



## PATIENT

Jinx Trombly

## SPECIES

Feline

## BREED

DSH

## SEX

Neutered Male

## AGE

8 Years

## WEIGHT

4.8 kg

## INTERPRETED BY

Brad Harris, DVM,  
DACVECC, DACVIM  
(cardiology)

## IMAGING PERFORMED BY

Melissa Randolph

## HOSPITAL NAME

Shores Veterinary  
Emergency Center

## REFERRING VET

Dr. Laurie Brewer

## INVOICE

72461

## DATE

1/25/26

## PRESENTING CLINICAL SIGNS

Anorexia for at least 3 days. owner has an automatic feeder and other cats in household. owner also concerned with weight loss. was seen at another ER (rossmoynne). blood work done, note elevated liver values and icteric. transfer to Shores for further care. admitted for iv fluids with vitamin B complex, buprenorphine, cerenia, ondansetron, vitamin K, metronidazole, and unasyn. overnight developed hypoglycemia and started on dextrose CRI. NG tube placed and started on RCVD recovery feedings.

concern for Hepatic lipidosis - r/o liver failure, cholangiohepatitis; Anorexia - r/o severe dental disease, systemic illness, neoplasia; Icterus - r/o hepatic failure, extrahepatic biliary obstruction; Ataxia and dull mentation - r/o hepatic encephalopathy, intracranial disease; Severe dental disease and halitosis - r/o chronic infection, periodontitis; other

Abnormal PE/Chem/CBC/UA Results: PE: icteric pinna; bcs 4/9 cachectic; Severe halitosis, severe dental disease with severe tartar, and missing incisor teeth; Reactive to abd palpation, uncomfortable on abd palpation; Unthrifty, unkempt coat, Skin is extremely icteric. chem: ALP: 294, ALT: 157, Amylase: 1,763, Calcium: 8.3, Cholest: 250, Creat: 0.6, GGT: 15, Glob: 6.4, T Bili: 7.2, TP: 8.9 T4: < 0.50 CBC: HCT: 19.7, WBC: 36.36, Lymph: 0.68, Neut: 28.98, Eos: 6.24 Shores: iCa++: 1.19, Lac: 4.24, Manual PCV: 21% rads: firm stools appreciated in the colon with a mixed gas pattern, normal pulmonary parenchyma coag: PT: 9.3, APTT: 101.3 cbc (repeat): wbc 39.85 H, neut 28.93 H, hct 15% felv/fiv: negative cbc (repeat): wbc 17.72, rbc 2.69, neut 9.76, hct 11.7%

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. The bladder is moderately distended with anechoic urine. There is a moderate amount of suspended echogenic mobile debris. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size. The cortices are hyperechoic with loss of corticomedullary detail. The cortex to medulla ratio is appropriate. No pyelectasis or ureteral dilation noted. Renal capsules are mildly irregular bilaterally. Left kidney measures 3.91 cm. Right kidney measures 3.76 cm.

### Adrenal Glands

The adrenal glands are not discretely visualized.

### Spleen

The spleen measures 0.90 cm at the hilus. It is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented.

### Liver

The liver is subjectively enlarged with a diffusely hyperechoic echotexture and maintenance of normal structure. Vasculature is within normal limits with no evidence of congestion. The gallbladder has thin walls which contain anechoic bile. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. No hepatic lymphadenopathy is documented.



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## *Gastrointestinal*

The gastrointestinal tract is non-distended, with no significant shadowing foreign material or concern for mechanical obstructive disease. The gastrointestinal wall is diffusely mildly thickened with a prominent muscularis layer that distorts the normal 1:3 muscularis to mucosal ratio. The pylorus and ileocecolic junction are patent. The colon contains normal shadowing feces.

## *Pancreas*

The visible pancreas is isoechoic to surrounding omental fat. The pancreatic duct and capsular contour are normal. There is no overt evidence of active inflammatory or neoplastic disease.

## *Free Abdomen*

There is a hypoechoic, enlarged, rounded structure in the mid cranial abdomen of unknown etiology. This is suspected to be lymphatic in origin, given its location and appearance. However, other etiologies can't be definitively excluded. There is no significant free peritoneal effusion identified and no other overt lymphadenopathy documented.

## ULTRASONOGRAPHIC FINDINGS

- The kidneys are relatively normal in size and structure, and cortex:medulla ratio (cortex 1/3 of medulla) is essentially maintained. There is age-related loss of the normal smooth capsular contour and C/M junction definition. The cortices are largely uniform in texture with mild hyperechogenicity expected for this patient's age. There is no evidence of pelvic dilation present.
- The liver is subjectively enlarged and uniformly hyperechoic to falciform fat without disruption of normal architecture. This finding is most consistent with hepatic lipidosis, however infiltrative disease such as round cell neoplasia cannot be completely excluded.
- The diffusely thickened gastrointestinal muscularis is suspected to be secondary to underlying infiltrative disease such as chronic enteropathy or round cell neoplasia.
- The cranial abdominal mass effect is suspected to be lymphatic in origin. This would support round cell neoplasia as a potential underlying cause of the gastrointestinal changes as well as potential hepatic changes.
- The urinary bladder contains echogenic, suspended debris contrasted with anechoic urine. This is often related to urinary tract infection but may represent exfoliated debris or sterile inflammation.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection.

Fine needle aspirates of the liver and cranial abdominal mass with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.



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A gastrointestinal panel (TLI, PLI, B12, folate) via Texas A&M gastrointestinal laboratory is indicated to further evaluate for potential chronic enteropathy. Ultimately, gastrointestinal biopsies may be required for a definitive diagnosis.

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Continue enteral feeding tube supplementation and supportive care as clinically indicated pending additional diagnostic tests.

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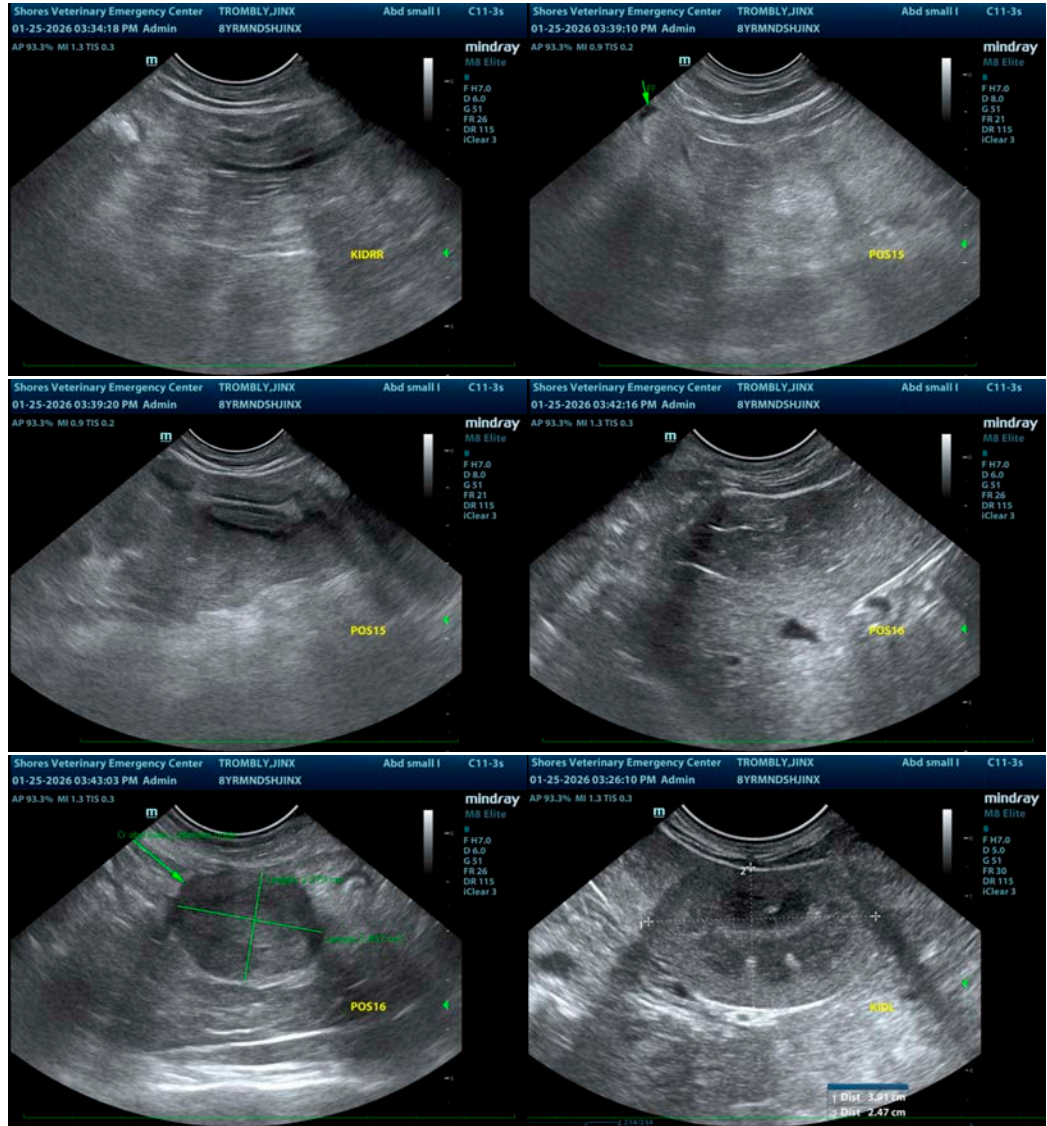
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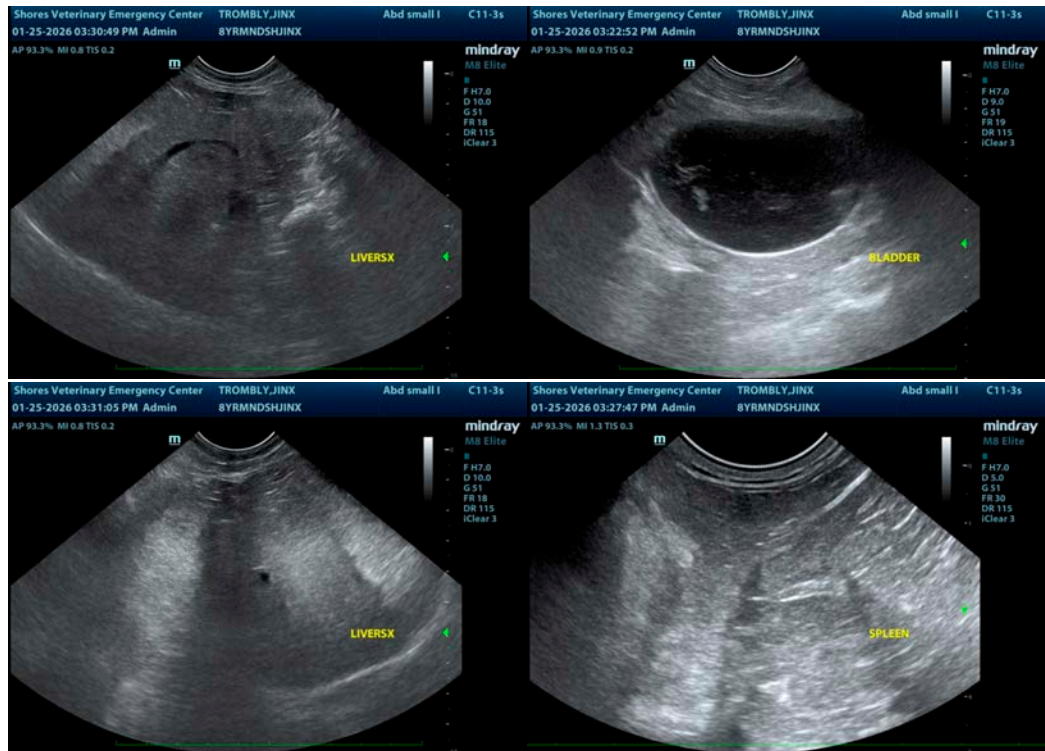
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

[info@SonoPath.com](mailto:info@SonoPath.com)