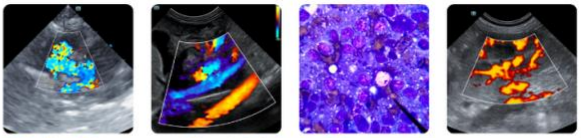

PATIENT

Tom Carrillo

SPECIES

Feline

BREED

DSH

SEX

Male

AGE

4 Years 6 Months

WEIGHT

11.3 Pounds

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Chloe Lowe, CVT

HOSPITAL NAME

Budd Lake AH

REFERRING VET

Dr. Horn

INVOICE

36456

DATE

3/31/26

PRESENTING CLINICAL SIGNS

- Inappetence
- Progressive weight loss over 5 pounds since July
- Vomiting initially and now stopped
- Jaundice
- Mirtaz, metro, or ax, I/D
- Initially Cerenia, fluids, b12
- Abnormal PE/Chem/CBC/UA Results: Alt 245, AST 118, Alkphos 477, Bili+ 9.9, chip 50, lymph 0.19 Felt/fiv negative

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 4.05 cm in length. The right kidney measured 3.66 cm in length. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis bilaterally. The right kidney is visualized and measured at a slightly oblique angle, which likely underestimates its true 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 gland measured 0.32 cm in thickness. The right adrenal gland measured 0.40 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 significantly enlarged in size and diffusely hypoechoic. The margins are rounded. There are no specific nodules or masses seen.

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

Gastrointestinal

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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.

The ileocecal junction was not visualized. 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 mesentery surrounding the pancreas is significantly hyperechoic. Visible portions of pancreas are prominent.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

- Hyperechoic hepatomegaly – consistent with hepatic lipidosis versus infiltrative disease
- Peripancreatic inflammation

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 suspected 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. Peripancreatic inflammation is likely secondary to hepatitis, though primary pancreatitis cannot be completely ruled out.

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

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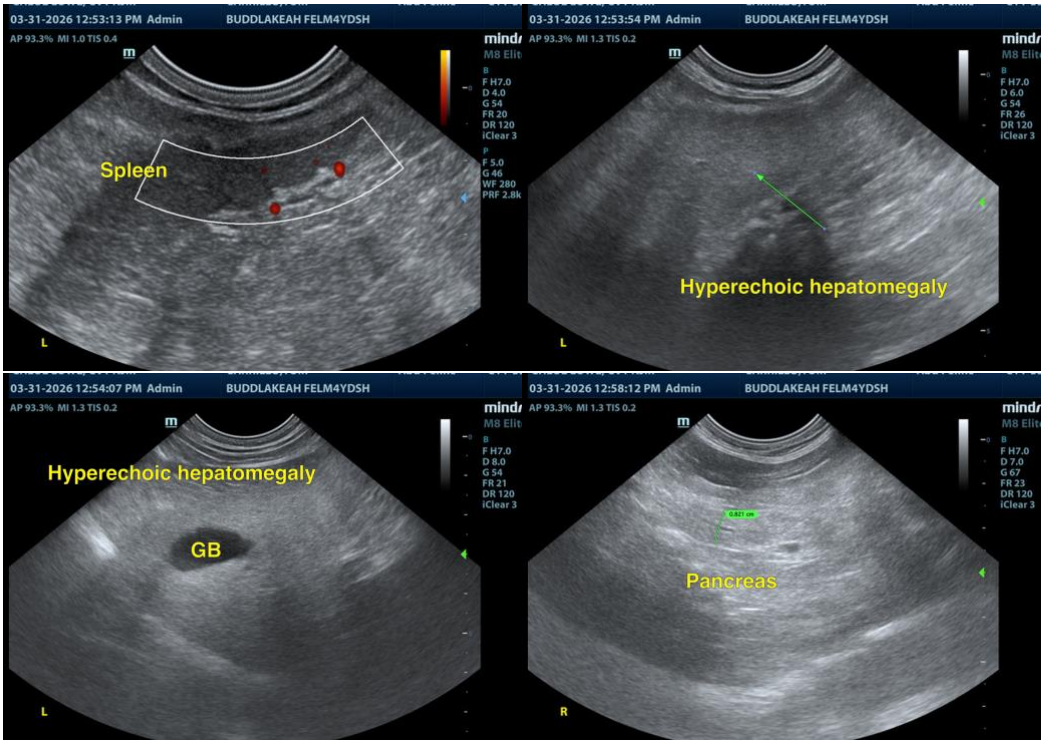
anesthetic candidate the further liver dysfunction progresses. Hepatic encephalopathy can develop post anesthesia for E-tube placement in some patients but often resolves in 24-48 hours with supportive care.



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