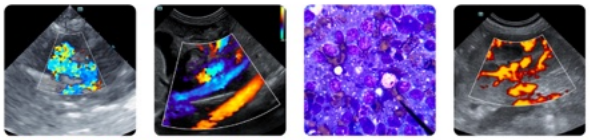


PATIENT

Simon Mink

SPECIES

Feline

BREED

Domestic Longhair

SEX

Neutered male

AGE

8 years

WEIGHT

12.42 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Melissa Pascucci

HOSPITAL NAME

American AH

REFERRING VET

Dr. Troyer

INVOICE

77665

DATE

5/18/26

PRESENTING CLINICAL SIGNS

History: h/o possible triaditis, pancreatitis, diabetes. No acromegaly. Fuo today, lethargic, not eating
On glargine, pimobendan, budesonide
Abnormal PE/Chem/CBC/UA Results: Tbili 1.3 ALT 643 Lipa 2009 BG 511 WBC 30k

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary 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 ultrasonographic evidence of inflammatory or neoplastic changes.

The left kidney measures 4.68×3.24 cm, with a cortical thickness of 0.57 cm in the sagittal plane. The right kidney measures 5.01×2.79 cm, with a cortical thickness of 0.50 cm in the sagittal plane. Both kidneys demonstrate mild globose morphology. The renal cortices are 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. 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 0.25 cm at the cranial pole and 0.25 cm at the caudal pole. The right adrenal gland measures 0.24 cm at the cranial pole and 0.25 cm at the caudal pole.

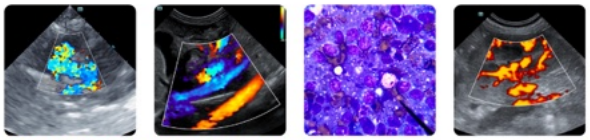
Spleen

Splenic thickness is 0.66 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 mildly enlarged, with mildly rounded margins and a regular contour. The hepatic parenchyma is homogeneous and isoechoic relative to the surrounding falciform fat, with a normal echotexture. No hepatic lymphadenopathy is identified.

The gallbladder lumen is normally distended. The wall is thin and smooth, and the contents are predominantly anechoic. The common bile duct measures 6.37-3.37-3.05 mm along its visualized course. No cholelithiasis or biliary sludge is identified within the gallbladder lumen. However, small amounts of echogenic material are identified within portions of the intrahepatic biliary ducts.



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Gastrointestinal

The stomach is empty and folded, with preserved wall layering and a wall thickness of 1.83 mm.

The pyloric wall measures 3.87 mm. The duodenal wall measures 2.12 mm and demonstrates mild corrugation. The jejunal wall measures 2.35 mm, with mucosa measuring 1.47 mm, submucosa 0.42 mm, and muscularis propria 0.30 mm. The ileal wall measures 2.16 mm, with mucosa measuring 0.92 mm, submucosa 0.72 mm, and muscularis propria 0.44 mm. Wall layering is preserved throughout the visualized small intestine. The ileocecal junction is not confidently visualized.

The descending colonic wall measures 0.99 mm and contains formed fecal material.

Pancreas

The pancreas measures approximately 1.05-1.16 cm in thickness. The pancreatic margins are irregular. Pancreatic parenchyma is mildly heterogeneous and hypoechoic. Mild active inflammatory change is present within the surrounding peripancreatic fat. The pancreatic duct measures 2.16 mm in diameter.

Free Abdomen

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

PRIMARY FINDINGS

- Enlarged irregular hypoechoic pancreas with mild heterogeneous echotexture and marked pancreatic duct dilation
- Active peripancreatic inflammatory change
- Mild hepatomegaly
- Moderate extrahepatic biliary duct dilation and echogenic intraductal material

SECONDARY FINDINGS

- Duodenal corrugation
- Mild bilateral renomegaly with globose morphology

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pancreas is enlarged, irregularly marginated, mildly heterogeneous and hypoechoic, with associated active peripancreatic inflammatory change and marked pancreatic duct dilation. Although ultrasound cannot reliably differentiate acute from chronic pancreatitis, the combination of pancreatic enlargement, irregular contour, ductal dilation, and architectural distortion is considered most compatible with chronic pancreatitis with active/reactivated inflammation. Mild duodenal corrugation may occur secondary to adjacent pancreatic inflammation.

Mild hepatobiliary involvement is also present, including mild hepatomegaly, mild common bile duct dilation, and small amounts of echogenic intraductal material within portions of the intrahepatic bile

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ducts, raising concern for early hepatolithiasis and/or inspissated biliary material. In cats, this type of intrahepatic biliary sediment/concretion formation is commonly associated with chronic biliary inflammation, cholangitis/cholangiohepatitis, and chronic biliary stasis. Although no definitive obstructive cholelithiasis or complete extrahepatic biliary obstruction is identified ultrasonographically at this time, partial biliary outflow impairment or inflammatory cholangiohepatobiliary involvement cannot be completely excluded.

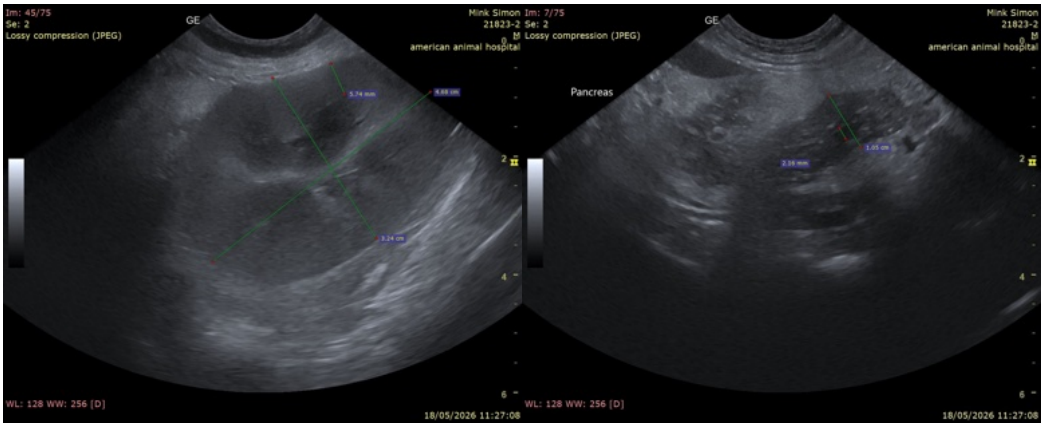
Subtle or early chronic enteropathy cannot be entirely excluded ultrasonographically; however, there is currently no convincing sonographic evidence of severe infiltrative intestinal disease or high-grade alimentary lymphoma.

The mild bilateral renomegaly with globose morphology is nonspecific and may reflect diabetic change, compensatory enlargement, or mild nephropathy.

Recommendations

- Correlation with serial bilirubin values, liver enzymes, pancreatic lipase testing, blood glucose regulation, hydration status, and clinical progression is recommended.
- Supportive management for pancreatitis and hepatobiliary inflammation should be considered as clinically appropriate by the attending veterinarian.
- Correlation with urine ketones, acid-base status, and diabetic regulation is recommended if concern for diabetic decompensation persists clinically.

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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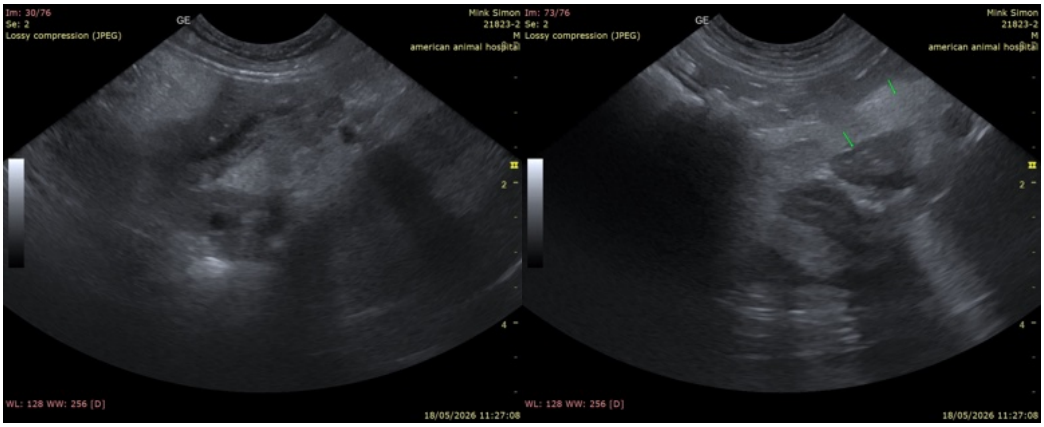

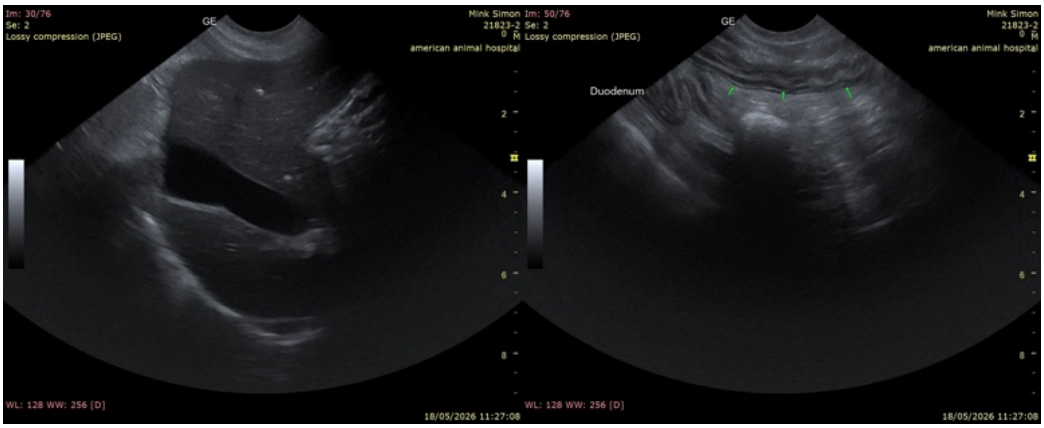

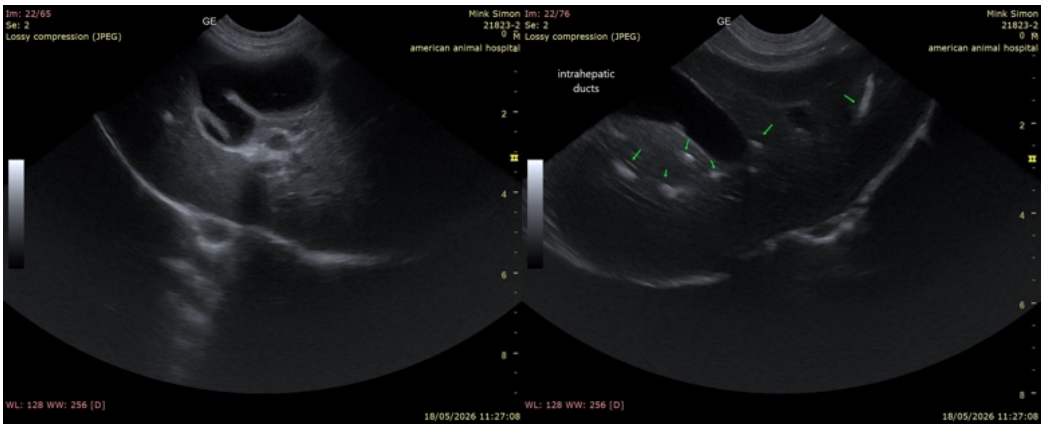

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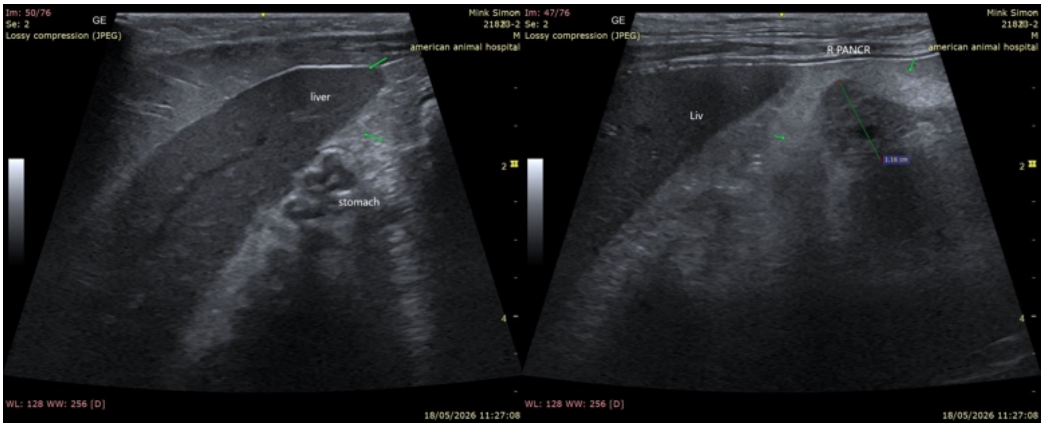

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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