



## PATIENT

Chiana Neiderer

## SPECIES

Feline

## BREED

Nor. Forest Cat

## SEX

Spayed Female

## AGE

11 Years

## WEIGHT

13 Pounds

## INTERPRETED BY

Eric Lindquist, DMV

DABVP, Cert. IVUSS

## IMAGING PERFORMED BY

Dr. Maggiulli

## HOSPITAL NAME

Willamette VH

## REFERRING VET

Dr. Maggiulli

## INVOICE

37468

## DATE

5/6/22

## PRESENTING CLINICAL SIGNS

24-36 hrs of lethargy, social disconnection, 24 hrs of anorexia. PE = icteric sclera, pinna  
Abnormal PE/Chem/CBC/UA Results: Chem = ALT (with 1:3 dilution) 2679, ALKP 281, CHOL 331, GGT 11, GLU 238, TBIL 6.3, TP 9.9, GLOB 6.6. CBC unremarkable

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal.

The **left kidney** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 3.0 cm.

The **right kidney** presented a pericapsular inflammatory pattern. It was normal in size and contour. The right kidney measured 3.0 cm.

### Adrenal Glands

The regions of the **adrenal glands** were unremarkable.

### Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

### Liver

The **liver** presented coarse architecture and increased portal markings. Gallbladder calculi noted. The gallbladder was otherwise empty. Non-specific cholangitis/cholangiohepatitis pattern. The common bile duct was thickened, yet normal width.

### Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

### Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxyphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.



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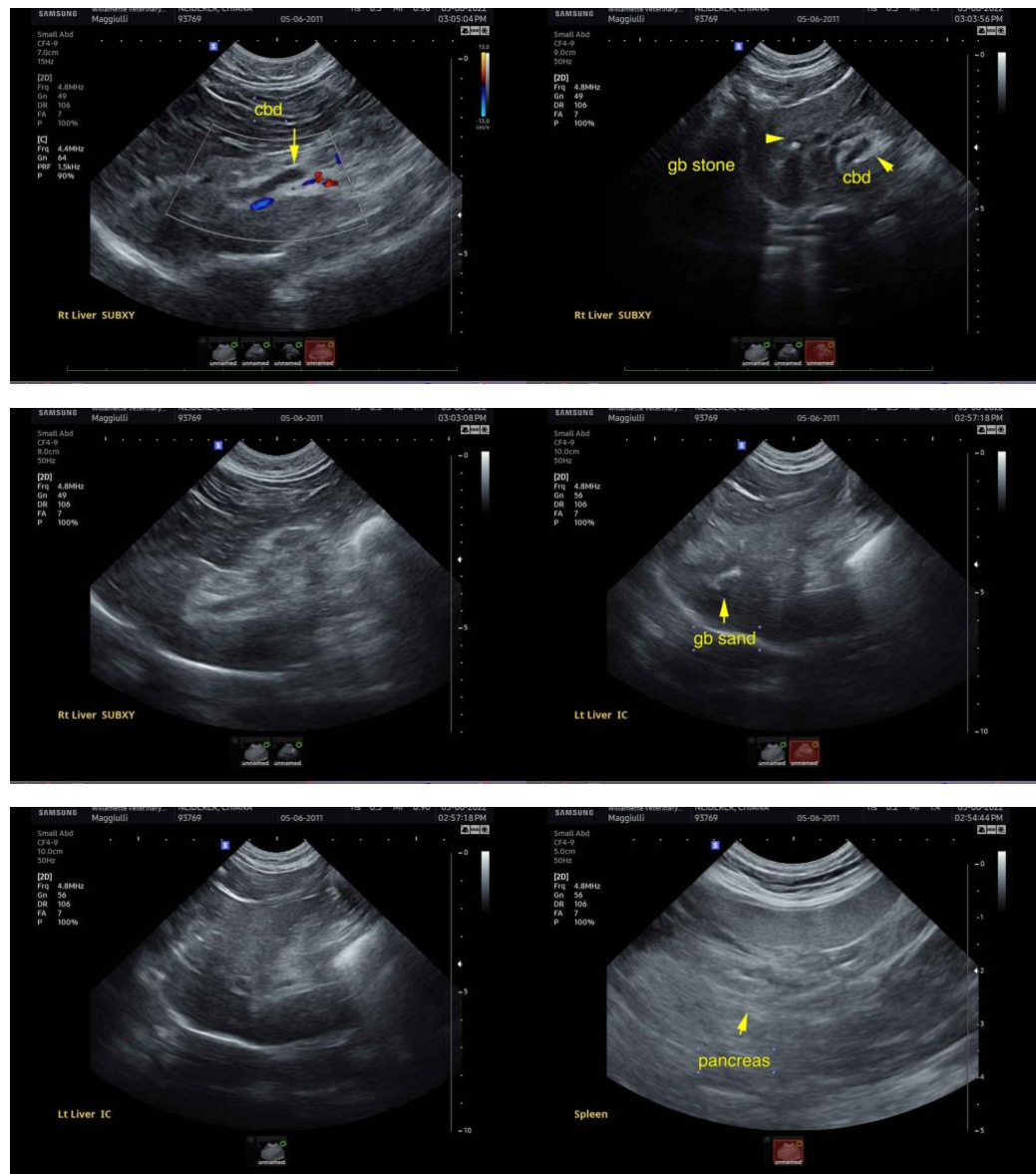
5/6/22

**ULTRASONOGRAPHIC FINDINGS**

- Chronic cholangitis pattern with biliary calculi, non-obstructive
- Possible concurrent nephritis

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Urinalysis indicated to assess for inflammatory sediment that would support potential nephritis. Liver biopsy would be ideal, or FNA to assess inflammatory cell type. Infectious agents such as toxoplasmosis and bartonella should be considered. No suspicion of neoplasia. A clinical trial of Enrofloxacin/Clindamycin combination with Ursodiol over a 6 week period warranted as well as liver oriented diet and nutraceuticals to be utilized empirically. However, given the degree of cholangiohepatitis and level of liver enzyme elevations, sampling is essential after coagulation panel.





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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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com

[info@SonoPath.com](mailto:info@SonoPath.com)