



PATIENT

Samantha Nester

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

16 ½ years

WEIGHT

6.8 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Dr. Arms

HOSPITAL NAME

Gilbertsville VH

REFERRING VET

Dr. Reist

INVOICE

75024

DATE

4/30/26

PRESENTING CLINICAL SIGNS

History: Progressive weight loss, flares of vomit and decreased appetite. Hypercalcemia and increased pancreatic specific lipase.

Abnormal PE/Chem/CBC/UA Results: 3/18/26 wellness, had lost 1 pound. increased PSL 110, Leukocytosis with neutrophilia and mild eosinophilia. Ca. 13.0 4/29/26 - vomit and decreased appetite - 2# additional weight loss.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is thin and smooth. The urine is anechoic. 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 2.87×1.91 cm, with a cortical thickness of 0.33 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.68×1.68 cm, with a cortical thickness of 0.30 cm in the sagittal plane. In both kidneys, the cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis.

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 0.29 cm at the cranial pole and 0.30 cm at the caudal pole.

Spleen

Splenic thickness is 0.95 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 hepatic parenchyma is homogeneous and isoechoic relative to falciform fat, with normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder is markedly distended. The wall is thin and the contents are predominantly anechoic with a moderate amount of organized biliary sludge. The common bile duct is dilated, measuring 4.28–3.90–3.81–2.61 mm along its course to the level of the duodenal papilla (normal in cats typically ≤3 mm, often <2 mm). No discrete obstructive mass or cholelith is identified, and the appearance is suspected to be secondary to inflammation, although obstruction cannot be completely excluded.



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Gastrointestinal

The stomach is empty and folded, with a mural thickness of 1.90 mm and preserved wall layering. The pylorus measures 3.12 mm. Duodenum: 1.94 mm. Jejunum: 2.28 mm (mucosa 1.46 mm, submucosa 0.35 mm, muscularis propria 0.35 mm). Ileum: 2.73 mm (mucosa 1.19 mm, submucosa 0.62 mm, muscularis propria 0.62 mm). Wall layering is preserved. Ileocecal junction: 3.68 mm, with muscularis measuring 1.55 mm. Colon: 2.57 mm, with minimal luminal content.

Pancreas

The pancreas is enlarged, measuring 8.81–9.65 mm in thickness (normal feline pancreas typically ~4–7 mm). The margins are irregular. The parenchyma is hypoechoic relative to adjacent omental fat. The pancreatic duct is markedly dilated, measuring 2.30–4.05 mm (well above typical feline values, usually ≤1 mm, occasionally mildly increased with age). No overt hyperechogenicity of the peripancreatic fat is identified.

Free Abdomen

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

PRIMARY FINDINGS

- Marked dilation of the common bile duct
- Markedly distended gallbladder with organized biliary sludge
- Pancreatic enlargement with irregular margins and marked pancreatic duct.
- Disproportionate muscularis thickening at the ileocecal junction.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The common bile duct dilation clearly exceeds accepted feline reference ranges (typically ≤2–3 mm), indicating clinically relevant biliary outflow obstruction or marked cholestasis. The absence of a visible obstructive mass or cholelith suggests that the obstruction is most likely functional or inflammatory at the level of the duodenal papilla, or secondary to pancreatitis. However, early or subtle obstructive disease cannot be definitively excluded.

The pancreas is abnormal, with enlargement (up to 9.65 mm), irregular margins, hypoechogenicity, and pronounced pancreatic duct dilation (up to 4.05 mm). This degree of ductal dilation is not typical of mild pancreatitis and indicates significant pancreatic involvement, either due to severe chronic pancreatitis with ductal obstruction or infiltrative disease affecting the pancreaticobiliary junction.

In cats, the close anatomical relationship between the pancreatic duct and common bile duct supports a shared disease process, and these findings are most consistent with pancreatitis-associated biliary obstruction (triaditis spectrum) or obstruction secondary to pancreatic disease.

The gastrointestinal tract shows preserved wall layering throughout, which argues against advanced



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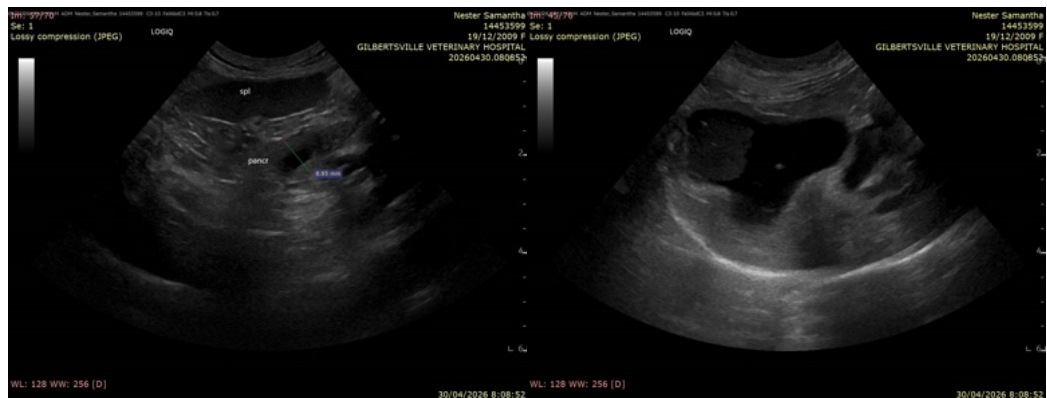
infiltrative intestinal disease. However, the ileocecal muscularis is disproportionately thickened, exceeding values typically seen in normal cats and overlapping with those described in chronic enteropathy or small cell lymphoma.

Overall, the ultrasonographic findings are dominated by a marked pancreatobiliary inflammatory pattern with secondary biliary obstruction, which represents a strong and plausible explanation. However, given hypercalcemia and the severity of the findings, underlying neoplasia cannot be excluded.

Recommendations

- Initiate medical management targeting pancreatobiliary inflammation, including supportive care for suspected pancreatitis and measures aimed at promoting bile flow and reducing cholestasis, as this represents the most immediate and plausible driver of the current clinical signs.
- Close clinical and biochemical monitoring is strongly recommended, particularly bilirubin and fPLI trends.
- Concurrently, pursue evaluation of the hypercalcemia, including confirmation with ionized calcium and appropriate workup for hypercalcemia of malignancy, as this remains clinically relevant.
- If there is progression toward clinically significant biliary obstruction (rising bilirubin, development of icterus), further evaluation with advanced imaging or interventional procedures should be considered to assess for potentially obstructive disease at the level of the distal bile duct or papilla.

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.

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