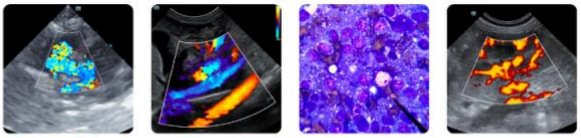




**PATIENT**

Jasper Cook

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

6 Years 7 Months

**WEIGHT**

17.1 Pounds

**INTERPRETED BY**

Beth Johnson, DVM, DACVIM (SAIM)

**IMAGING PERFORMED BY**

Rebecca Hamilton

**HOSPITAL NAME**

Wantage VH

**REFERRING VET**

Dr. Bullock

**INVOICE**

36799

**DATE**

2/10/26

## PRESENTING CLINICAL SIGNS

- Weight loss, decreased appetite
- Increased liver enzymes
- Abnormal PE/Chem/CBC/UA Results: Inc. ALT, AlkP, TBili, GGT, Inc. Globs

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are large in size with increased cortical echogenicity. Normal smooth peripheral margination and shape are maintained. 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 measures 4.8 cm. The right kidney measures 5.4 cm.

### *Adrenal Glands*

Left adrenal gland is normal in size (0.29 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.33 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### *Spleen*

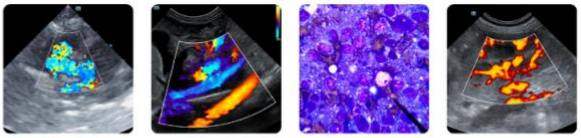
Spleen measures just over the upper end of normal limits (just over 1.0 cm thick at the hilus) with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

### *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 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 are multiple tortuous anechoic tubular structures throughout the liver parenchyma, adjacent to the gallbladder and biliary tree. Focally, there is an approximately 2.2 cm in diameter, distended area just caudal to the gallbladder that could represent a focal or segmental dilation of the cystic or common bile duct. There is no definitive mineral or nodular changes, etc., to indicate the cause of an obstruction if present.

### *Gastrointestinal*



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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 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.

### *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

- The suspected focally/segmentally dilated portion of the biliary tract described above could represent a normal anatomic variant, i.e., bilobed gallbladder, although given the location of it, combined with patient's reported clinical signs, etc., a bile duct, diverticulum, or pathologic dilation/cyst versus other, can't be ruled out. Partial obstruction due to mineral or nodule/tissue or other inflammatory debris is possible, but there is no visible evidence of these things in these images at this time.
- 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.
- Splenomegaly- can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- Renomegaly- These renal changes can be seen with glomerular or interstitial nephritis, FIP, amyloidosis, acute tubular necrosis or infiltrative neoplasia such as lymphoma. Normal variant due to fat deposition cannot be ruled out, especially in a large cat.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sampling of the multiple enlarged organs via fine needle aspirates with attention paid especially to the liver and spleen could be considered if patient's coagulation status is appropriate.

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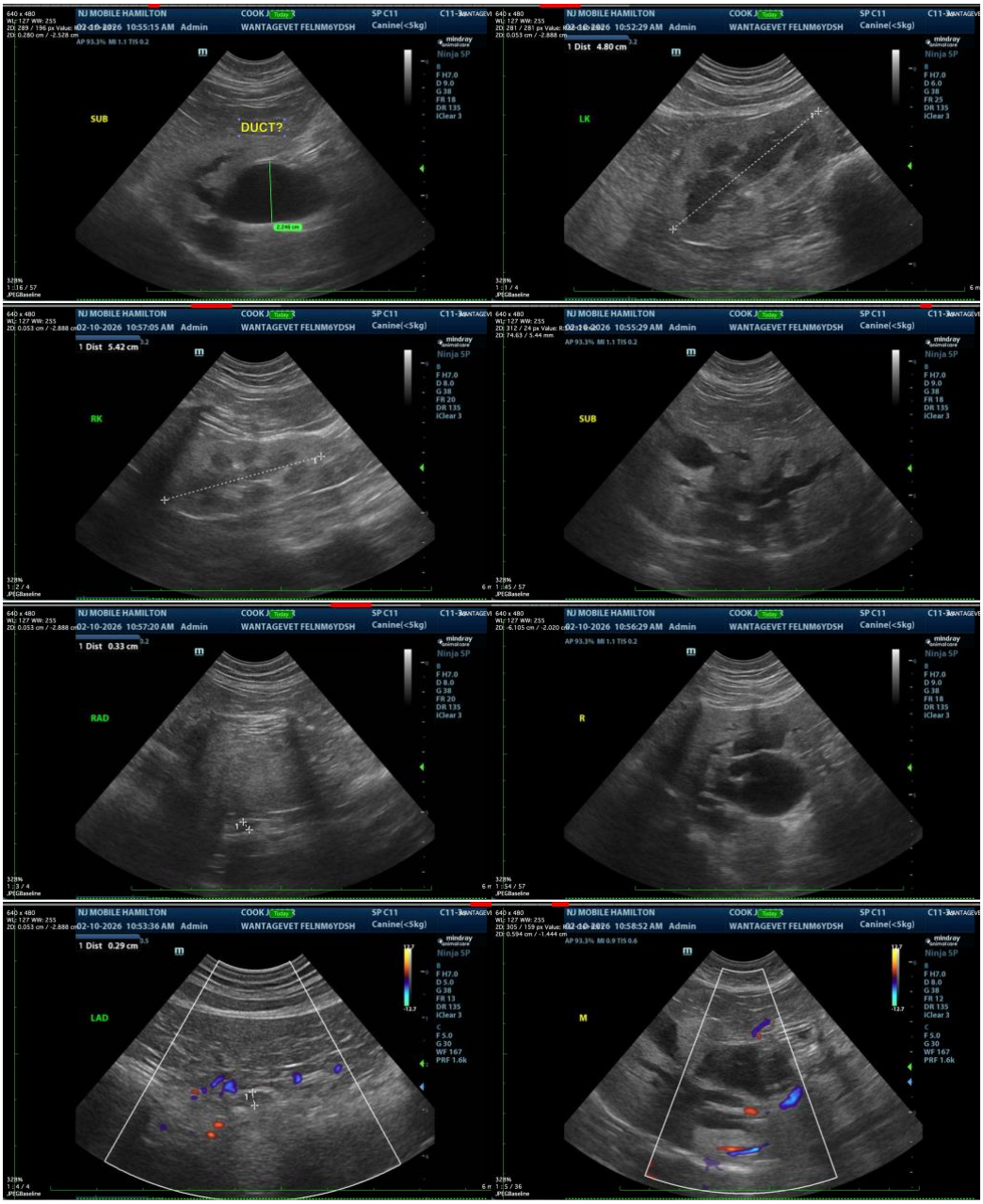
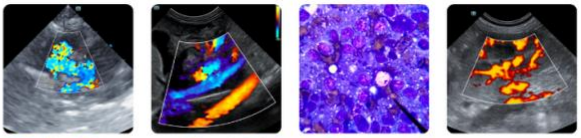
Given the atypical appearance of the focally dilated anechoic structure in the mid liver, however, additionally, and/or alternatively, advanced imaging, such as an abdominal contrast CT scan, may be warranted.

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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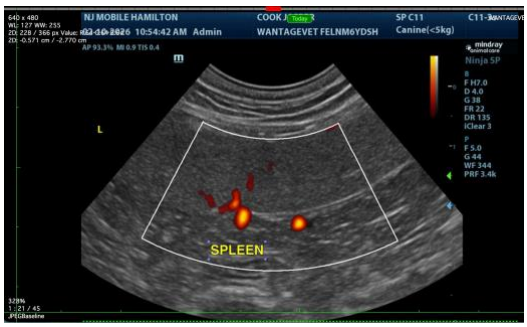


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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**

info@sonopath.com