



**PATIENT**

George Guevara

**SPECIES**

Feline

**BREED**

DLH

**SEX**

Neutered Male

**AGE**

12 Years 3 Months

**WEIGHT**

14.9 Pounds

**INTERPRETED BY**

Beth Johnson, DVM,  
DACVIM (SAIM)

**IMAGING PERFORMED BY**

Rebecca Hamilton

**HOSPITAL NAME**

Animal General  
Hudson

**REFERRING VET**

Dr. DiGiuseppi

**INVOICE**

37066

**DATE**

5/11/26

**PRESENTING CLINICAL SIGNS**

History: Elevated Liver enzymes, history of lethargy and vomiting  
Abnormal PE/Chem/CBC/UA Results: ALT 1252, ALP 452, Bili 10.6, AST 442

**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 (4.3 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 (4.5 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.

**Adrenal Glands**

Left adrenal gland is normal in size (0.45 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is unable to be well visualized in these images.

**Spleen**

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 (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 moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

**Gastrointestinal**

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less



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likely but cannot be definitively ruled out. If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

The visible small intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

***Pancreas***

Throughout the cranial abdomen, in the area of the pancreas, most significant in the right limb, is coarse, irregular, scalloped, hypoechoic tissue, surrounded by enhanced hyperechoic fat and mesentery that appears to be a prominent inflamed pancreas. In the left limb, there is a subtle, approximately 1.5 cm x 0.7 cm area that almost appears anechoic in some views, and could represent a cyst, abscess, dilated duct, other. Additionally, several ill-defined hypoechoic densities surrounding, what I believe is pancreatic parenchyma, are present and could represent prominent lymph nodes in the area.

***Free Abdomen***

Otherwise, there is no visible free peritoneal effusion or apparent pathologic lymphadenopathy noted in these images.

**ULTRASONOGRAPHIC FINDINGS**

- Suspect moderate to severe acute pancreatitis.
- Concurrent mild/emerging inflammatory bowel disease pattern- Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- 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.
- Mild gallbladder debris- Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The appearance of this study is consistent with possible “triaditis” with pathology involving the GI tract, the hepatobiliary system, and primarily the pancreas. Therefore, further diagnostic recommendations include:



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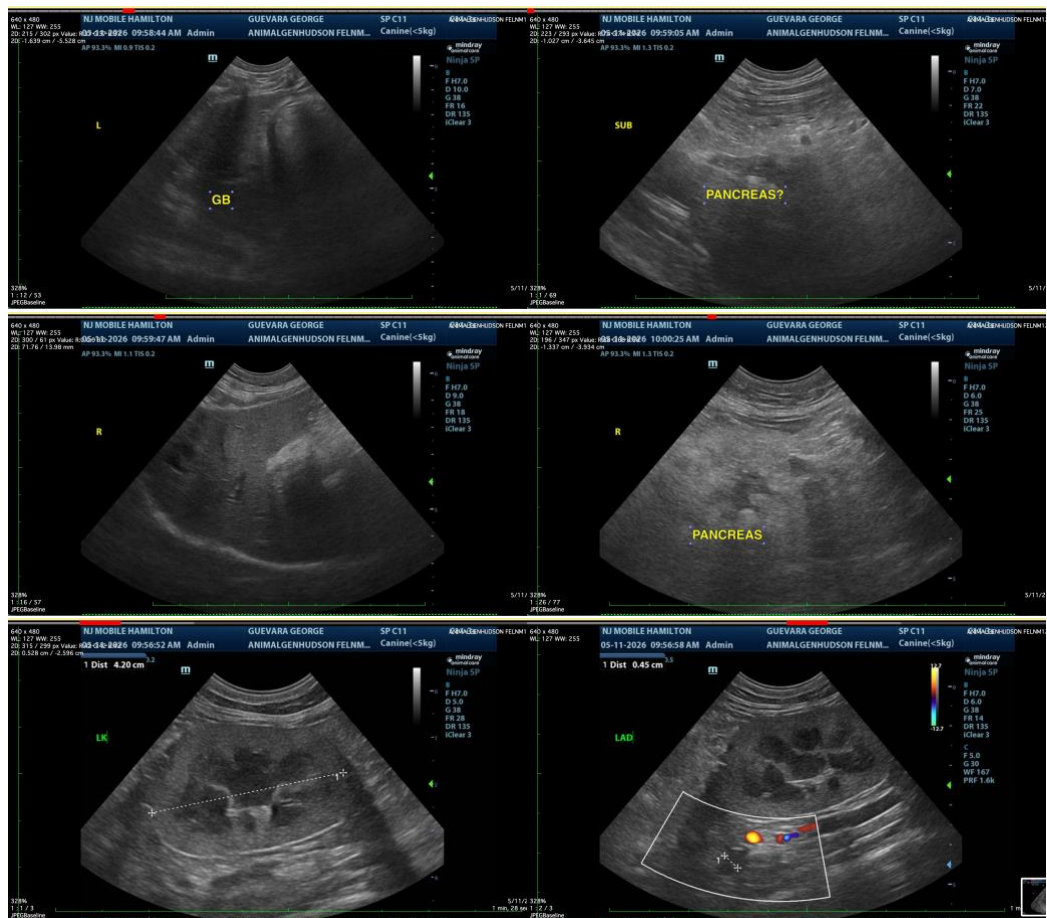
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- A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.
- Fine needle aspirates of the liver can be considered if patient's coagulation status is appropriate.
- In the meantime, medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support (including a feeding tube) as needed, pain management, broad spectrum antibiotics, and fluid therapy is recommended. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc.





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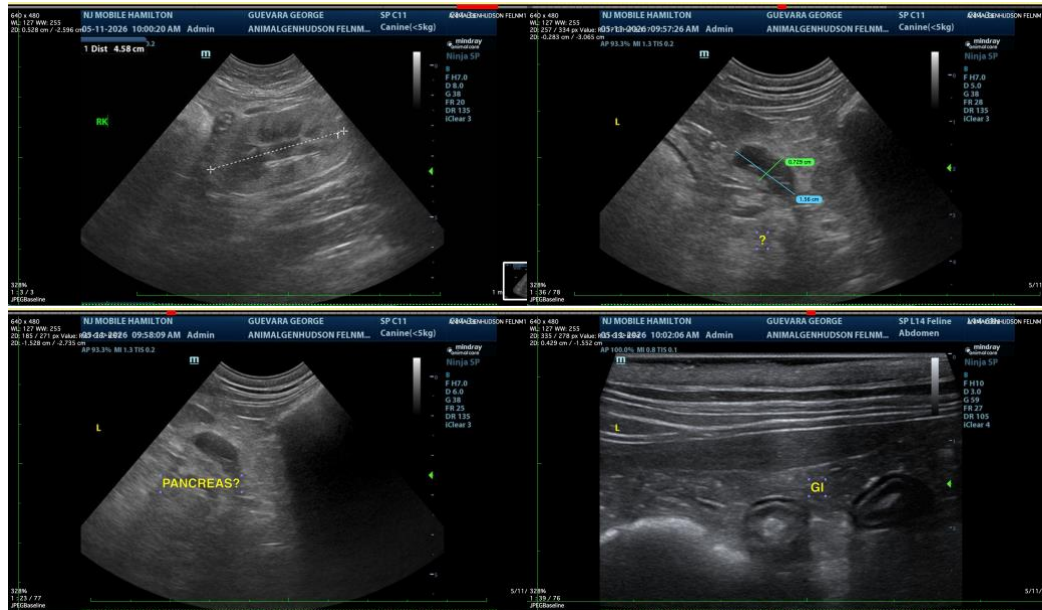
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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