



**PATIENT**

Jinx Weickardt

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

11 Years

**WEIGHT**

11.3 Pounds

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

M. Kermendy, CVT

**HOSPITAL NAME**

Wauwatosa Vet

**REFERRING VET**

Dr. Elaine Binor

**INVOICE**

35511

**DATE**

2/8/22

**PRESENTING CLINICAL SIGNS**

History of hyporexia. Anorexic last few days to weeks. On steroids for a URI that seems to be working well. Vomits partially digested food every few days. On Purina dry diet--gets 1/4 cup twice a day and fresh pet tuna. On physical exam pet is jaundice with thick, ropey intestines. Thin body condition--BCS=3/9. Owner declined ER hospitalization. Gave pet cerenia, SQ fluids, and started gabapentin for pancreatitis. Pet feeling a little better. Imaging to check for cause of triaditis. Check for neoplasia, cholangiohepatitis, pancreatitis.

Abnormal PE/Chem/CBC/UA Results: FPL=positive for pancreatitis ALT=479 (12-130) suspect hepatic failure/lipidosis GGT=41 (0-4) T. Bili=6.7 (0-0.9)

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is moderately 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.

The right kidney is normal in size (4.26 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 (4.24 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 (0.42 cm thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.35 cm thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

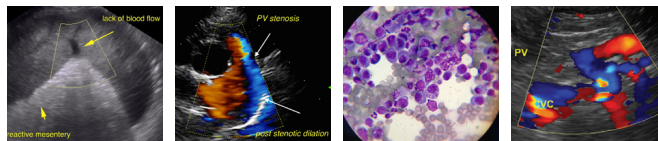
**Spleen**

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. Margins are smooth but round. 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. No focal lesions are observed. Lobar biliary duct dilation is noted.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. The cystic duct and common bile ducts are markedly distended. The common bile duct measures 1.5 cm at the maximal distention and contains an abundant amount of echogenic debris including mineral at the termination to which the dilation can be traced.



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**Gastrointestinal**

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with 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. Normal layering is maintained except for a diffusely disproportionately thick muscularis layer relative to mucosa. 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.

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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 is prominent and hypoechoic to surrounding tissue. The visible capsule is smooth and normal in contour. Parenchyma is diffusely heterogeneous. The pancreatic duct is mildly dilated, measuring 0.31 cm in dilation. There is mild evidence of peripancreatic inflammation around the previously reported common bile duct debris.

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**Free Abdomen**

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

**WEIGHT**

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**ULTRASONOGRAPHIC FINDINGS**

- Post-hepatic obstruction with severe distal common bile duct dilation and lobar biliary duct dilation with evidence of echogenic debris and mineral at the termination of the traceable common bile duct. Differentials include biliary debris and choleliths primarily. However, a mineralized mass cannot be ruled out.
- Chronic pancreatitis
- Hyperechoic hepatomegaly – consistent with benign hepatic lipidosis. Infiltrative disease such as amyloidosis or neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.
- Thick muscularis – This finding has been reported in cats with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Ultimately, resolution of the obstruction will likely warrant surgery, at which time gallbladder and biliary tree should be assessed unobstructed, redirected, etc., and given the concurrent small bowel changes, full thickness biopsies of the small bowel, being sure to include the ileum if possible. A biopsy of the liver at the time is recommended as well. If surgery is declined, a fine needle aspirate of the liver is recommended if patient's coagulation status is appropriate.

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A gastrointestinal malabsorption panel is recommended including TLI, PLI, folate and cobalamin to Texas A&M GI laboratory to help better direct medical management of possible infiltrative small bowel disease. The gastrointestinal panel is recommended in either scenario. Medical management could be tried with hospitalization, IV fluid therapy, broad-spectrum antibiotics, antiemetics, pain management, etc., with close monitoring of the total bilirubin +/- the ultrasound changes for improvement versus progression, at which time surgery would have to be pursued.

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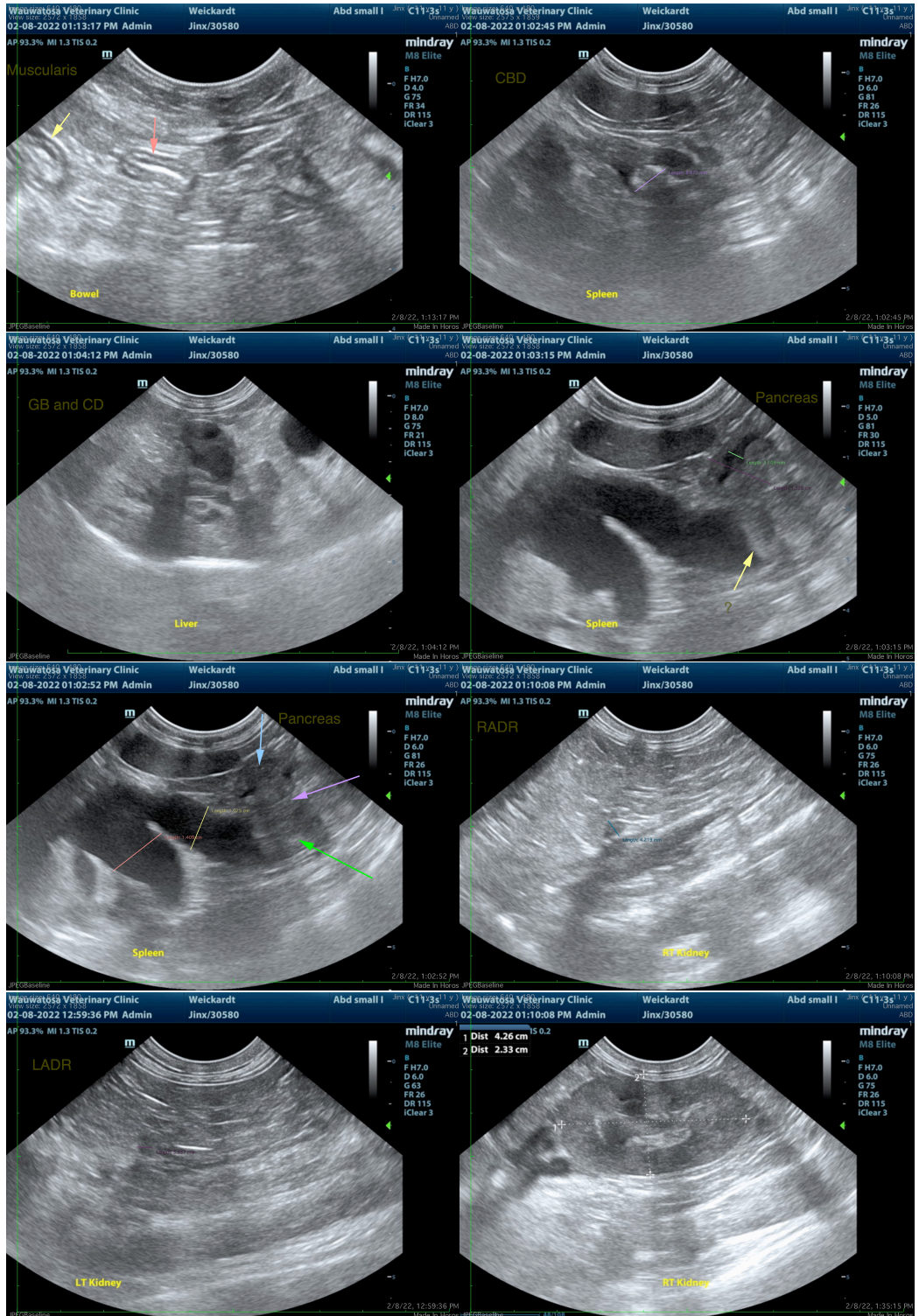
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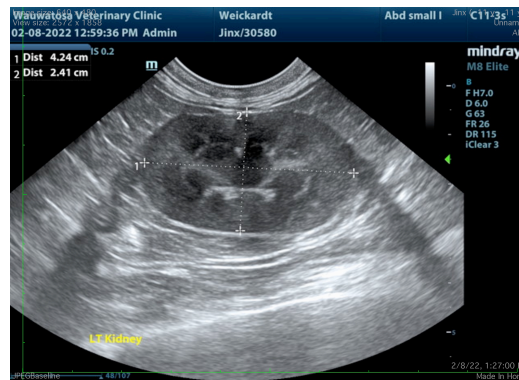
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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