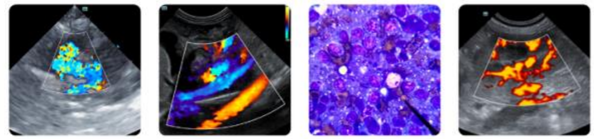

PATIENT

Simba Simpson

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

14 Years

WEIGHT

3.68

INTERPRETED BY

Karen Ebersole, DVM, DABVP (Canine and Feline practice)

IMAGING PERFORMED BY

Dr. Kuzimski

HOSPITAL NAME

AEH Deland

REFERRING VET

Dr. Kuzimski

INVOICE

36774

DATE

12/7/25

PRESENTING CLINICAL SIGNS

History: presents for not eating and possible constipation
Abnormal PE/Chem/CBC/UA Results: CBC - WBC 50.11, NEU 46.65, LYM 0.55, MON 2.86, EOS 0.00, HCT 23.6, HGB 8.2, RBC 5.37 Chemistry - BUN 10.4, CRE 0.5, Ca 8.1, GLU 193, TCHO 327, ALT 829, ALP 340, TBIL 4.5 EPOC - BE -8.7, Na+ 140, BUN 9, Glu 186, Hct 23.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder was normal in size and shape. The bladder wall was normal in thickness for the volume of urine present. The bladder contents were anechoic with echogenic sediment, without visible discrete urolith formation. There was no visible inflammation in the bladder or urethra.

Both kidneys were normal in size with a mildly irregular capsule contour. There was a mild to moderate increase in cortical echogenicity. The corticomedullary junction was mildly indistinct. There was no pelvic dilation. The left kidney measured 4.7 cm in length. The right kidney measured 4.5 cm in length.

Adrenal Glands

The adrenal glands were not clearly visualized. The region of the adrenals appeared free of overt pathology.

Spleen

The spleen was normal in size and shape, with a smooth capsule contour. The parenchyma was finely textured and homogeneous. There were no visible masses, nodules or evidence of infiltrative disease. The vasculature showed good vascularity with power doppler.

Liver/Gallbladder

The liver was mildly increased in size with a rounded capsule contour. The parenchyma is diffusely heterogenous with increased portal markings. There are no distinct overt nodules or masses within the liver. The hepatic vasculature appears normal in volume and structure.

The gallbladder is markedly dilated and rounded, measuring approximately 8.0 cm x 6.0 cm. There is a moderate amount of echogenic and mineralized sludge within the gallbladder lumen. There is adjacent free fluid to the cystic duct and common bile duct. The cystic duct is markedly dilated and tortuous. The distal common bile duct measures 0.75 cm in width. The duodenal papilla could not be clearly visualized, partly due to machine resolution.

Gastrointestinal

The stomach was distended with fluid. The stomach wall was diffusely thickened within the body of the stomach with a possible loss of wall layering. The stomach wall measured 0.97 cm. The wall layering in the stomach could not be discerned, possibly due to machine resolution. The small intestine displayed normal curvilinear patterns throughout. Subjectively normal wall thickness and layering was maintained. The visible colon wall was normal in thickness and layering. There were no visible masses or focal lesions in the GI tract.

Pancreas

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The pancreas was mildly to moderately enlarged in size. The capsule contour was mildly asymmetric and irregular. The parenchyma was hypoechoic to heterogeneous with mildly bright mesentery around it. There was no overt evidence of neoplasia.

Free Abdomen

Focal, mildly prominent to enlarged mesenteric nodes were present. The lymph nodes were largely isoechoic to adjacent fat with no evidence of peripheral inflammation. There was a normal width: length ratio (<0.5).

A moderate volume, cellular peritoneal effusion was present. The mesentery was hyperechoic and irregular with a diffuse nodular pattern.

ULTRASONOGRAPHIC FINDINGS

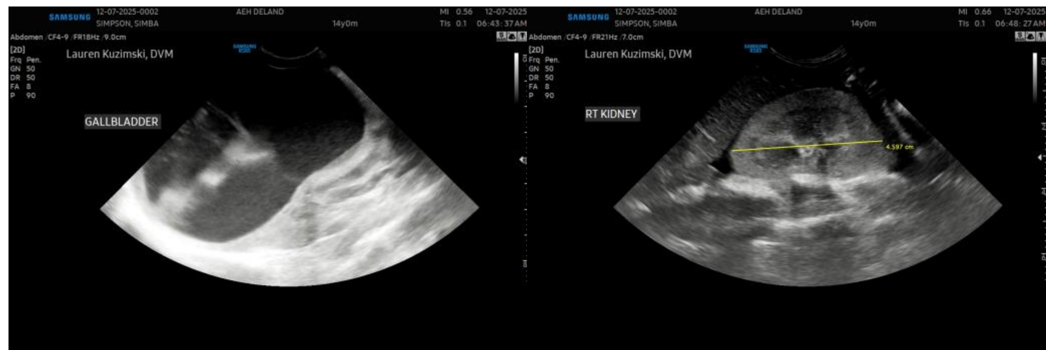
- Markedly distended GB, cystic duct and CBD with adjacent inflammation and free fluid - suspect EHBDO
- Stomach wall thickening - ddx severe gastritis vs potential for emerging neoplasia
- Peritoneal effusion - moderate volume
- Hepatomegaly with diffusely heterogeneous parenchyma
- Pancreatitis, low-grade, suspect chronic

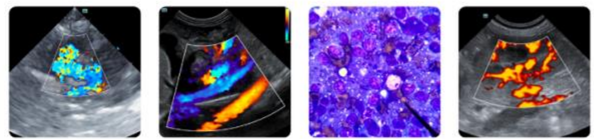
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I suspect there is an EHDBO causing the markedly elevated bilirubin levels. There is likely hepatic dysfunction as well. Sampling of the peritoneal effusion could be considered for fluid analysis and cytospin/cytology. Bile peritonitis is possible.

Aggressive supportive care is indicated. A feeding tube may need to be placed if the patient is unable to begin eating within 24-48 hours.

Prognosis is currently guarded. Referral for CT and surgical intervention may be needed.





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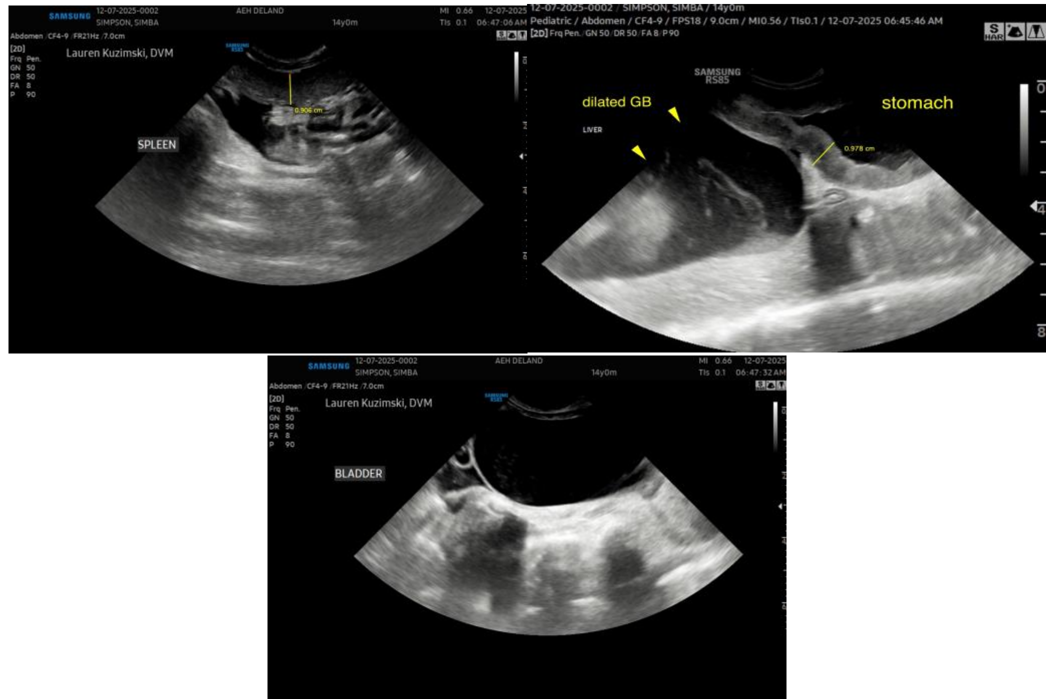

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Karen Ebersole, DVM, DABVP (Canine and Feline practice)

info@SonoPath.com