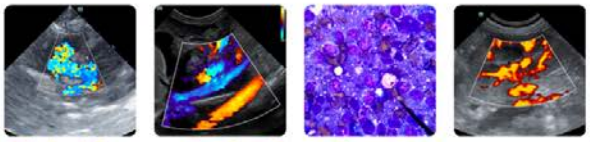


PATIENT

Boot Laporta

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

14 Years

WEIGHT

5.9 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Gira

HOSPITAL NAME

Sabadilla Animal Clinic

REFERRING VET

Dr. Nathaniel Ademadahun

INVOICE

72490

DATE

1/27/26

PRESENTING CLINICAL SIGNS

Referred for a third opinion regarding recurrent vomiting spells and a previously identified abdominal foreign body. Reports episodes of vomiting for hours, followed by lethargy for the next day, with recovery by the second day. These spells occur approximately once every one to two weeks.

A recent episode involved vomiting for three hours, associated with drooling and significant lethargy, prompting an emergency visit. Associated signs include behavioral changes (growling, decreased cuddling, intermittent play), lethargy, and inappetence over the past few days. Yesterday was the first day of lethargy without a preceding vomiting spell.

Abnormal PE/Chem/CBC/UA Results: Attached

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 occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also 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.

The right kidney is normal is size (3.78 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.

The left kidney is normal is size (3.87 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

The right adrenal gland is normal in size (0.25 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.40 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

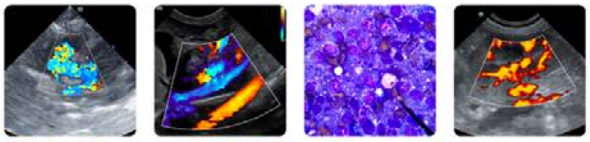
Spleen

The 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

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. The neck of the gallbladder into the cystic duct and beyond is tortuous and



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dilated to the level of an approximately 0.60 cm in diameter hard shadowing mineral density, beyond which the common bile duct remains tortuous but is less distended. I don't believe this patient has a bilobed gallbladder. I think what looks like the other gallbladder is actually a markedly dilated biliary system proximal to the stone. A bilobed gallbladder, however, can't be ruled out.

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

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Suspect an obstructive cholecystolith – Given patient's clinical history, it could be partially obstructive or intermittently obstructive. A concurrent hepatopathy including both benign and/or infiltrative neoplastic processes can't be ruled out based on the mildly heterogeneous liver.

SECONDARY FINDINGS

- Age related pancreatic remodeling.
- Moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Further evaluation of the liver could be considered, beginning with fine needle aspirates for cytology +/- culture and sensitivity, etc. if patient's coagulation status is appropriate.

Given the intermittent clinical signs and the relatively mild laboratory changes, it is difficult to determine the degree of clinical effect of this stone. Intermittent movement of the stone or potentially other historical, already passed stones could be contributing to intermittent abdominal pain and nausea, although secondary infections, underlying gastrointestinal disease, or a hepatopathy, etc. could be

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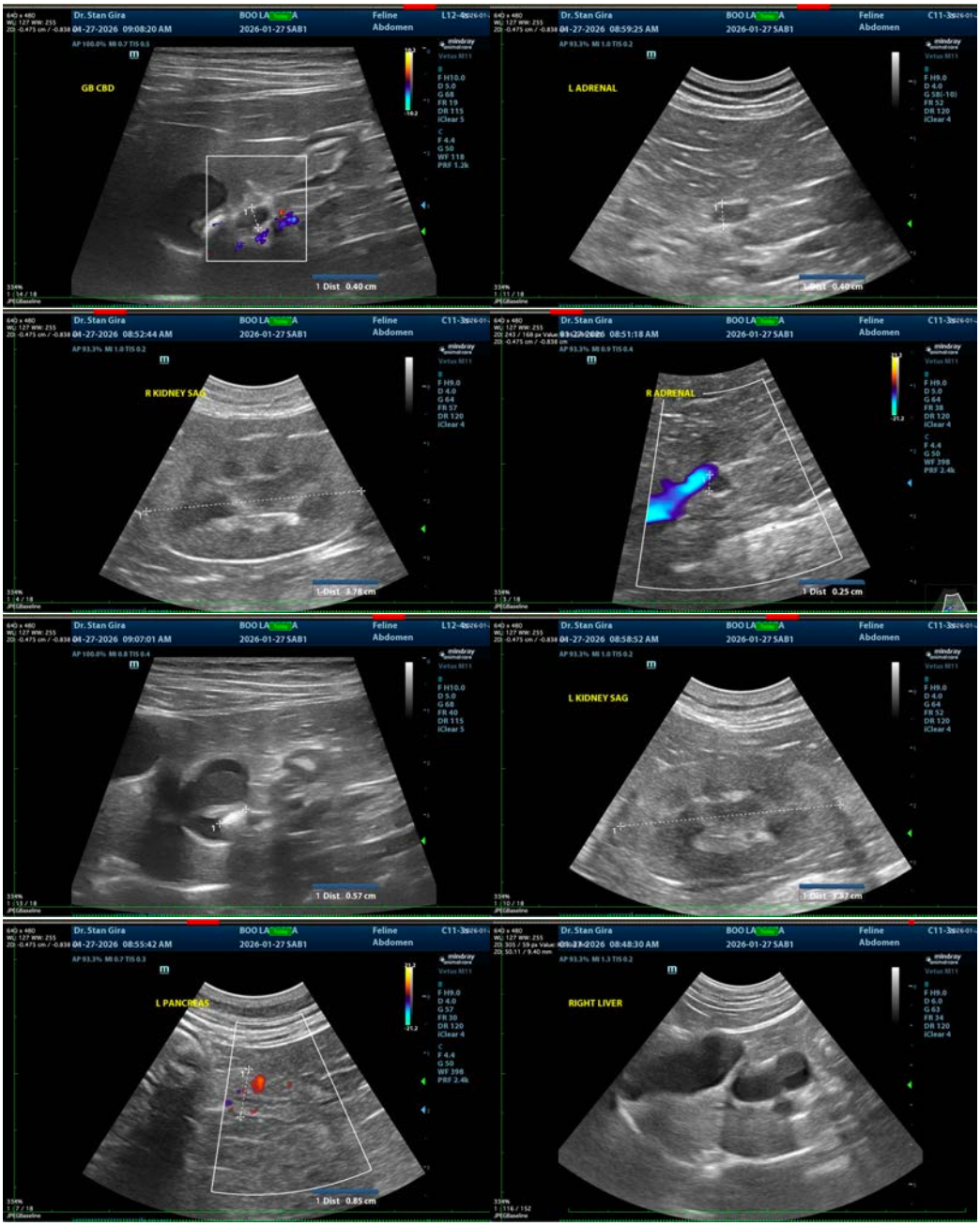
contributing as well. Therefore, if surgery is elected, an exploratory laparotomy for further evaluation, removal of the stone, if possible, potential biopsy of the liver, etc. would be an appropriate plan, and if pursued, consultation with a veterinary surgeon is recommended. However, if a conservative approach is elected first. 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.



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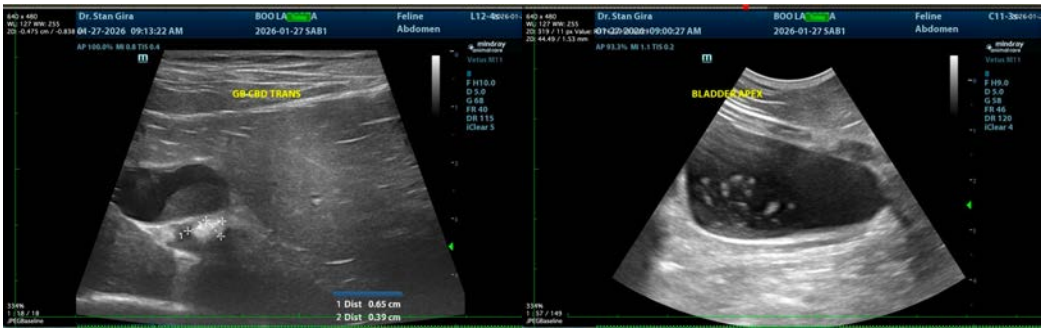

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com