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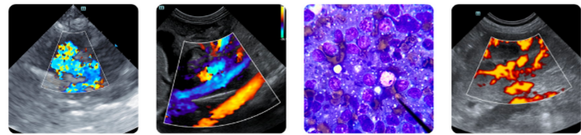


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

**PATIENT**

Dante Russell

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Neutered male

**AGE**

7 years

**WEIGHT**

10.2 lbs

**INTERPRETED BY**

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

**IMAGING PERFORMED BY**

Kathleen Byrnes

**HOSPITAL NAME**

Pet Care Clinic of High Country

**REFERRING VET**

Dr. Russell

**INVOICE**

69484

**DATE**

12/22/25

## PRESENTING CLINICAL SIGNS

History: P presented for not eating. P has history of HCM
Abnormal PE/Chem/CBC/UA Results: BUN 15, Cl 110, ALT 717, GGt 18, Tbili 6.8, Chol 353 HCT 21.9%

## 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. A mild amount of suspended, echogenic debris is noted. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size and structure. The cortices are hyperechoic with a loss of normal corticomedullary definition. The cortex to medulla ratio is appropriate with no significant pyelectasia or pelvic dilation. The capsules are irregular bilaterally. The left kidney measured 3.34 cm. The right kidney measured 3.9 cm.

### *Adrenal Glands*

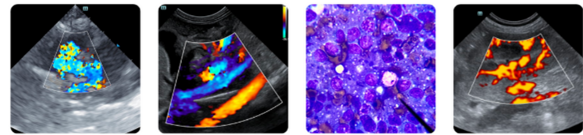
Both adrenal glands are visualized and have normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 0.37 cm and the right adrenal gland measured 0.4 cm.

### *Spleen*

The spleen 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. The spleen measured 0.83 cm at the hilus.

### *Liver*

The liver is subjectively normal in size and contour with a diffusely, heterogenous or mottled parenchymal echotexture. Vasculature is within normal limits with no evidence of congestion. The gallbladder contains anechoic bile and the gallbladder wall is thickened and hyperechoic. 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 stomach and intestines are free of stasis and peristaltic activity, with no significant dilation noted. There is normal wall thickness and acceptable curvilinear mural detail. The pyloric-duodenal junction and ileocecocolic junction are patent, and the colon contains normal shadowing feces. There is no evidence of shadowing obstructive material or overt infiltrative disease noted. No associated abnormal lymphatic activity is documented.

### *Pancreas*

The pancreas is hypoechoic with irregular, margins and mixed hyperechoic and hypoechoic nodular changes. The pancreatic duct is mildly dilated and there is mild regional, hyperechoic mesentery or omental fat.

### *Free Abdomen*

There is no evidence of abdominal lymphadenopathy. No free fluid was noted.

## ULTRASONOGRAPHIC FINDINGS

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.

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 mottled liver is likely non-specific and may represent chronic hepatitis or other infiltrative disease such as round cell neoplasia. Other chronic hepatopathies cannot be definitively excluded.

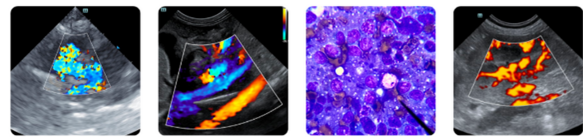
The mildly thickened gallbladder wall may be normal variant for this patient; however, inflammatory processes such as cholangitis or cholangiohepatitis must also be considered.

The prominent, hypoechoic pancreas with an irregular contour and mixed ill-defined hyper and hypoechoic changes is most consistent with pancreatic remodeling and nodular hyperplasia. This may be secondary to active or acute-on chronic inflammatory disease or pancreatitis.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the changes to the liver and pancreas a chronic inflammatory condition such as triaditis cannot be definitively excluded.

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





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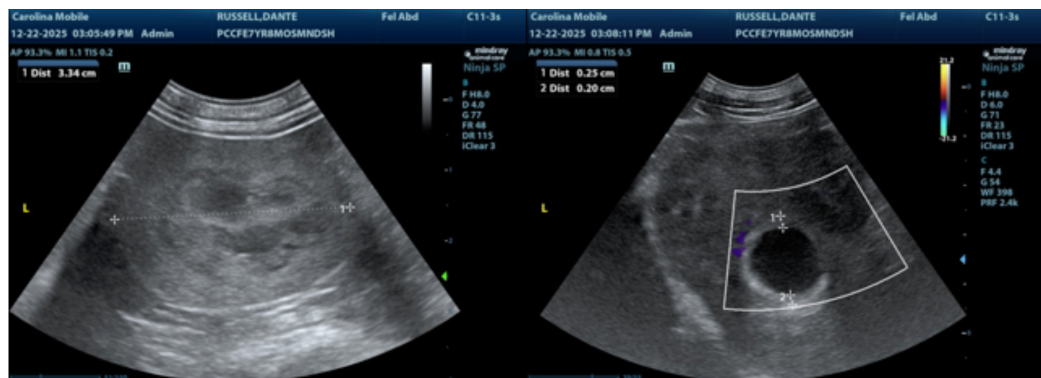
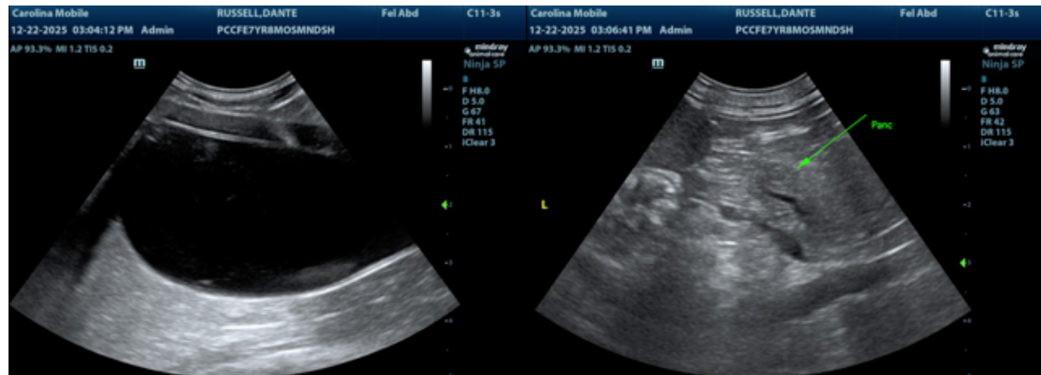
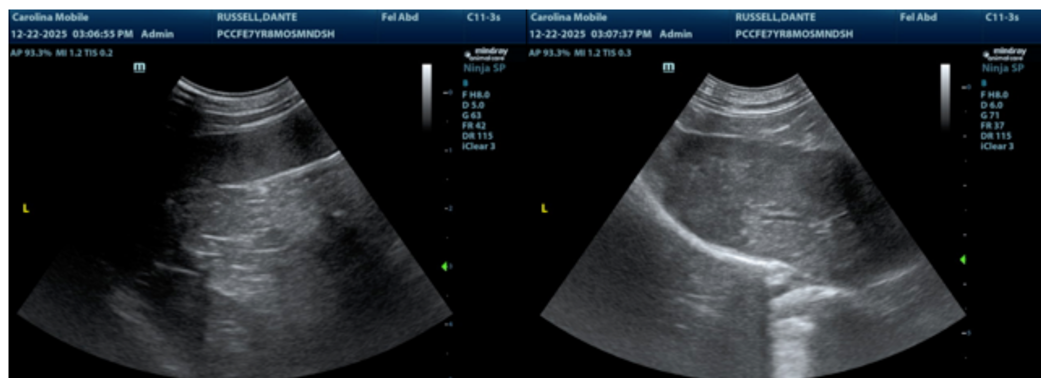
Fine needle aspirates of the liver with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology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

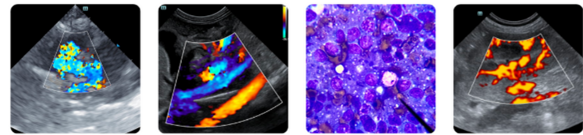
Consider an fPLI to further evaluate for evidence of active pancreatic inflammation or pancreatitis.

Also consider 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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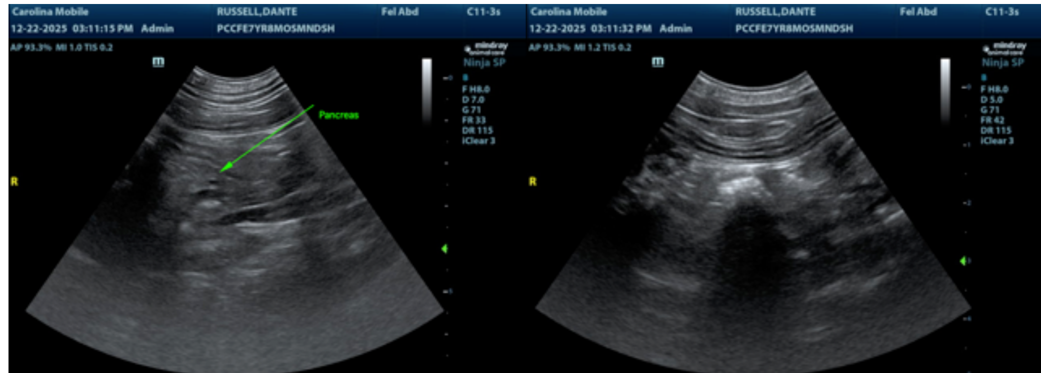


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

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