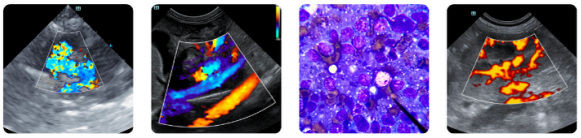

PATIENT

Dobby Pelletier

SPECIES

Feline

BREED

DLH

SEX

FS

AGE

15 years

WEIGHT

6.4 lbs

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Meghan Morse, LVT, CVT

HOSPITAL NAME

Middlehope Veterinary Hospital

REFERRING VET

Dr. Rich

INVOICE

11810

DATE

4//29/2026

PRESENTING CLINICAL SIGNS

Elevated bilirubin and liver enzymes, tense on abdominal palpation, decreased appetite and v+ for 3-4 days, icteric.

Current meds: Methimazole 2.5mg BID.

Abnormal PE/Chem/CBC/UA Results: Creat 2.3, BUN 47, TP 9.2, Glob 6.0, ALP 383, GGT 16, T bili 11.8.

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 left kidney is irregular with nearly complete loss of corticomedullary definition. Left kidney measures 3.13 cm in length.

The right kidney is severely atrophied with minimal normal structure. The right kidney measures 2.08 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.

Left adrenal measures 0.29 cm in thickness, and the right adrenal measures 0.47 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 anechoic bile. Common bile duct is mildly distended to the level of the duodenal papillae measuring approximately 0.22 cm, just prior to the duodenal papillae. There is thickening at the papillae but no discrete mass.

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.

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 pancreas is significantly enlarged and heterogenous with surrounding hyperechoic mesentery. There is a heterogenous nodule noted in the right limb of the pancreas.

ULTRASONOGRAPHIC FINDINGS

- Mild gallbladder distension with mild common bile duct distension to the level of the duodenal papillae.
- Pancreatitis.
- Significant degenerative changes to the left kidney, with right renal atrophy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Pancreatic changes are consistent with severe pancreatitis. The mild common bile duct distension and gallbladder distension together with hyperbilirubinemia is most consistent with at least partial post hepatic biliary duct obstruction secondary to pancreatic inflammation. The mild thickening at the duodenal papillae may represent an early mass but I suspect this is more likely to represent an inflammatory response of the tissue. The prognosis of acute pancreatitis is largely dependent on the severity of clinical signs and response to treatment. Mortality is reported as high as 25% and secondary organ dysfunction and systemic inflammatory response syndrome can occur as inflammation progresses. Ultrasonographically, pancreatic inflammation is severe in this patient. Ultimately the need for hospitalization for treatment is based on the patient's cardiovascular stability, pain and appetite. Hydration and enteral nutrition are key factors in positive outcomes and if these cannot be achieved on an outpatient basis, hospitalization for 24-hour care is strongly recommended.

Treatment for pancreatitis is entirely supportive and involves fluid support, GI support - anti-nausea (ondansetron, cerenia 2mg/kg PO SID), appetite stimulation (mirtazapine, elura), analgesia (buprenorphine, gabapentin) and enteral nutrition as needed (syringe feeding, NG tube placement, etc). Antibiotics are generally not warranted for acute pancreatitis as it is usually sterile, however given the severity of inflammation and presence of elevated liver values, I would use antibiotics (ex unasyn +/- fluoroquinolone) in this case. Intravenous antibiotics are preferred to ensure absorption and decrease GI side effects of oral antibiotics which can lower appetite compromising treatment and recovery. Anti-inflammatory steroids may be tried in an attempt to reduce inflammation if traditional supportive care is inadequate. Serial imaging is indicated to monitor response to treatment.

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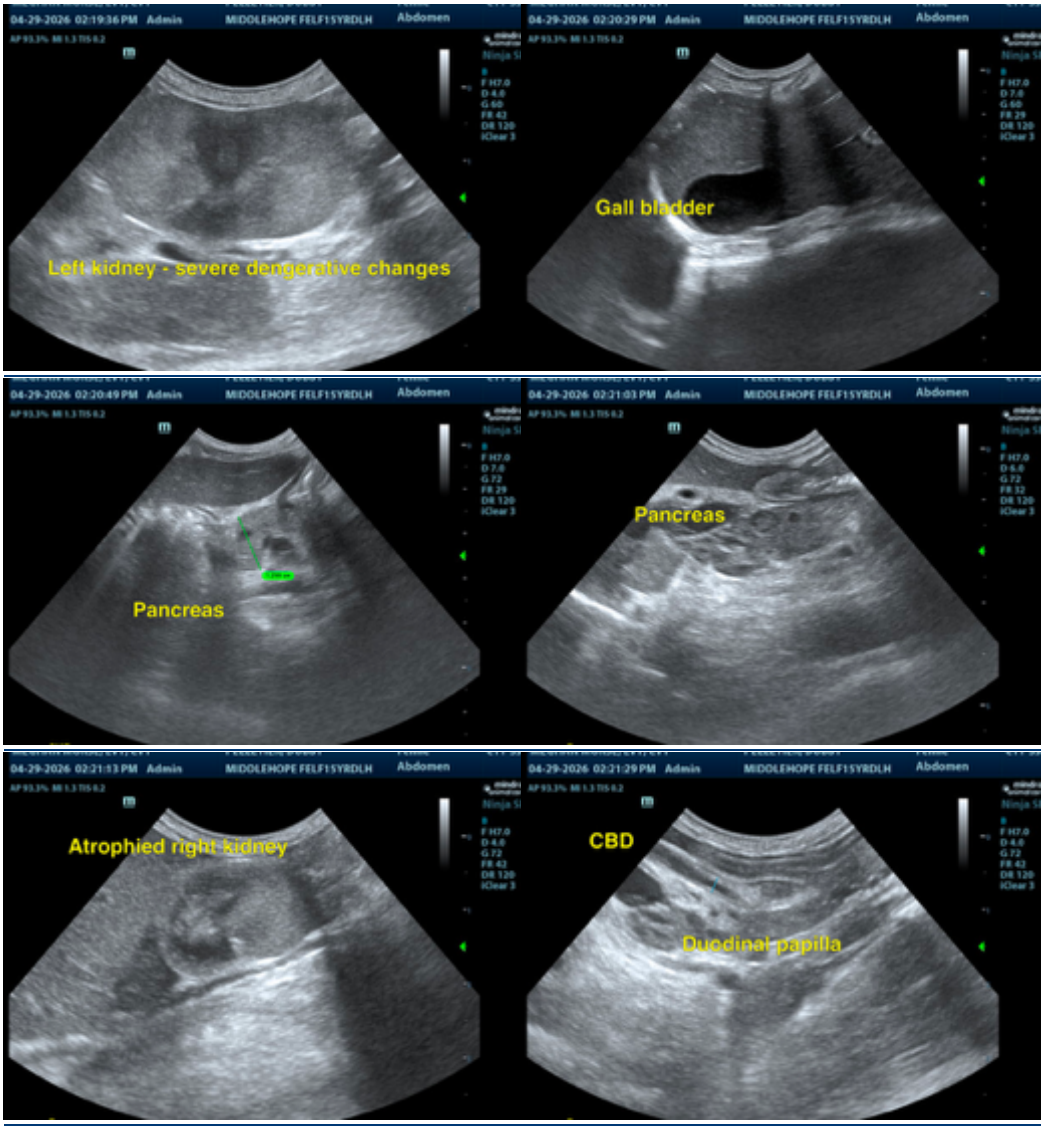
Renal changes are likely age-related degeneration. The right renal atrophy is likely a chronic change. Correlate ongoing clinical significance of kidney changes with serial bloodwork and urinalysis monitoring.



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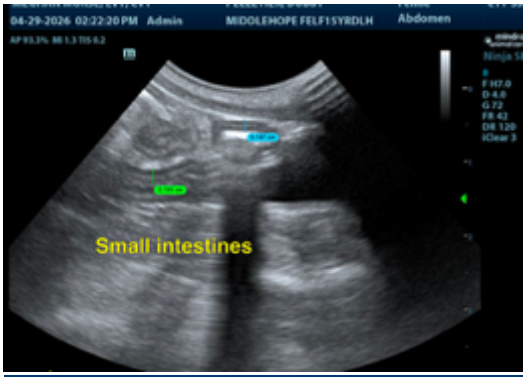

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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