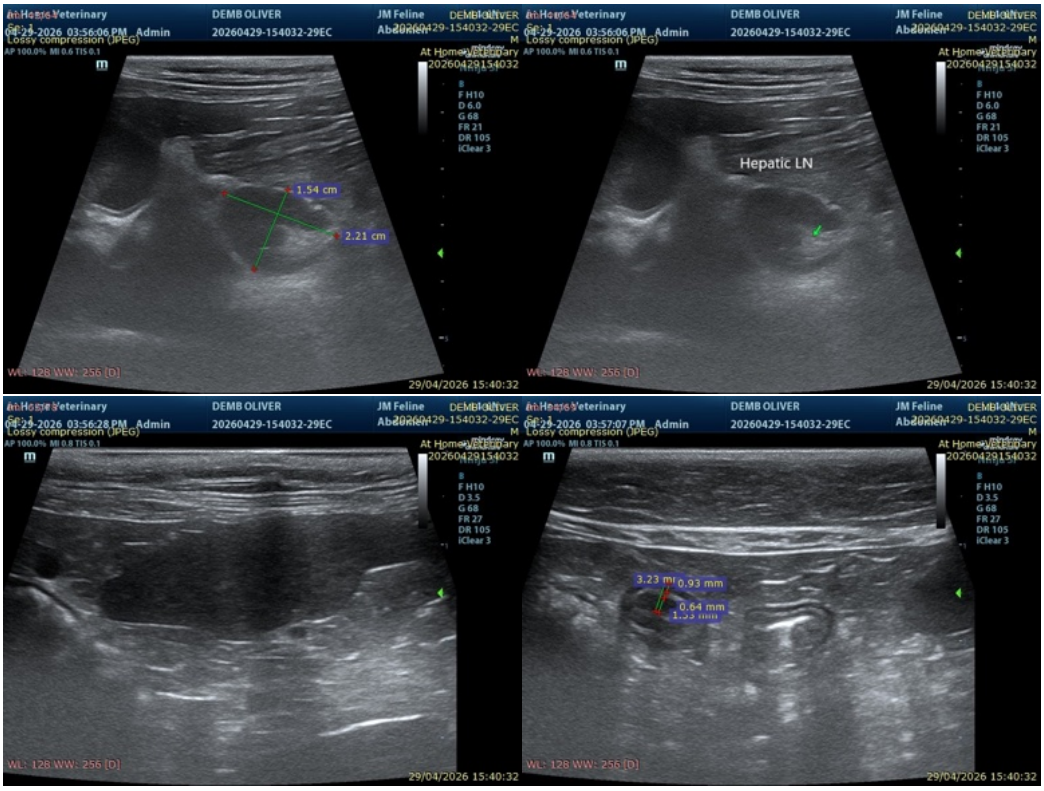

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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