



DATE PRESENTING CLINICAL SIGNS

4/21/26 Patient History: Patient stopped eating and got bloodwork done, it showed elevated liver enzymes.

PATIENT

Current Medications: None listed.

Princess Waters

Labwork Results: Labwork not attached.

SPECIES

Date of Previous IntraPet Ultrasound: No previous.

Feline

Sedation: Declined.

BREED

Stat Report: STAT requested.

DSH

Imaging Performed by: Rachel Brillhart, RDMS.

SEX

Spayed Female

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

AGE

Urinary System

4/10/18

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.

WEIGHT

11.6 Pounds

Left kidney is normal in size (3.5 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.

INTERPRETED BY

Beth Johnson, DVM
DACVIM

Right kidney is normal in size (3.5 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.

HOSPITAL NAME

Adrenal Glands

AMC of Bel Air

Left adrenal gland is normal in size (0.42 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

REFERRING VET

Dr. Chaudhry

Right adrenal gland is normal in size (0.57 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

INVOICE

36664

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 normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. 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 is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. 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

- This is a largely unremarkable/normal structural abdomen without a definitive ultrasonographically visible intraabdominal explanation for patient's reportedly increased liver enzymes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

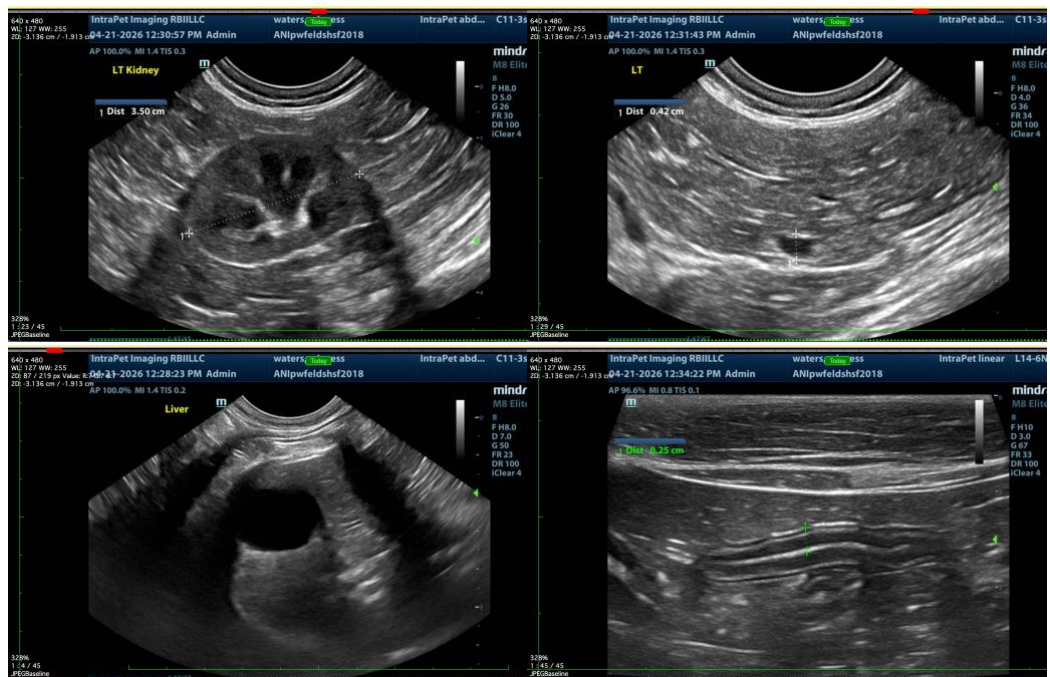
Given patients reportedly decreased appetite preceding the noticed liver enzyme change, hepatic lipidosis could be the top differential, in which case primary diagnostic recommendations are to determine the cause of decreased appetite. With that in mind, as well as further investigation of the liver to diagnose hepatic lipidosis, further recommendations include:

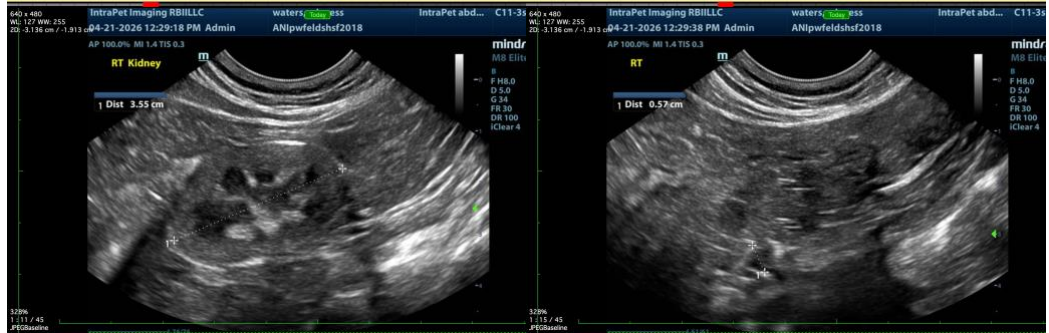
- A full general metabolic health screen, if not recently evaluated, to include CBC, chemistry panel, electrolytes, and urinalysis, and if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

- Fine needle aspirates of the liver could be considered if patients coagulation status is appropriate.
- 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.
- 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.





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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