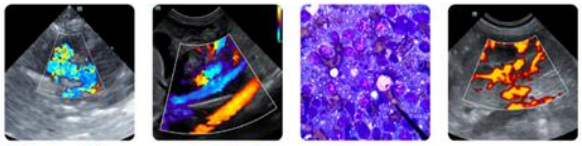


PATIENT

Ani Quinones

SPECIES

Feline

BREED

DMH

SEX

FS

AGE

3yr

WEIGHT

7.8lb

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Dr. Gabriel Ferrer

HOSPITAL NAME

Pulse Pet Ultrasound Services

REFERRING VET

Dr. Mario Roman

INVOICE

23886

DATE

02/13/2026

PRESENTING CLINICAL SIGNS

Px presented as a referral for an abdominal ultrasound to evaluate seizures, then during a visit to the rDVM he had elevated liver enzymes, Keppra (Keppra 100mg/mL: 1mL PO Q8) and Denamarin were started, but ALT has only continued to increase. The owner indicates that PX has had diarrhea for a week, and sometimes seems lethargic.

Abnormal PE/Chem/CBC/UA Results: Bloodwork attached below for your reference.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio. Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. The left kidney measured 3.37 cm in length. The right kidney measured 3.57 cm in length.

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. The left adrenal is 0.26 cm in thickness. The right adrenal is 0.22 cm in thickness.

Spleen

The spleen was normal with age appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

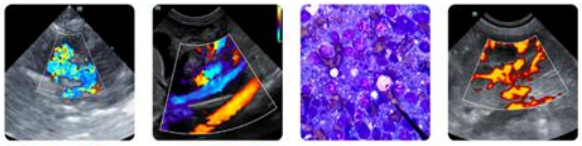
The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.



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The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The visible pancreas was observed to be largely isoechoic to surrounding omental fat.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

- Unremarkable abdomen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver parenchyma appears normal and there is no ultrasonographic explanation for the elevated liver enzymes in this patient. There is no significant disruption of architecture noted to suggest significant pathology. Low grade inflammatory hepatopathy/reactive hepatopathy is a likely cause of LE elevations. Seizure activity is a possible cause of acutely elevated ALT but does not cause persistently elevated ALT unless seizure activity is persistent. Fine needle aspirate is recommended to further characterize parenchymal changes and bile acid profile to assess liver function. Ultimately liver biopsy is often required for more definitive diagnosis. Empiric treatments (SAM-E, milk thistle, Vitamin E, ursodiol if bilirubin elevated or gall bladder sludge) could be tried and liver enzymes re-evaluated, especially if liver FNA does not show significant pathology before more invasive liver sampling is pursued.

There are no ultrasonographic abdominal abnormalities to explain seizure activity. If toxicity is unlikely, blood pressure is normal, cardiac disease is not suspected and thoracic radiographs do not show significant disease, MRI +/- CSF tap is indicated to further assess for intra-cranial disease. FIP and juvenile lymphoma are considerations in feline patients. Fungal and other infectious disease testing may be considered if regionally appropriate. Hypoadrenocorticism is rare in cats, but adrenal gland function testing could be considered to rule this out.

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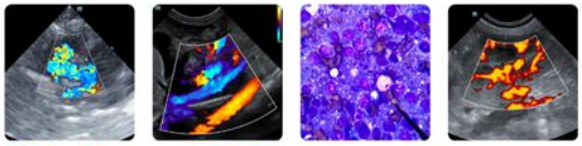

Clinical Sonography & Telecytology
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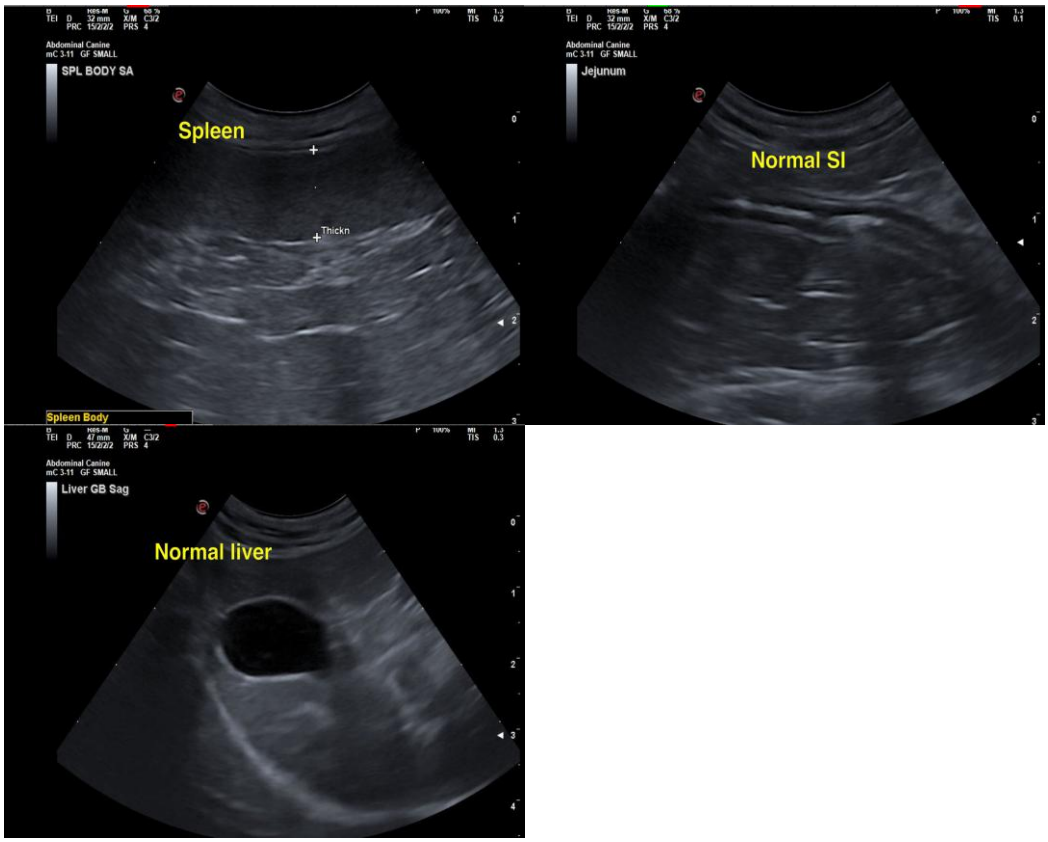

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com