



PATIENT

Monty Howlett

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

8 Years

WEIGHT

5 kg

INTERPRETED BY

Dr Brittany Sinclair,
 BVSc(hons),
 DACVECC

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Buck Animal Hospital

REFERRING VET

Dr. Sommers

INVOICE

73985

DATE

3/25/26

PRESENTING CLINICAL SIGNS

Not eating. Current Medications: Flovent

Abnormal PE/Chem/CBC/UA Results: ALT 249, GGT 11, CHOL 7.2 (From Jan 2026) Radiographic Findings NA Primary Question to Be Answered in This Exam reason for not eating

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. Mobile debris present in the urinary bladder. 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. Left kidney measures 3.95 cm. Right kidney measures 4.21 cm.

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. Left measures 0.29 cm in thickness. Right measures 0.20 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 enlarged with rounded borders and diffusely hyperechoic parenchyma. There are no specific masses or nodules seen.

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.

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.



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Pancreas

The area of the pancreas was isoechoic to surrounding tissue with no overt inflammation. Pancreatic tissue was not distinctly visualized which is common.

Free Abdomen

No clinically significant lymphadenopathy or abnormalities noted. No free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Hyperechoic hepatomegaly.

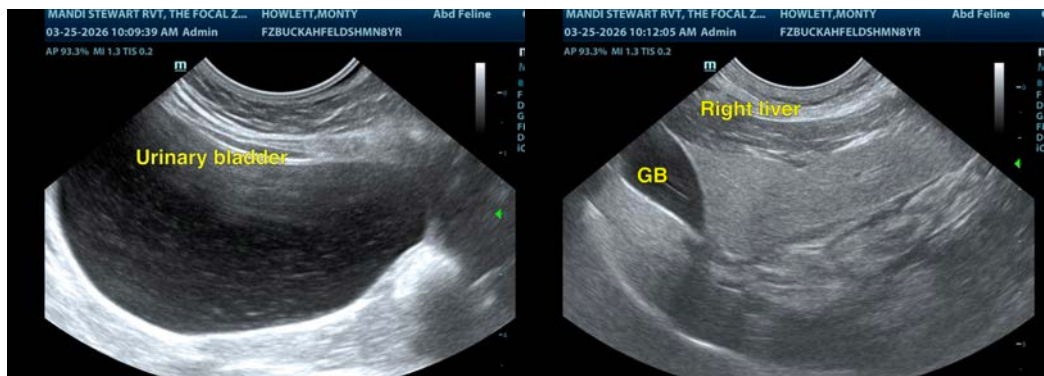
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Hepatic parenchymal changes are a common finding in the face of endocrinopathies, infectious or inflammatory hepatitis (bacterial, viral, auto-immune other), hepatic lipidosis and neoplasia among other things. As elevated liver enzymes are present, fine needle aspirate is recommended to further define. Ultimately liver biopsy may be required for more definitive diagnosis.

Hepatic lipidosis is a possibility in this case. This can be superimposed over other disease, both hepatic and non-hepatic and this suspicion does not obviate the recommendation for liver FNA.

Treatment is supportive and involves fluid support, analgesia, and GI support as needed. Early intervention to provide enteral nutrition is imperative to recovery and placement of a semi-permanent feeding tube such as an esophagostomy tube is often required. These have the benefits of allowing medication and water administration as well and after recovery from the quick anesthesia to place, patients can often be managed at home.

To reverse the disease process and allow liver healing the patient must be taking in full RER to stop the breakdown of fats and prevent further lipid deposition in the liver. This often cannot be achieved with syringe feeding or liquid feeding through an NG tube. The disease can progress quickly leading to development of coagulopathy, hepatic encephalopathy, and liver failure. The patient becomes a worse anesthetic candidate the further liver dysfunction progresses. Hepatic encephalopathy can develop post anesthesia for E-tube placement in some patients, but often resolves in 24-48 hours with supportive care.





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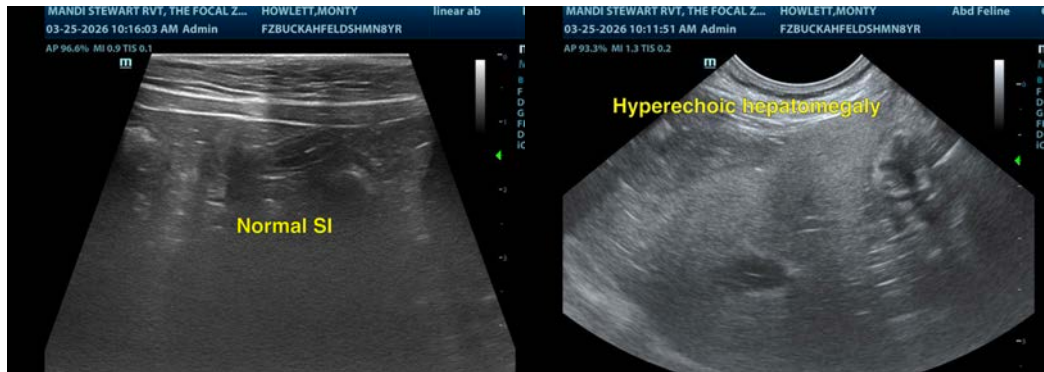
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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