



PATIENT

Sammy Kramer

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 Years 5 Months

WEIGHT

8.6 lbs

INTERPRETED BY

Dr Brittany Sinclair,
BVSc(hons),
DACVECC

IMAGING PERFORMED BY

Chloe Lowe, CVT

HOSPITAL NAME

VCA Blairstown Animal
Hospital

REFERRING VET

Dr. Summers

INVOICE

75727

DATE

6/5/26

PRESENTING CLINICAL SIGNS

Vomiting, not eating, chronic increased liver values.
Abnormal PE/Chem/CBC/UA Results: Ast 189, Alt 578, Alp 186, bili. 0.8, Wbc 22,500 , T4 2.3

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 has a smooth capsule and with mild hazing of corticomedullary definition. No evidence of pelvic dilation was present. Left kidney measures 3.5 cm.

The right kidney has a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis. No evidence of pelvic dilation was present. Right kidney measures 4.14 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 0.33 cm in thickness. Right measures 0.50 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 mildly enlarged with slightly rounded borders. The parenchyma is diffusely coarse and heterogeneous with no specific masses or nodules seen.

The gallbladder is moderately distended with a significantly thickened and hyperechoic gallbladder wall. Cystic and common bile ducts are tortuous and distended to the level of the duodenal papilla. There is mild thickening at the duodenal papilla consistent with inflammation, with no masses or definitive choleliths seen.

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.

Visible small intestinal loops are thickened, with hazy wall layering. Some loops have a hyperechoic mucosal layer. No specific masses are seen. Multiple fluid loop shave mild fluid distention.

Sections of colon are visualized with gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.



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Pancreas

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

Free Abdomen

A couple mesenteric lymph nodes are prominent, with normal length to width ratio.

No free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Cholangiohepatitis.
- Thickened small intestines with hazy wall layering, likely enteritis versus infiltrative disease.
- Mild mesenteric lymphadenopathy.
- Mild aging renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Liver parenchymal changes along with gall bladder wall thickening and concurrent ELE is most consistent with cholangiohepatitis. Acute toxic insult, infectious or inflammatory hepatitis (leptospirosis, other bacterial, viral, auto-immune other), and neoplasia among other things remain possibilities.

Liver FNA to further characterize parenchymal disease is indicated. Cholangiohepatitis may be sterile or infectious. Cholecystocentesis for cytology and culture should be considered. There is a low but present risk of causing bile peritonitis with this procedure. 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. Consider treatment with liver supportive medications (SAM-E, milk thistle, Vitamin E, ursodiol) and GI support as needed.

GI changes together with signs of cholangiohepatitis are most likely related to a secondary enteritis. Infiltrative disease cannot be completely ruled out. GI biopsy would be necessary to further differentiate. Empiric treatment for gastroenteritis includes maintenance of hydration with fluid support and GI support as needed (anti-nausea, appetite stimulant, analgesics if indicated). If initial treatments are unsuccessful, treatment for IBD could be considered which includes diet trial with either hydrolyzed or select protein diet, vitamin b-12 supplementation, and continued GI support as needed. Treatment with steroids (budesonide vs prednisolone) may be required – biopsies should be acquired prior to treatment with steroids.



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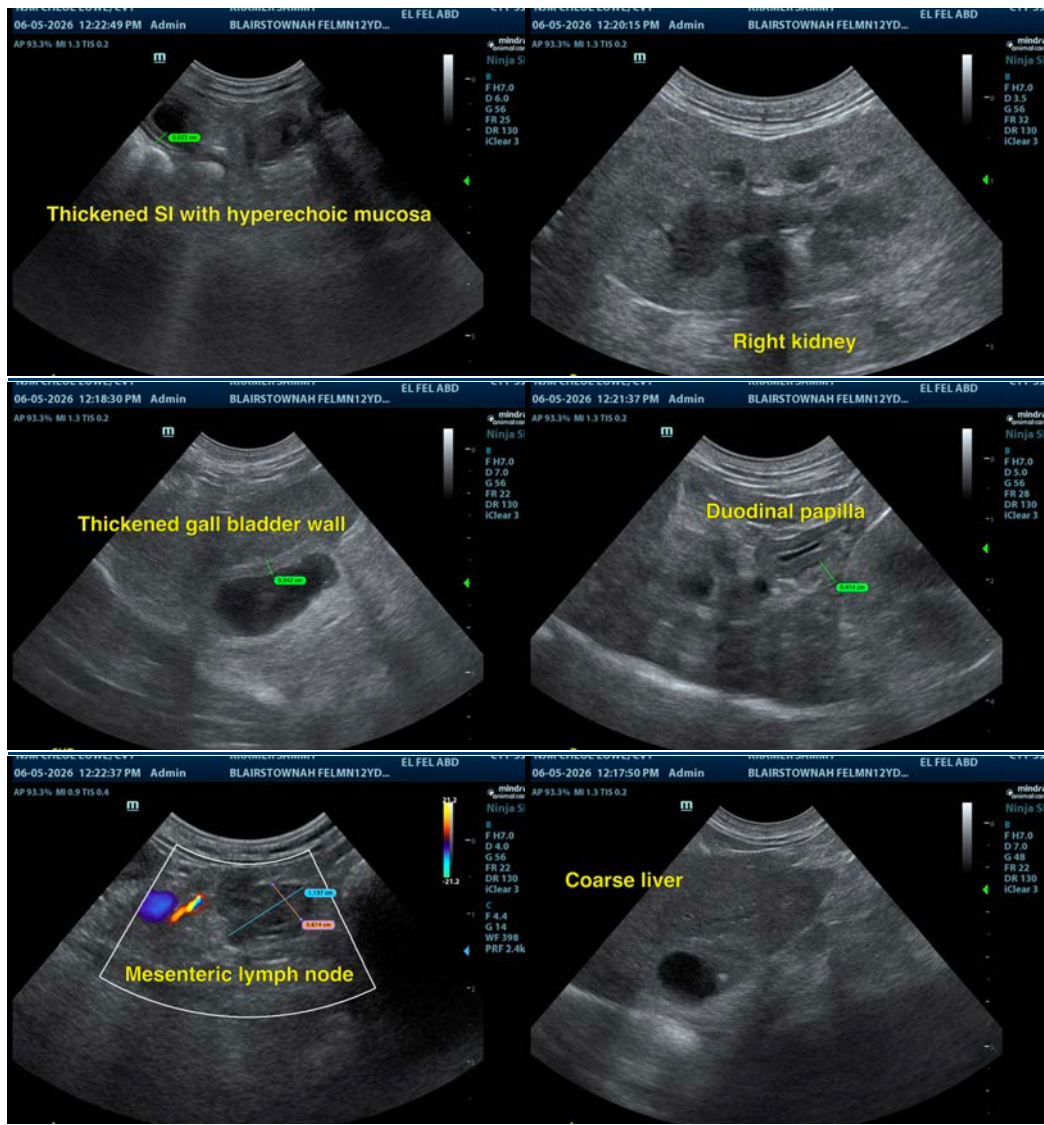
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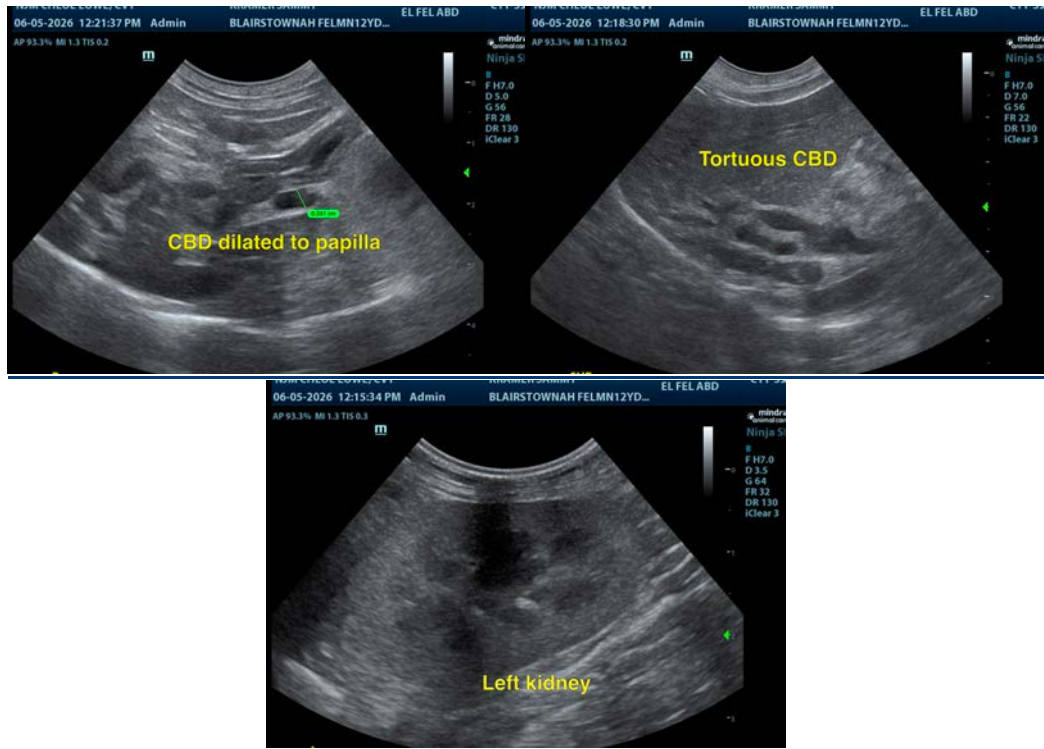
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
 info@SonoPath.com