



PATIENT

Princess Rivera

SPECIES

Feline

BREED

Domestic Longhair

SEX

Spayed Female

AGE

6 Years

WEIGHT

7.5 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Kaitlyn Rudie, DVM

HOSPITAL NAME

Sherwood Family Pet
Clinic

REFERRING VET

Shaina Jachter, DVM

INVOICE

72527

DATE

1/28/26

PRESENTING CLINICAL SIGNS

Sneezing for a few days, decreased appetite for approximately one week. Purr sounds different. Drinking more water lately. Still playing. No ocular or nasal discharge, dry sneezes. No vomiting or diarrhea. Uses slow feeder due to eating quickly when she does eat. Climbing instead of jumping, possible feeling weak. Tried multiple foods but refusing most

From cat adoption team: Not eating despite trying different foods - will sniff food but walk away. Drinking small amounts of water and tuna juice, below normal amount. Shows excitement when food drawer opens but won't actually eat. Given quarter tablet of mirtazapine. Client attempted hand feeding with spoon but cat refused. Tried warming food and different fish varieties without success. Client works night shift, only available Mondays and Tuesdays

Abnormal PE/Chem/CBC/UA Results: See attached, elevated liver enzymes and bilirubin, Decreased creatinine and BUN, Icteric AU, Bilirubinuria 3+, UA 1+ ammonium mg phosphate (1-5)/HPF

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 in size (3.4 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 in size (3.3 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 (0.47 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.29 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 (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than



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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.

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The 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.

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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.

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

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Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

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Kaitlyn Rudie, DVM

ULTRASONOGRAPHIC FINDINGS

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- 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.

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- Mild amount of echogenic urinary bladder debris.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the liver could be secondary to hepatic lipidosis brought on by the reported decreased appetite with the focus being on determining why the decreased appetite. Having said that, other infiltrative hepatopathies can't be ruled out. Therefore, fine needle aspirates of the liver are recommended if patient's coagulation status is appropriate.

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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.



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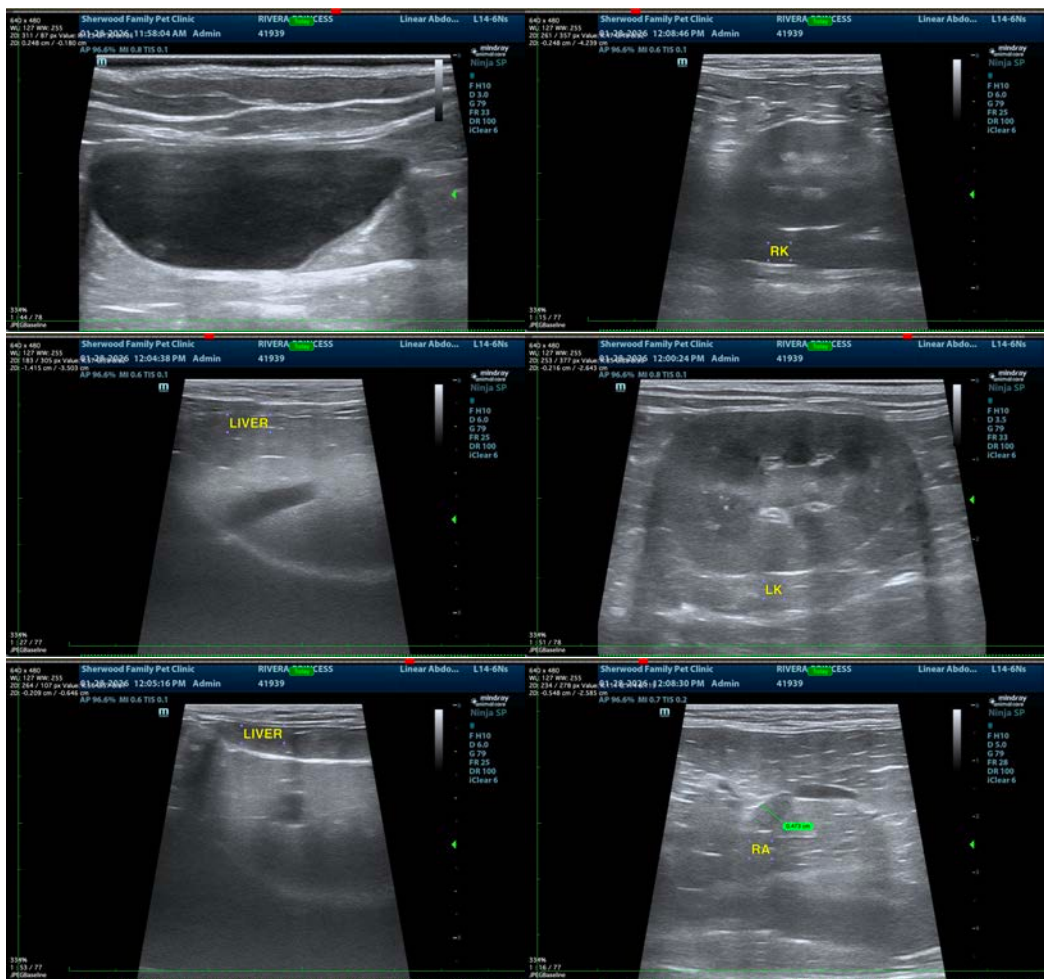
DATE

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Further investigation of the reported sneezing and purr could be considered as a potential cause for decreased appetite via advanced imaging such as contrast CT scan, rhinoscopy, etc.

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 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.





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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
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