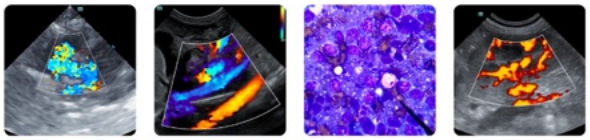


PATIENT

Fluffy Fultz

SPECIES

Feline

BREED

Domestic Longhair

SEX

Neutered male

AGE

4 ½ years

WEIGHT

8 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Mack E

HOSPITAL NAME

Northside VC

REFERRING VET

Dr. Mack

INVOICE

75218

DATE

5/5/26

PRESENTING CLINICAL SIGNS

History: Presents for hair loss, decreased grooming habits, lethargy, and vomiting:
- Signs noted over the weekend
- Vomited 4 times within the past week (foam and bile)
- Indoor/outdoor cat
- Decreased eating, food aversion (interested in breakfast but did not eat, refused treats and dinner)
- Digging at left ear
- Previous weight 11.4 lbs
- Up to date on rabies vaccine
- Incomplete FVRCP and leukemia vaccine series from October/November 2024
- Client noted yellow discoloration Friday evening
- Client had been treating ears with over-the-counter ear mite medication (first/last dose Sunday, 2 drops per ear)
- Normal urination and defecation habits
- Lives with two other cats all are indoor/outdoor cats
- Neighborhood fertilizer/pesticide spraying noted but client keeps cats inside during application
- No known toxin exposure

Abnormal PE/Chem/CBC/UA Results: Temperature: 103.9°F, P: 160 bpm, RR: 36 bpm, Mucous Membranes: yellow and moist with generalized icterus, Hydration: <5% dehydrated Pain score: Mild, BCS: 4/9, CRT: 3s Oral: Generalized icterus to oral mucous membranes, mild tartar, no string noted under tongue Heart: Grade 2-3/6 systolic parasternal murmur, normal rhythm Abdomen: Soft, non-tender, no masses or organomegaly, formed stool palpated in colon. Soft, non-distended urinary bladder - Feline combo test (FeLV/FIV/HW): Negative x3 - SNAP ProBNP: Abnormal - CBC: Neutrophils 12.51 (elevated), other parameters normal - Chemistry panel: Total protein 9.2 (elevated), globulin 5.9 (elevated), ALT 705 (elevated), ALP 157 (elevated), GGT 6, total bilirubin 12.4 (elevated), QPL 1.0 (wnl), T4: 2.0 (within normal limits)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

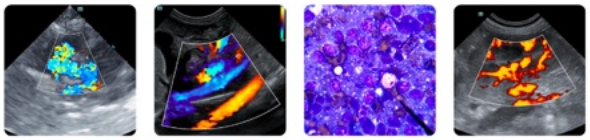
Urinary System

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 3.16×2.26 cm, with a cortical thickness of 0.29 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.49×2.30 cm, with a cortical thickness of 0.32 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. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

The left adrenal gland measures 0.29 cm at the cranial pole and 0.30 cm at the caudal pole. The right adrenal gland measures 0.30 cm at the cranial pole and 0.32 cm at the caudal pole.



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Spleen

Splenic thickness is 0.86 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.

The gallbladder is normally distended. The wall is thickened, measuring up to 1.93 mm (normal in cats typically ≤1 mm), and the contents are predominantly anechoic. Immediately dorsal to the gallbladder, there is a small, well-defined cystic structure measuring 0.50×1.14 cm, with thin walls and anechoic content, consistent with a peribiliary cyst or focal biliary structure; its exact origin cannot be definitively determined on ultrasound. The common bile duct is dilated, measuring 5.79 mm proximally, tapering to 4.95 mm, 4.02 mm, and 2.91 mm distally. (In cats, the common bile duct typically measures ≤2–3 mm).

Gastrointestinal

The is empty and folded, with a mural thickness of 1.68 mm and preserved wall layering. The pylorus measures 3.26 mm. Duodenum: 3.09 mm (mildly increased; normal typically ≤2.5–3 mm). Jejunum: 2.07–2.19 mm, with preserved wall layering. The ileocecal junction is not visualized. No evidence of mechanical ileus or foreign material is identified. Colon: 0.70 mm, containing firm fecal material with marked distal acoustic shadowing in the descending segment.

Pancreas

The evaluated pancreatic regions do not show evidence of overt inflammation or neoplastic disease.

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 (up to 5.79 mm)
- Gallbladder wall thickening (1.93 mm)
- Small peribiliary cystic structure (0.50×1.14 cm)
- Mild duodenal wall thickening

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gallbladder wall thickening is consistent with cholecystitis, particularly in the context of fever, neutrophilia, and systemic illness. The marked dilation of the common bile duct supports the presence of either extrahepatic biliary obstruction, or a severe functional obstruction secondary to inflammatory biliary disease.

In this clinical context (acute onset, fever, neutrophilia, and marked hyperbilirubinemia), the findings are most consistent with a primary inflammatory hepatobiliary disease. The normal hepatic echotexture argues against hepatic lipidosis as the sole explanation for the severity of the icterus.

A purely mechanical obstruction (non-visualized biliary debris, small calculi, or focal obstruction at the level of the papilla) cannot be completely excluded, but is considered less likely as a primary cause given the inflammatory clinical profile and the ultrasonographic findings.

The small cystic structure adjacent to the gallbladder is most consistent with a peribiliary cyst, which is unlikely to represent the primary cause of disease but may be secondary to increased biliary pressure or chronic biliary inflammation, further supporting the presence of significant biliary pathology.

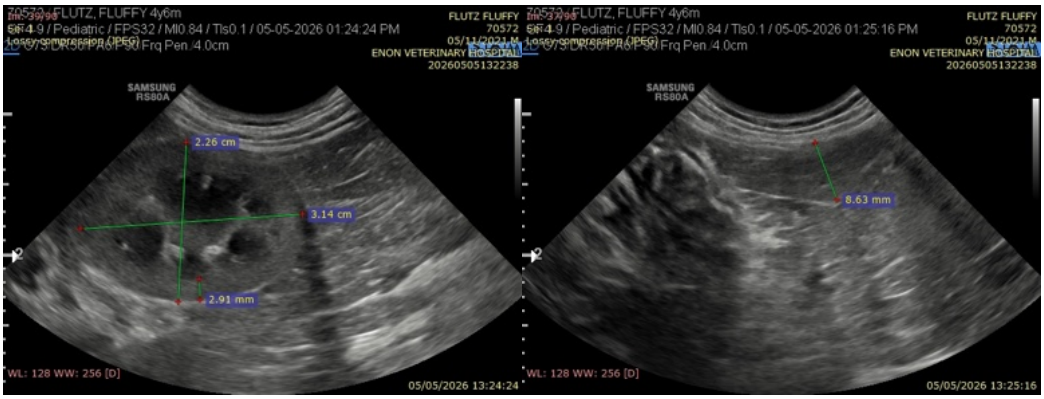
The pancreas appears unremarkable; however, pancreatitis cannot be excluded, as ultrasonographic changes may be subtle or absent in cats.

Overall, the findings are most consistent with a clinically significant inflammatory hepatobiliary disease (cholecystitis and cholangitis/cholangiohepatitis) with secondary obstructive cholestasis.

Recommendations

- Hospitalization and supportive care are recommended (IV fluids, antiemetics, analgesia, early nutritional support).
- Correlate with the liver FNA, and GB culture (pending).
- Start broad-spectrum antibiotics targeting hepatobiliary infection.
- Monitor bilirubin and liver enzymes every 24–48 hours to assess response.
- If anorexia persists, consider feeding tube placement to prevent/worsening hepatic lipidosis.

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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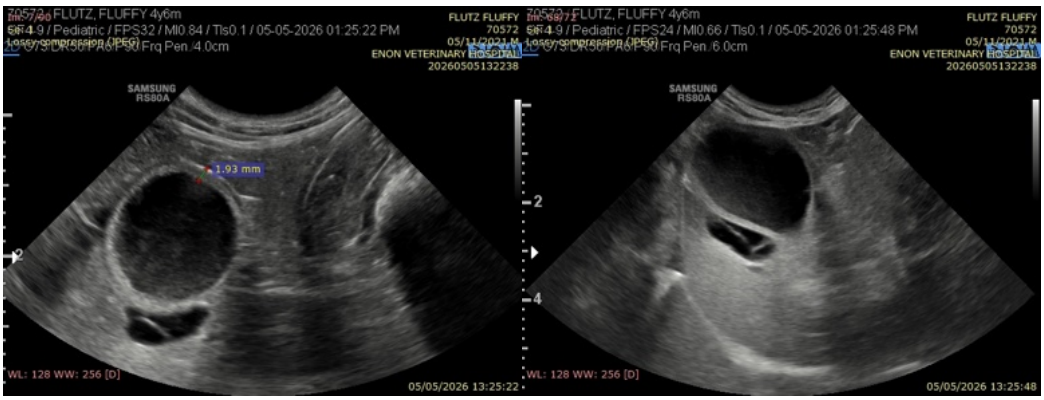

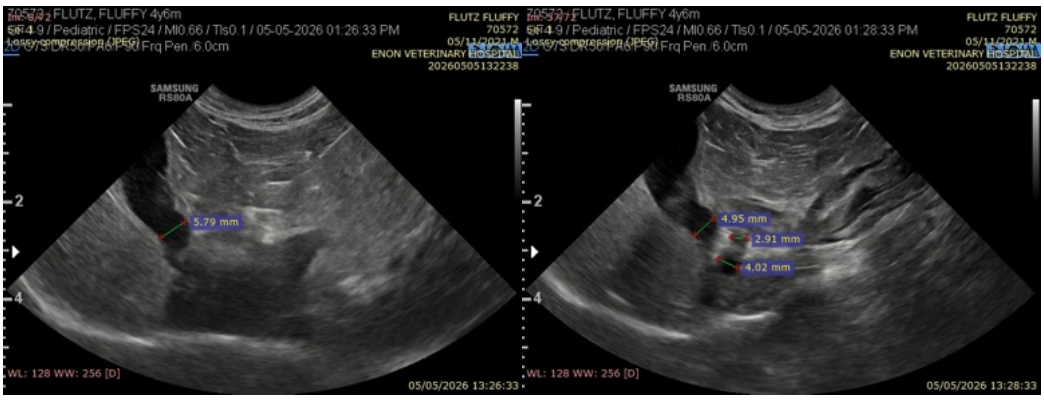

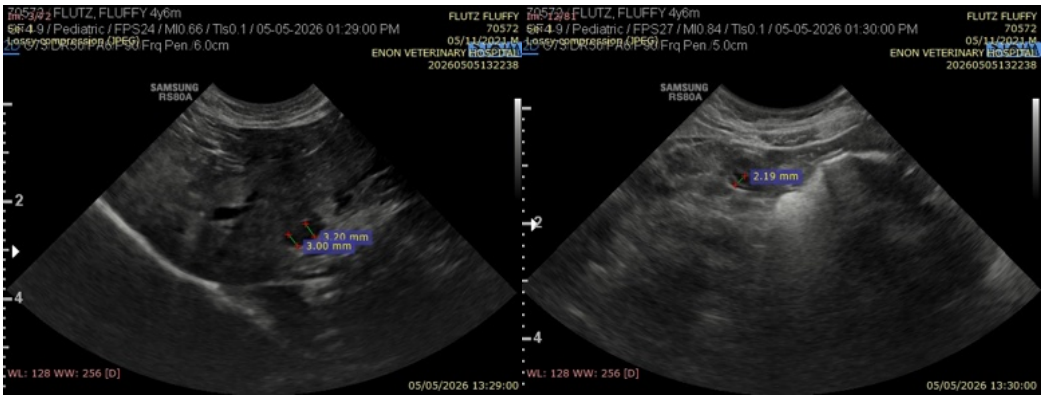

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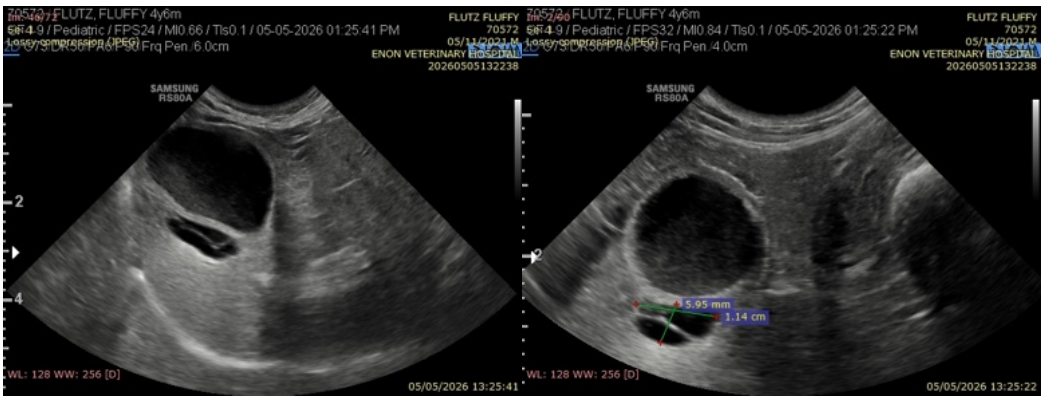

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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