



PATIENT

Satan Daley

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

8

WEIGHT

10.7

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Jenn

HOSPITAL NAME

Rockaway Animal
Hospital

REFERRING VET

Dr. Dubos

INVOICE

73368

DATE

3/4/26

PRESENTING CLINICAL SIGNS

Not eating, diarrhea Hx of fbd Current meds IVF

Abnormal PE/Chem/CBC/UA Results: Neutrophillia with bands eosinopena low phos Protein 30 Bilirubin 1 USG 1.030

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 (3.93 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 (3.88 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 areas of the adrenal glands are examined without evident adrenal gland pathology.

Spleen

Spleen measures just at the upper end of normal limits for thickness at 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) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. No focal lesions are observed. 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 cystic and common bile duct are diffusely tortuous in appearance and dilated, with a maximal dilation that I can see measuring 0.71 cm dilated. In several views, some subtle intraluminal echogenic debris is suspected within the ducts, but it is not visible in all views. The common bile duct at the level of the duodenal papilla is difficult to fully visualized.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen is mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. 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 of the small intestine contains fluid.

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

- Based on the appearance of the liver and gallbladder, cholangitis/cholangiohepatitis with potentially some partial contribution or even blockage from debris or mineral unable to be ruled out. Having said that, this change should be interpreted in combination with laboratory changes, clinical signs, etc., as some of the appearance could be a chronic change related to previous, not currently active or clinically significant episodes. Infiltrative inflammatory or neoplastic disease affecting the liver can't be ruled out without tissue sampling.
- There is no definitive ultrasonographically visible evidence of concurrent pancreatitis or bowel disease. However, neither can be definitively ruled out.

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.

A routine fecal/giardia exam is recommended.

Fine needle aspirates of the liver +/- spleen could be considered if patient's coagulation status is appropriate.

If a diagnosis is not obtained, a fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Other than supportive/symptomatic medical management of clinical signs, further diagnostic and treatment recommendations are largely dependent on results of the above.



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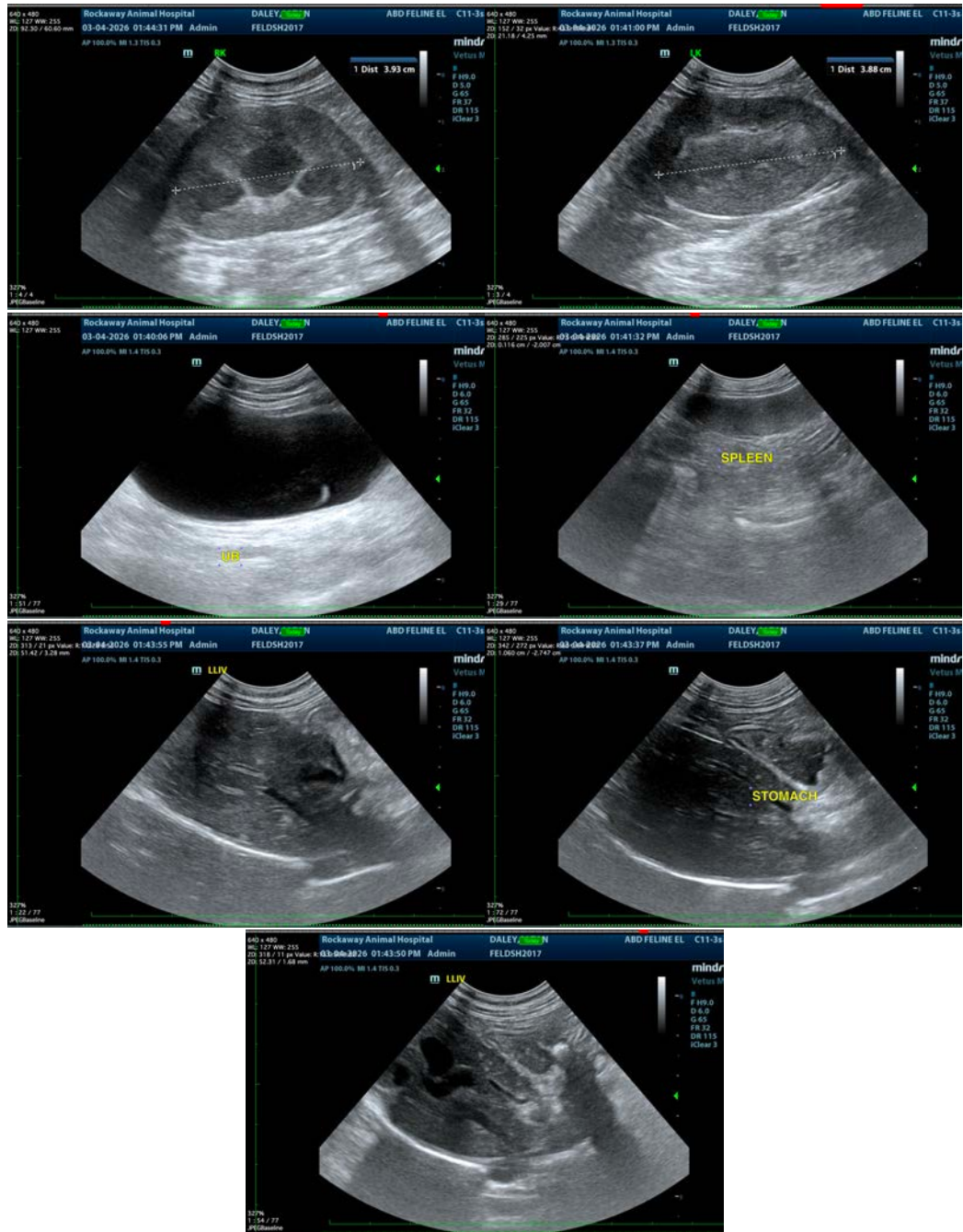
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com