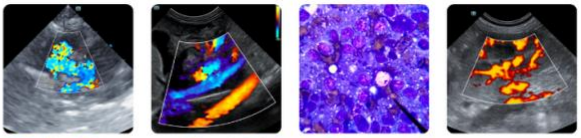

PATIENT

Gorgon Butner

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

8 Years 6 Months

WEIGHT

8.9 pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Shari Reffi CVT

HOSPITAL NAME

Harmony Animal Hospital

REFERRING VET

Dr. Gruber

INVOICE

15133

DATE

04/16/26

PRESENTING CLINICAL SIGNS

BCS 4/9; dilated GB, inflamed, losing weight, pale mm, icteric, distended abdomen. FIV/FELV/HW-neg. Convenia 4/13

Abnormal PE/Chem/CBC/UA Results: MCV-55.5; MCH-20.5; Glu-177 (stress); GGT-26; TBili-2.5; Glob-5.3.

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.

Left kidney is normal in size (4.38 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.

Right kidney is normal in size (4.57 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

Left adrenal gland is normal in size (0.49 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.36 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. No discrete sizable focal nodules or masses are observed. Splenic vasculature appears normal. The spleen measured 1.1 cm thick at the hilus.

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 mildly subjectively distended. The wall is smooth without visible thickening. Luminal contents are primarily anechoic, but the cystic and comal bile duct are diffusely tortuous and dilated, ranging between 0.6 cm and 0.7+ cm dilated at the duodenal papilla.

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

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. No pancreatic duct dilation is noted.

Free Abdomen

There's a very large amount of free fluid in these images with no lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Coarse 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 well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- The hepatobiliary changes are nonspecific with differentials for microscopic hepatopathy including benign cholangiohepatitis such as bacterial or lymphoplasmacytic cholangiohepatitis, potentially hepatic lipidosis, other infectious or inflammatory benign process or infiltrative neoplasia such as round cell neoplasia, i.e. lymphoma, can't be ruled out without tissue sampling.
- Concurrent chronic low-grade smoldering pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
- A very large amount of free fluid- Free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sampling of the free abdominal fluid for analysis and cytology is recommended if patient's coagulation status is appropriate.

Pending that result, fine needle aspirates of the spleen and liver could also be considered if patient's coagulation status is appropriate.

In the meantime, further cardiac evaluation including an echocardiogram is recommended. While continuing workup, treatment recommendations include fluid therapy, anti-emetics, gastroprotectants, hepatic nutraceuticals such as ursodiol and/or Denamarin, and broad-spectrum antibiotics. Nutritional

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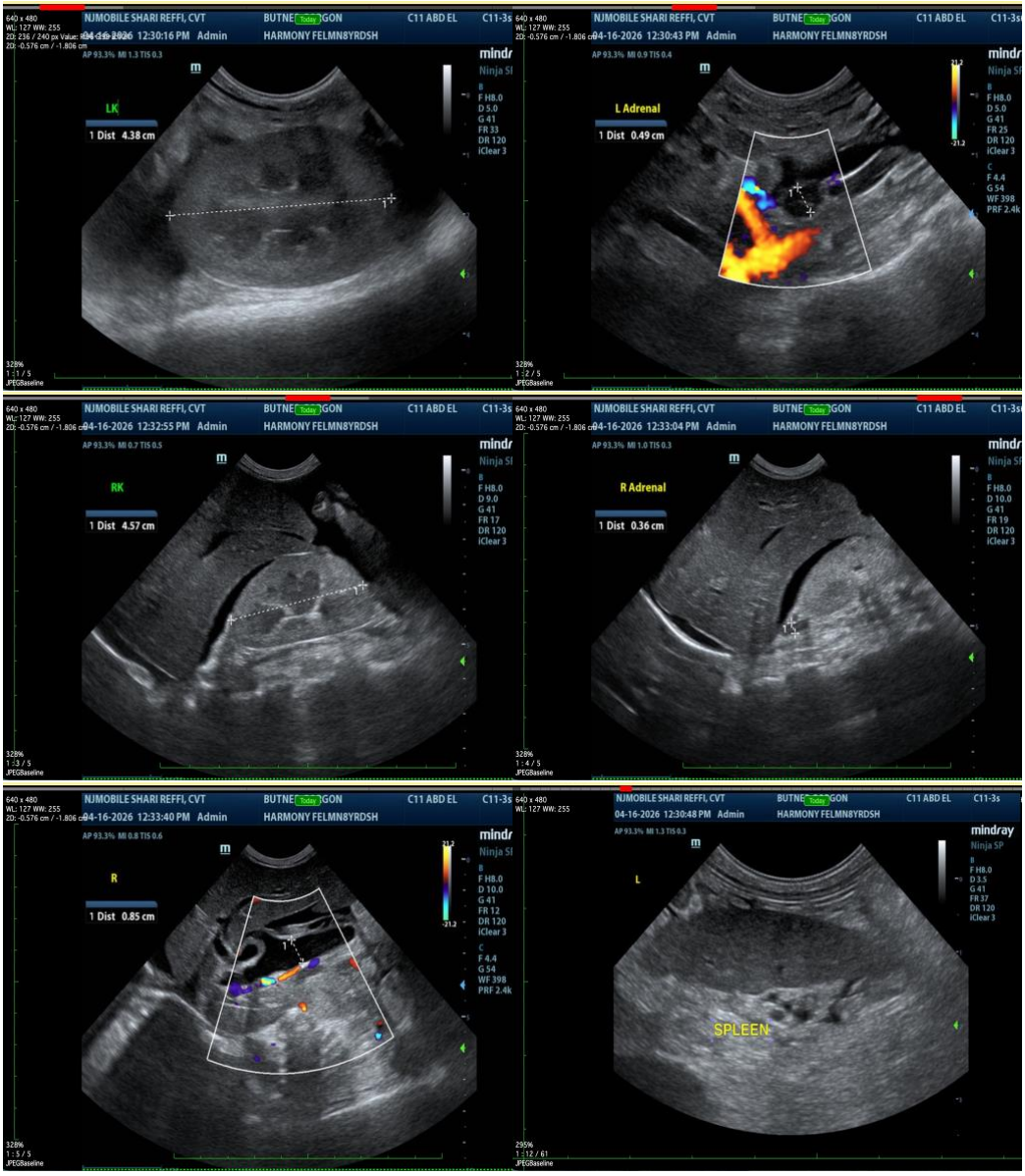
support is critical to prevent/manage concurrent hepatic lipidosis, so appetite stimulants and/or, if indicated, feeding tube placement is also recommended.



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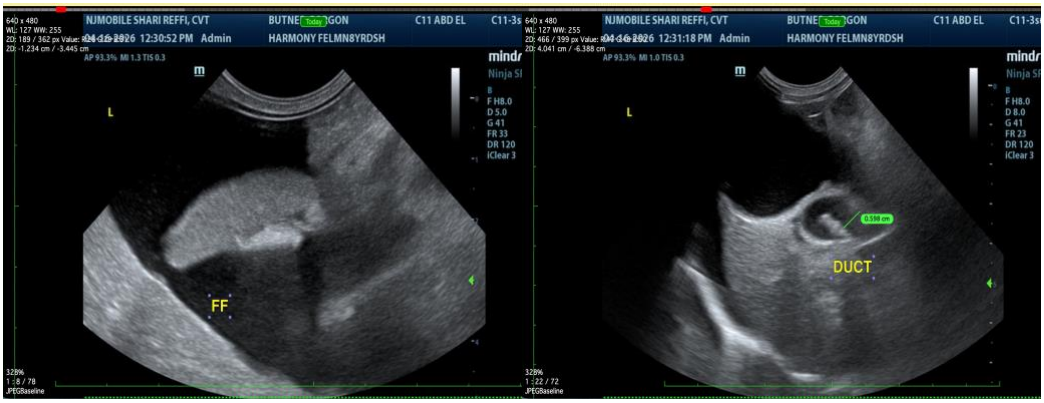

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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