



PATIENT

Aberdeen England

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

16 Years

WEIGHT

6.7 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Pamela Harrigan,
RDCS, Certified Vet
Sonographer

HOSPITAL NAME

Rutland Veterinary
Clinic

REFERRING VET

Katie Taylor, DVM

INVOICE

75054

DATE

5/12/26

PRESENTING CLINICAL SIGNS

Elevated liver enzymes and bilirubin - no improvement on Denamaron and orbax. Weight loss. Clinically well per owner.

Abnormal PE/Chem/CBC/UA Results: AST 115, ALT 526, ALP 141, Tbili 0.8, BUN 46

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The 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.

Kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. No mineral is observed. The left kidney is small at 3.02 cm with mild pyelectasia measuring 0.36 cm in the transverse view. The right kidney is small-normal at 3.45 cm with pyelectasia measuring 0.24 cm in the transverse view.

Adrenal Glands

The right adrenal gland is normal in size (0.39 cm at the cranial pole and 0.31 cm at the caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.39 cm), shape and overall architecture, echogenicity and echotexture. 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 with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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 lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of moderately thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic. In some views there are bowel loops that demonstrate less distinct than normal layering. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.



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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 observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

There is no visible free peritoneal effusion noted in these images.

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There is no apparent pathologic lymphadenopathy noted in these images.

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ULTRASONOGRAPHIC FINDINGS

- The moderate bowel changes described can be seen with benign infiltrative bowel disease, including benign inflammatory disease as well as infiltrative neoplasia such as lymphoma and can't be fully differentiated without tissue sampling.
- Pancreatic age-related remodeling/Chronic pancreatitis – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
- The moderate liver changes are non-specific but concerning for possible microscopic hepatopathy including benign hepatopathy such as bacterial or lymphoplasmacytic cholangiohepatitis, hepatic lipidosis, other benign infectious or inflammatory hepatopathy, or infiltrative neoplasia such as round cell neoplasia i.e., lymphoma versus other, which can't be ruled out without tissue sampling.
- 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.
- Moderate bilateral chronic kidney disease changes with mild bilateral pyelectasia.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a T4 +/- free T4 is recommended.

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 could be considered if patient's coagulation status is appropriate. If a cytologic diagnosis is unable to be obtained, however, ultimately biopsies of the GI tract, being sure to include ileum, if possible, may be necessary for a definitive diagnosis and to further guide medical management, as well as to more definitively rule out infiltrative neoplasia.

In the meantime, treatment recommendations include fluid therapy, anti-emetics, gastroprotectants,

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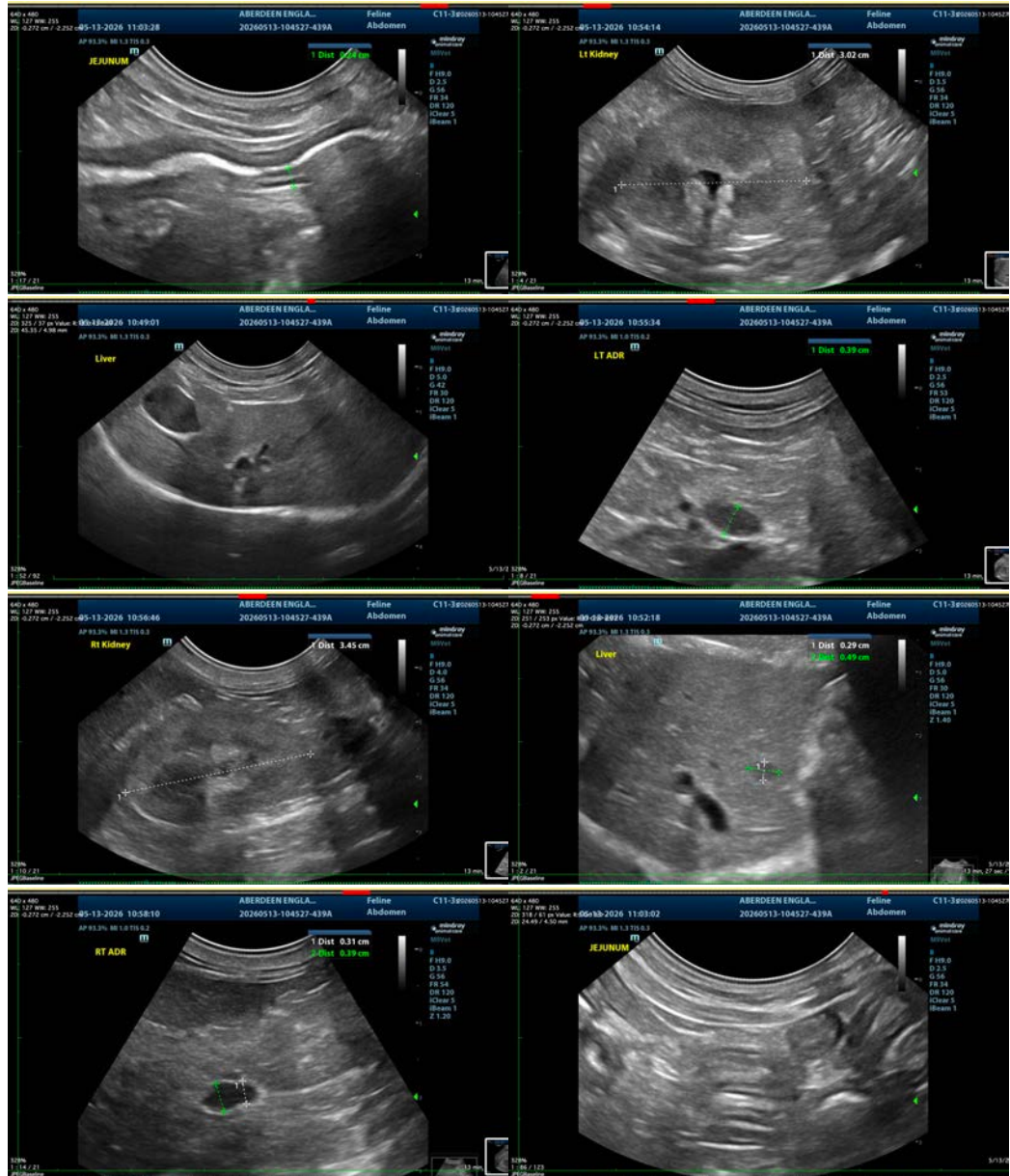
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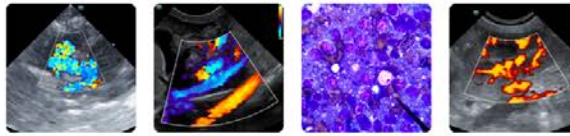
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hepatic nutraceuticals such as ursodiol and/or Denamarin, and broad-spectrum antibiotics. Nutritional support is critical to prevent/manage concurrent hepatic lipidosis, so appetite stimulants and/or, if indicated, feeding tube placement is also recommended.





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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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