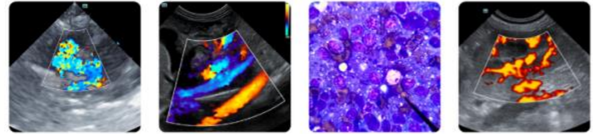


PATIENT

Rudy Stresing

SPECIES

Feline

BREED

Ragdoll

SEX

Neutered Male

AGE

14

WEIGHT

11 lbs

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Dr Danni Shemanski

HOSPITAL NAME

Western NY Vet Svcs

REFERRING VET

Dr Jeff Cacia Hilton VH

INVOICE

22323

DATE

11-29-25

PRESENTING CLINICAL SIGNS

History: RDVM REASON FOR REFERRAL: elevated liver values, rapid breathing, vomiting, acting painful History of fluctuating liver values with elevated bilirubin, and mild GB sludge. Prednisolone 7.5mg daily has gotten the bilirubin down to 0.8. Now bili is elevated again History of non-clinical hypertrophic cardiomyopathy, proBNP WNL at emergency center Eupneic during scan; Jaundiced, Eating again now and vomiting has stopped MEDICATIONS: Prednisolone 5mg AM, 2.5mg PM (for several months Ondansitron oral Gabapentin 50mg sid - tid Clavamox 62.5mg bid Intermittently on Ursodiol

Abnormal PE/Chem/CBC/UA Results: BUN 31MG/DL, ALT = 457 U/L ALP 174 U/L AST 227 U/L TBILI 2.2 MG/DL GLU = 265 MG/DL TP = 8.3 G/DL (ALB 4.3) K+ = 2.6 MMOL/DL WBC = 0.6 X10^3/UL NEU = 0.5X10^3/UL MON = 0 X10^3/UL EOS = 0.1 X10^3/UL BASO = 0 X10^3/UL PLT = 88.5 X10^3/UL RETIC = WNL, HCT = 31.6%

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. A moderate amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is mildly enlarged (4.64 cm in length) with a normal architecture and smooth peripheral contours. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

The right kidney is mildly enlarged (4.73 cm in length) with a normal shape, architecture and smooth peripheral contours. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter.

Adrenal Glands

The region of the adrenal glands is evaluated. No obvious pathology is observed in this region.

Spleen

A 0.63 x 0.57 cm isoechoic, expansile nodule is arising from the medial aspect, near the hilus. In the remainder of the spleen, the margins are curvilinear, and the parenchyma is homogenous. Splenic vasculature appears normal with no obvious evidence of thrombosis.

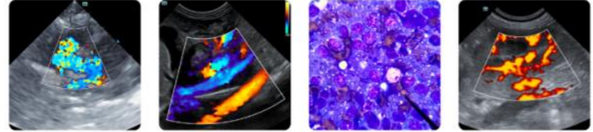
Liver

The liver is subjectively enlarged, with swollen peripheral contours. The parenchyma is isoechoic relative to the spleen, and mildly heterogenous in appearance. Cystic areas are observed throughout the liver. There is suspected intrahepatic biliary duct dilation.

The gallbladder is distended. The wall is thickened (up to 0.33 cm) and irregular, with mineralization embedded within the wall. A small amount of echogenic-to-mineralized debris +/- tiny choleliths are observed within the lumen. The cystic and common bile duct walls are subjectively thickened. The lumen is tortuous and dilated (up to 1.36 cm). Echogenic-to-mineralized debris is observed within the lumen. A 0.59 cm choledocolith is suspected at the distal aspect of the common bile duct, adjacent to the duodenal papilla.

Gastrointestinal

The gastric lumen is moderately distended with ingesta. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally dilated with chyme. The small intestinal



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wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas
The right limb is visible, with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. The pancreatic duct is visible, but not overtly dilated. Surrounding mesentery is slightly hyperechoic.

Lymph Nodes
The abdominal lymph nodes are normal/not visible.

Free Abdomen
There is no obvious evidence of free fluid.

Other
A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

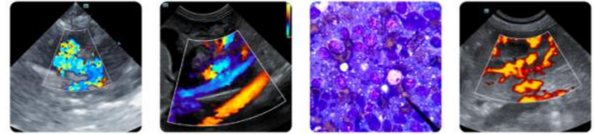
- The gallbladder and cystic/common bile duct changes are most consistent with cholecystitis and cholangitis, respectively. Respectively, there is evidence of choleliths and choledocoliths, one of which is at the distal aspect of the common bile duct.
- The hepatic parenchymal changes are nonspecific and could be secondary to emerging hepatic lipidosis, inflammatory disease (i.e., cholangiohepatitis, lymphoplasmacytic hepatitis), emerging neoplasia, and/or other hepatopathy.

Secondary Findings

- Bilateral age-related renal changes with trace right pyelectasia
- The pancreatic changes are consistent with mild pancreatitis with slight adjacent peritonitis.
- The splenic nodule could be consistent with a benign focus (i.e., lymphoid hyperplasia or similar) or an emerging tumor.
- If the patient was fasted for this study, the presence of ingesta within the gastric lumen could suggest delayed gastric emptying.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Surgical evaluation of bile duct patency with liver biopsies, as well as aerobic and anaerobic bile cultures, +/- bile duct rerouting is recommended. If pursued, biopsies of the splenic nodule should also be obtained. If surgery is pursued, thoracic radiographs and clotting times should be performed prior to anesthesia. If surgery is not pursued, an attempt at medical therapy for cholecystitis/cholangiohepatitis/cholangitis/pancreatitis can be considered. However, if the total bilirubin continues to increase, surgery may be warranted.



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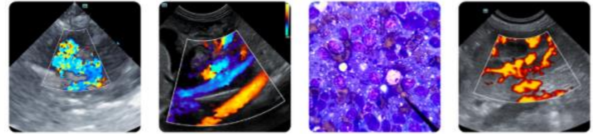

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com