



PATIENT

Gooby Cumming

SPECIES

Feline

BREED

Persian

SEX

Neutered Male

AGE

3 Years

WEIGHT

5.6 kg

INTERPRETED BY

Dr Brittany Sinclair,
 BVSc(hons), DACVECC

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Beatties PH Stoney
 Creek

REFERRING VET

Dr. Manwa

INVOICE

14943

DATE

04/08/26

PRESENTING CLINICAL SIGNS

HX of anorexic for 24hr, with vomiting and diarrhea off and on, lethargic. Pyrexia. Known heart murmur (grade 3/6 on presentation). Normal ProBNP in 2024

Current Medications: maropitant, ampicillin, metronidazole, famotidine, methadone, Zentonil advanced

Abnormal PE/Chem/CBC/UA Results: BW - m2 elevated: WBCs 18.3, ALT 600, TBil 33, Pancreatic Lipase 10.3, m1 decreased urea, phos, K UA - bilirubinuria Radiographic Findings - cholelithiasis - hepatomegaly - generalized splenomegaly - equivocal cardiomegaly

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 4.11 cm in length. The right kidney measured 4.35 cm in length.

Adrenal Glands

Adrenal glands are visualized and measured on still images only. Resolution is inadequate to assess glandular detail or confirm measurement. The left adrenal gland measured 0.35 cm in thickness. The right adrenal gland measured 0.31 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.

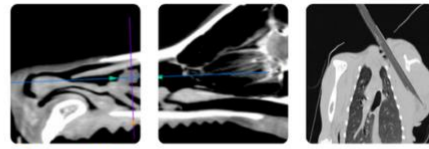
Liver

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. There is mineral opacity visible throughout the intrahepatic biliary tract consistent with intrahepatic biliary mineralization.

The gallbladder is distended with anechoic bile with multiple hyperechoic shadowing objects consistent with small choleoliths visible within the lumen. The common bile duct and duodenal papilla are not distinctly visualized.

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.



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The visualized areas of 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 gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is not distinctly visualized.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

- Intrahepatic biliary mineralization.
- Choleliths visible in gallbladder lumen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The presence of choleliths is the likely explanation of reported liver value elevations. Their presence can cause inflammation and may cause subclinical or clinical cholangitis which can cause elevations in liver values. GI signs of inappetence or vomiting may be seen as their presence can cause intermittent abdominal pain and nausea. Their presence may act as a nidus of infection and predispose to cholangiohepatitis. They have the potential to move into the common bile duct causing obstructive cholangitis.

The visible intrahepatic biliary mineralization and concurrent gall bladder distension and choleliths visible within the gallbladder are concerning for biliary tract obstruction. A definitive obstruction is not visualized. The common bile duct and duodenal papilla are not visualized. Abdominal CT may be of use to better visualize this area.

Emergency abdominal exploratory surgery could be considered to further investigate. This may be both diagnostic and curative. Biliary surgery is not without significant perioperative morbidity and mortality and consultation with a veterinary surgeon is recommended. 24-hour post-op monitoring is recommended until clinically stable. The risk of postponing surgery includes gall bladder rupture and subsequent bile peritonitis, which is commonly fatal.

Medical therapy is an alternative option if surgery is not desired. Therapy includes fluid therapy as needed, GI support, pain control, antibiotic therapy and liver supportive medications (N-acetylcysteine, SAM-E, milk thistle, Vitamin E). Empiric antibiotic therapy is not unreasonable and antibiotics that are effective against gram-negative, aerobic, enteric bacteria and excreted into the bile are recommended. Amoxicillin, amoxicillin-clavulanic acid, cephalosporins, and fluoroquinolones are suggested first choices. Metronidazole (7.5 mg/kg PO, IV q 12 hrs) may be added for extra anaerobe coverage. Serial monitoring of vital signs, fluid balance, electrolytes and liver values including bilirubin and imaging is recommended.



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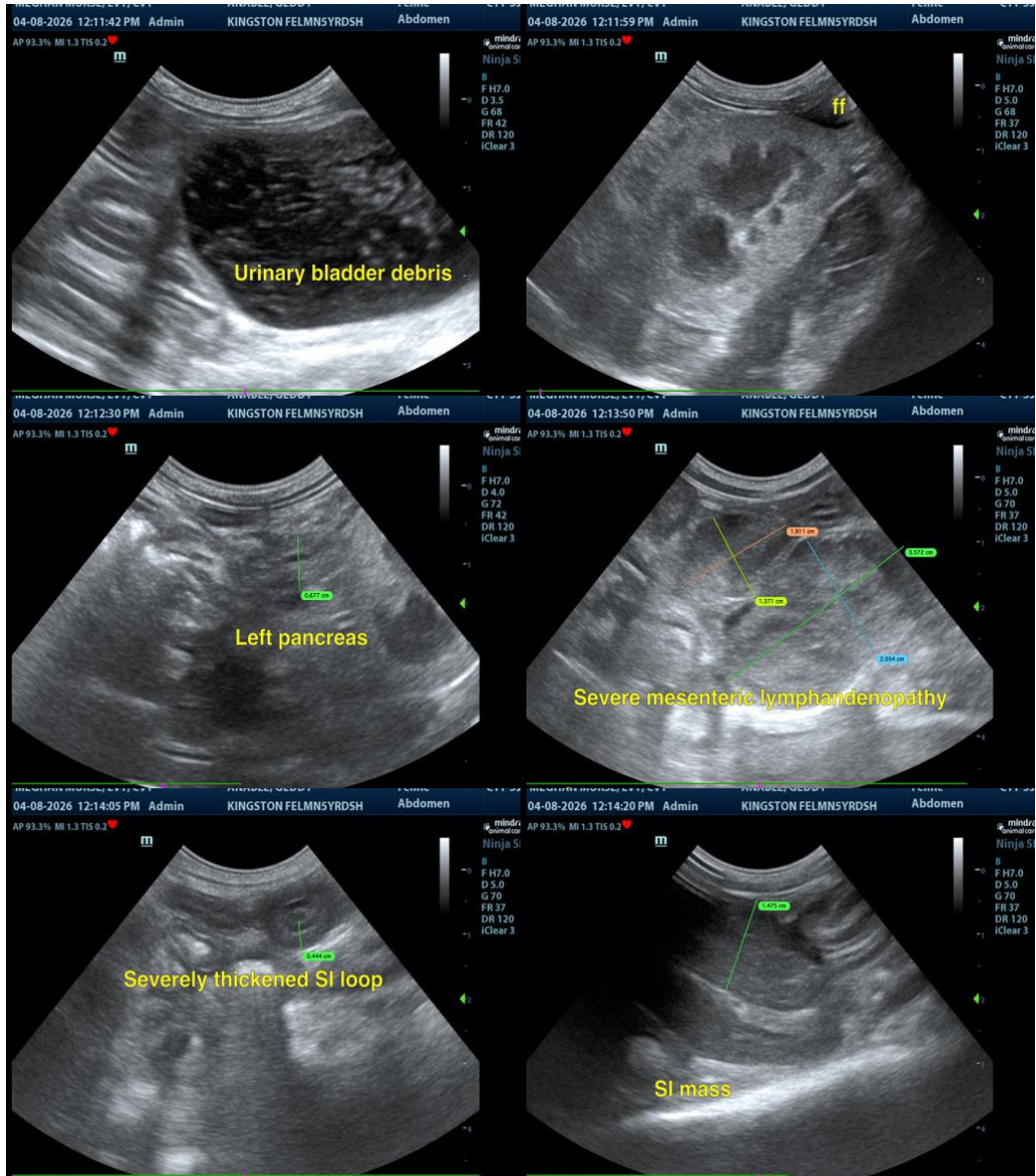
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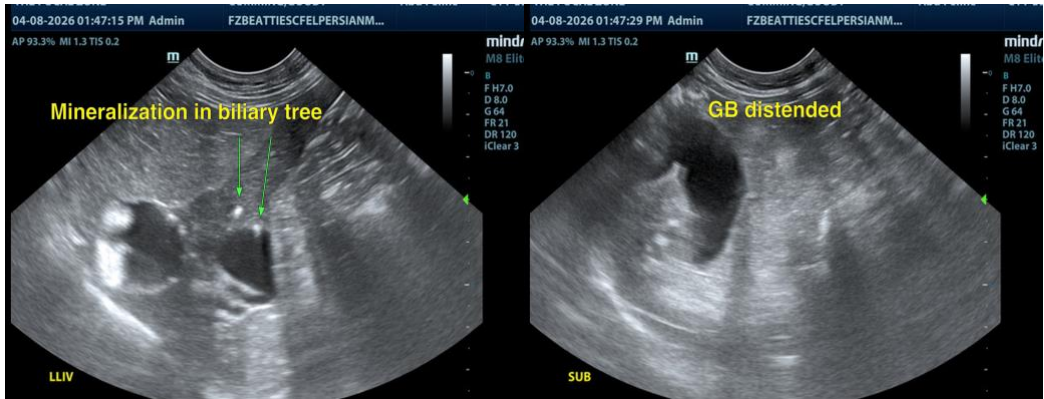
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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