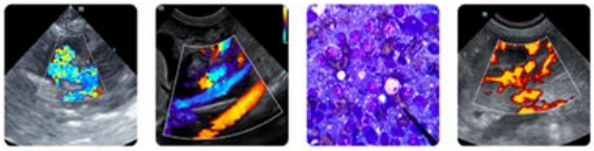


PATIENT

Lola Russell

SPECIES

Feline

BREED

DLH

SEX

F

AGE

18yr

WEIGHT

4.8kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Lea Button

HOSPITAL NAME

Valley Veterinary

REFERRING VET

Dr. Lea Button

INVOICE

24999

DATE

06/02/2026

PRESENTING CLINICAL SIGNS

9/16/2024 - Suspected pancreatitis episode

5/26/2026 presentation for jaundice: Yellow skin tinge, decreased appetite, weight loss, vomiting - Physical exam: Clinically jaundiced (MM, sclera, skin), dehydrated, tense cranial abdomen, severe muscle cachexia, low stance with posterior pelvic tilt- Large volume hard stool palpable, urinating/defecating outside litter box- Radiographs(2 views) M1 gastric distension; suspect ingesta appreciable in gastric lumen- focal area of mineralized material in right upper quadrant, suspect cholelith's? mild gas/fluid diffusely in SI; no FB or obstructive pattern- M2 fecal material in entirety of large intestine. No megacolon. - possible small mineralization in R kidney (superimposition makes localization difficult - cannot visualize on V/D)- urinary bladder medium-sized

5/28/2026 - Ultrasound follow-up Sedated from pre-visit medications, no additional sedation needed- Ultrasound findings: Mass with hyperechoic material attached to liver; pancreas visible and prominent. Yellowing of mucous membranes and skin persists- O syringe feeding (up to 100mL, increasing to 125mL), urinating but no bowel movements yet- Some grooming and movement when medications wear off

Abnormal PE/Chem/CBC/UA Results: **5/26/2026 Presenting complaints: Yellow skin tinge, decreased appetite, weight loss, vomiting (clear/foamy with yellow tinge) Physical exam: Clinically jaundiced, dehydrated, tense cranial abdomen, severe muscle cachexia, low stance with posterior pelvic tilt. Large volume hard stool palpable, urinating/defecating outside litter box. Radiographs (2 views)M1 gastric distension; suspect ingesta appreciable in gastric lumen, focal area of mineralized material in right upper quadrant, suspect cholelithsؘ mild gas/fluid diffusely in SI; no FB or obstructive pattern. M2 fecal material in entirety of large intestine. No megacolon. Possible small mineralization in R kidney. Urinary bladder medium-sized Bloodwork:M1-2 elevations in liver enzymes as well as marked increase in total bilirubin

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is moderately 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 overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The left kidney measured 3.7 cm. The right kidney measured 3.4 cm.

Adrenal Glands

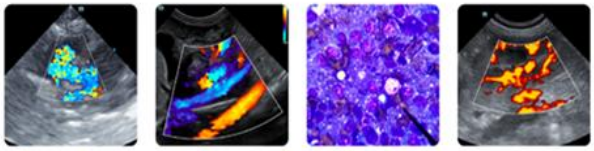
Adrenal glands are unable to be visualized in these images.

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). A well-demarcated hyperechoic homogenous nodule is noted. Splenic vasculature appears normal.

Liver

Multifocal intrahepatic biliary system /bile duct dilation is suspected. See other.



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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. Some mineral debris /cholelithiasis is noted within the gallbladder lumen, but I do not see evidence of mineral within the ducts, although it cannot be ruled out.

Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent. See other.

The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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

See other.

Free Abdomen/Other

Medial to the spleen is ~ 3 cm long by 1.1 cm dark hypoechoic density that is difficult to see much detail within, but I suspect is prominent left limb of the pancreas. In the mid to right cranial abdomen is a ~ 2.5 cm x 4.0 cm ill-defined mildly heterogeneous hypoechoic mass that could also represent pancreas, although it appears to in some views be caudal to the stomach. Although in some views it appears to originate from the liver, and in some views it has a bright echogenic center consistent with gas in gastrointestinal tract lumen and therefore could represent a bowel mass and /or all of the above.

ULTRASONOGRAPHIC FINDINGS

- The cranial abdominal mass is difficult to determine the origin of, but could represent proximal bowel, i.e. stomach or duodenum or even ileocecocolic junction, pancreas, or liver. Given the location of the mass, I suspect some degree of post-hepatic biliary obstruction from the mass is contributing to the tortuous dilated intrahepatic bile ducts. Having said that, there is mineral within the gallbladder and partial or full obstruction from cholelith cannot be ruled out. Similarly, chronic low-grade smoldering pancreatitis could be contributing.

Secondary

- Hyperechoic splenic nodule(s) – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.
- Age related kidney changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.
2. FNA of the cranial abdominal mass is recommended if patient's coagulation status is appropriate. Additionally, advanced imaging such as abdominal contrast CT scan is recommended to help further localize the pathology.
3. In the meantime, treatment recommendations include fluid therapy, anti-emetics,

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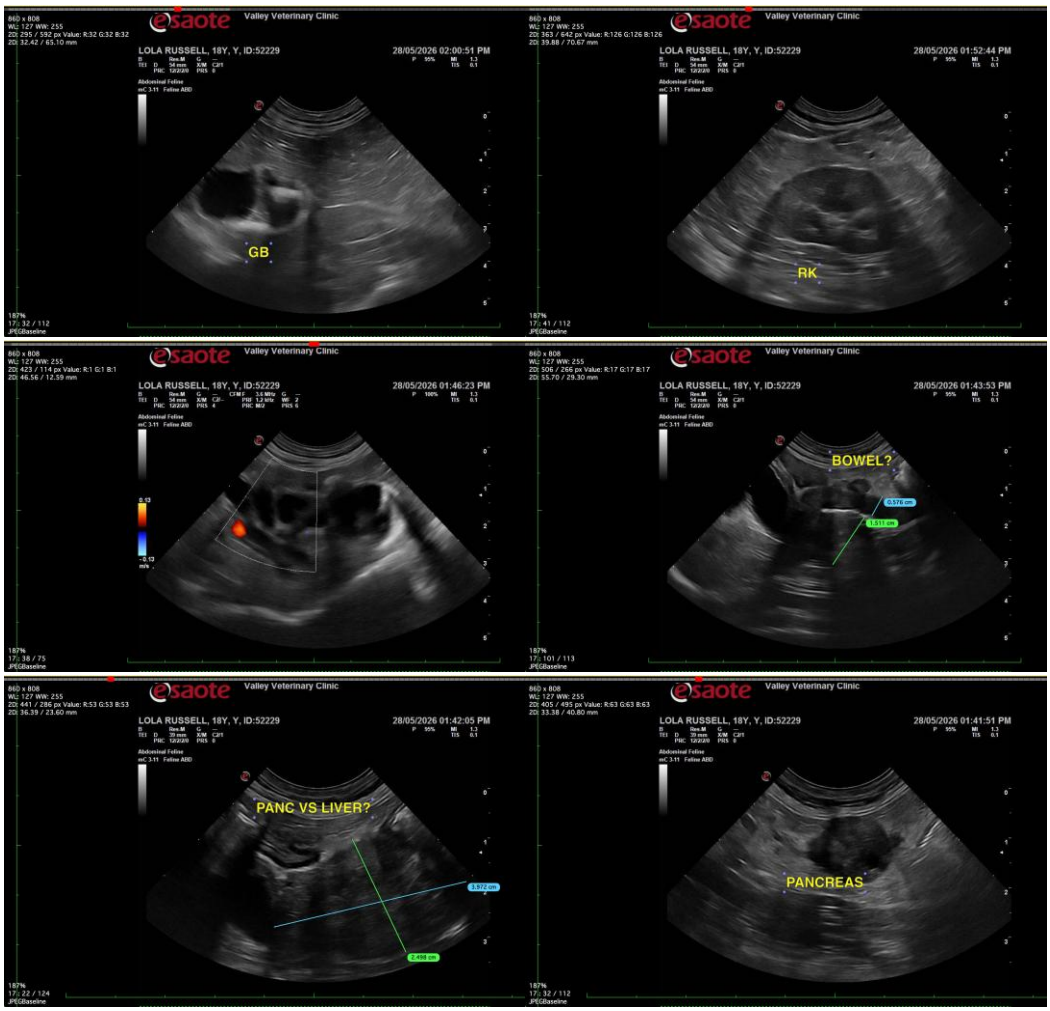
gastroprotectants, hepatic nutraceuticals such as ursodiol and/or Denamarin, and broad-spectrum antibiotics. Nutritional support is critical to prevent/manage concurrent hepatic lipidosis, so appetite stimulants and/or, if indicated, feeding tube placement is also recommended.



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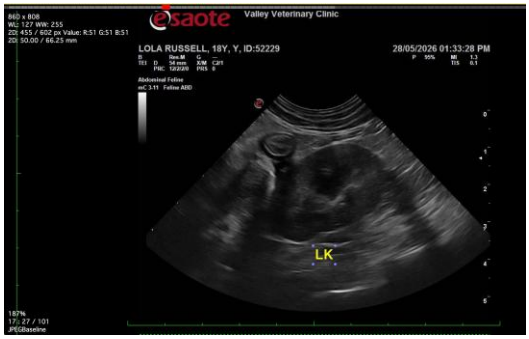

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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