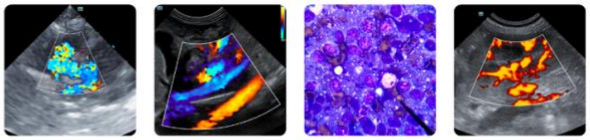


PATIENT

Oliver Cudden

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

3 Years

WEIGHT

6.6 pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Ryan Leal

HOSPITAL NAME

Wellesley Animal Hospital

REFERRING VET

Dr. Ryan Leal

INVOICE

13169

DATE

01/15/26

PRESENTING CLINICAL SIGNS

Pt presents for evaluation of prolonged anorexia. Pt originally presented in early December 2025 for hyporexia. Labwork revealed mild leukocytosis (20k), mild hyperglycemia (250), mild elevated lipase. A barium study was conducted which did not reveal any foreign material or evidence of obstruction. Treated with GI support at that time (Cerenia, mirtazapine, sqf). Pt has not improved since that time. Pt is hyporexic/anorexic (last ate two days ago and it was some beef), is becoming notably paretic/weak. Today, repeat labwork revealed a resolved leukocytosis but now elevated liver values and a hyperbilirubinemia. Patient has lost 1 pound in that month. AUS elected as next diagnostic step. Top concern for infectious cholangiohepatitis given age and chronicity. Concern that liver is impacted by hepatic lipidosis secondary to anorexia vs primary issue. While results are pending, patient give SQF, Cerenia, cefovecin, and B12 to treat suspect infectious cholangiohepatitis.

PE: icteric, BCS 3/9, diffuse sarcopenia CBC: NSF (low platelets but clumping noted on smear) Chem: Glu 166, BUN 12, Creat 0.9, ALT 164, ALP 157, tbili 6.0 T4: 1.2 UA unable to be performed due to lack of urine in bladder at time of diagnostics.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a large amount of echogenic non-shadowing debris, most consistent with exfoliated cells, crystals, mucous and/or small blood clots likely combined with incidental suspended lipid. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal in size (3.14 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal in size (3.28 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

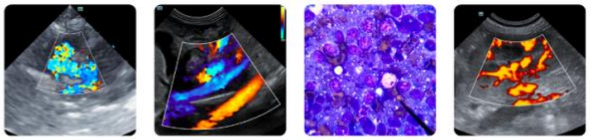
Left adrenal gland is normal in size (0.36 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.41 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver



PATIENT

Oliver Cudden

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

3 Years

WEIGHT

6.6 pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Ryan Leal

HOSPITAL NAME

Wellesley Animal Hospital

REFERRING VET

Dr. Ryan Leal

INVOICE

13169

DATE

01/15/26

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. No pancreatic duct dilation is noted. This change is very mild and appreciated in one focal area of the pancreas.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected as at least a partial contributor in the face of appropriate clinical signs.
- Hyperechoic hepatomegaly- This appearance is most consistent with benign hepatic lipidosis or endocrine/DM hepatopathy. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.
- A moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.
- A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

PATIENT

Oliver Cudden

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

3 Years

WEIGHT

6.6 pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Ryan Leal

HOSPITAL NAME

Wellesley Animal Hospital

REFERRING VET

Dr. Ryan Leal

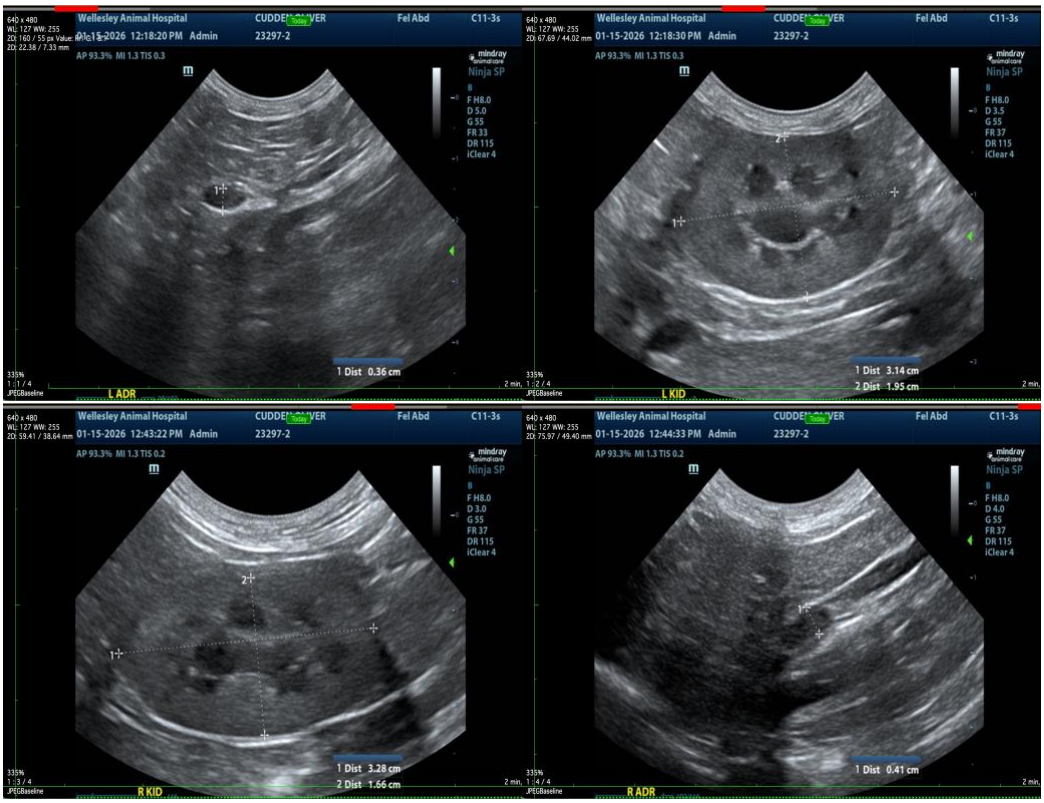
INVOICE

13169

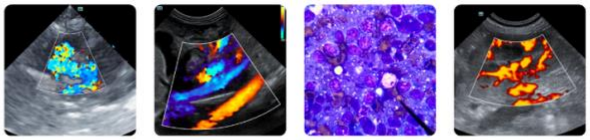
DATE

01/15/26

- Given patient's history, primarily the lack of liver enzyme changes when patient was first ill, it's difficult to solely blame a primary hepatopathy as the whole problem and is more consistent with hepatic lipidosis secondary to anorexia. Having said that, further workup for hepatopathy is indicated, beginning with fine needle aspirate of the liver of patient's coagulation status is appropriate.
- Otherwise, further evaluation for possible pain (dental, orthopedic, other), upper respiratory disease or oropharyngeal disease, cardiac disease and/or neurologic disease vs other as possible causes for decreased appetite and/or unintentional weight loss is also recommended.
- In the meantime, treatment recommendations include fluid therapy, anti-emetics, gastroprotectants, hepatic nutraceuticals such as ursodiol and/or Denamarin, and broad-spectrum antibiotics. Nutritional support is critical to prevent/manage concurrent hepatic lipidosis, so appetite stimulants and/or, if indicated, feeding tube placement is also recommended.



SonoPath
FOSTERING THE ART OF VETERINARY MEDICINE™



Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

Oliver Cudden

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

3 Years

WEIGHT

6.6 pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Ryan Leal

HOSPITAL NAME

Wellesley Animal Hospital

REFERRING VET

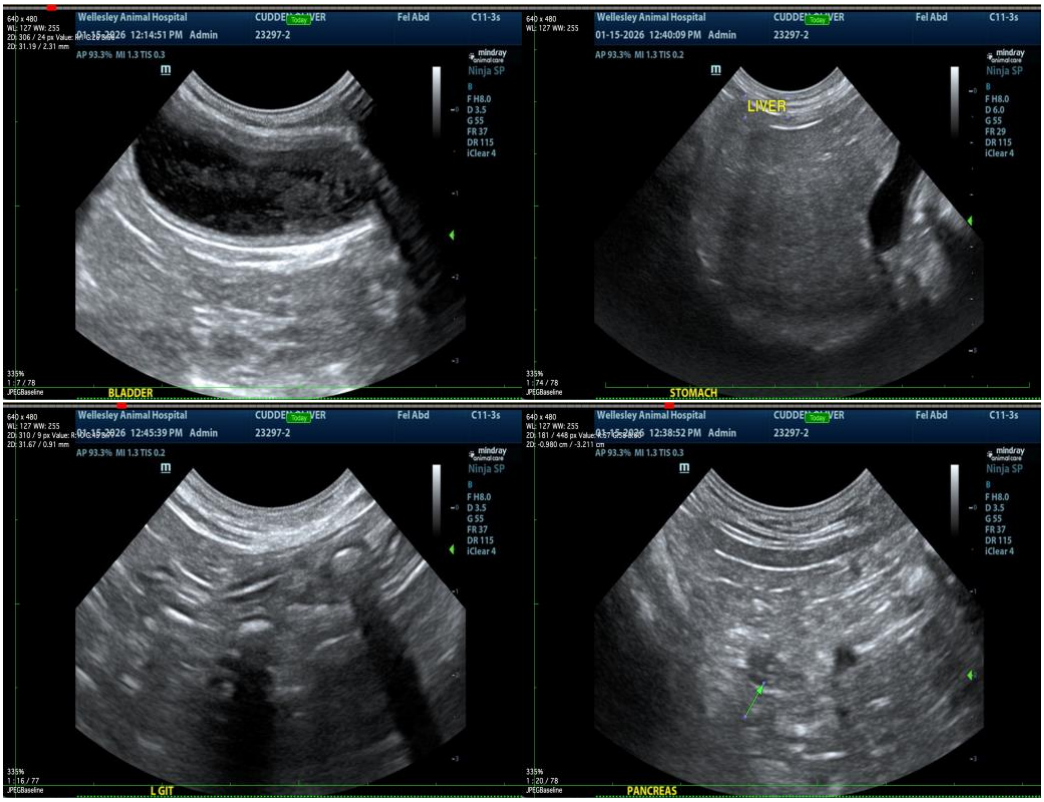
Dr. Ryan Leal

INVOICE

13169

DATE

01/15/26



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.

Beth Johnson, DVM DACVIM

info@sonopath.com