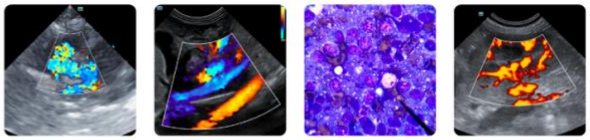


PATIENT

Gulliver Williams

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

14

WEIGHT

4.54 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Bennett

HOSPITAL NAME

Wilvet South

REFERRING VET

Dr. Bennett

INVOICE

35845

DATE

2/15/26

PRESENTING CLINICAL SIGNS

- History for abd US:
- Presented to rDVM on 2/11/26 for several days inappetence. Ate a bird about a week ago.
- Blood work showed elevated liver enzymes, hyperbilirubinemia, hyperthyroidism, and proteinuria. Rx methimazole and denamarin. Has received a few doses of oral methimazole but difficult to give oral meds, so planning to start transdermal next week. Has not started Denamarin. No improvement in appetite after mirtazapine.
- Abnormal exam findings: Icteric, thin BCS. Fleas.
- Abnormal PE/Chem/CBC/UA Results: 2/11/26 at rDVM: CBC: Hct 41.1%, Mono 0.48k (H), rest NSF. Chem: ALT 648 (H), ALKP 360 (H), GGT 10 (H), TBIL 9.6 (H), Crea 1.1, rest NSF. TT4: 8.3 (H) UA: USG 1.029, pH 6.0, Bil 2 +, rest NSF. UPC 0.6 (H) 2/14/26 ALT 710 (H) PT 19 sec (WNL) EPOC: HCO3 27.1 (H), K 3.2 (L), Hct 27% (L), rest NSF.

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. The cortex was diffusely hyperechoic. There was hypertrophy of the cortex, resulting in an altered corticomedullary ratio. There was a mild loss of corticomedullary distinction. The left kidney measured 4.6 cm in length. The right kidney measured 4.6 cm in length.

The iliac trifurcation was visualized and evaluated. There was normal vascular perfusion with no evidence of thrombus formation. There was no visible lymphadenopathy.

Adrenal Glands

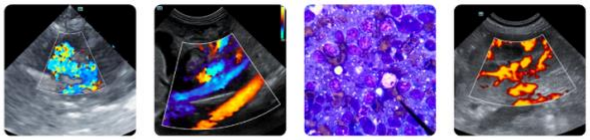
The adrenal glands were not clearly visualized. The region of the adrenals appeared free of overt pathology.

Spleen

The spleen was mildly increased in size with a rounded to mildly scalloping capsule contour. The parenchyma was diffusely homogeneous with no overt nodules or masses. The spleen measured 1.0 cm in width at the hilus.

Liver/Gallbladder

The liver was subjectively normal in size with mildly irregular capsule contour. The hepatic parenchyma was mildly heterogenous with moderate coarse echotexture. The parenchymal changes are subjectively benign remodeling and likely represent an aging change. The hepatic vasculature was normal in volume and structure.



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The gallbladder and cystic duct were mildly dilated in size with a moderate amount of sludge. The gallbladder wall was diffusely mildly thickened. The cystic and common bile duct were tortuous without visible post-hepatic obstruction. The common bile duct measured 0.28 cm diameter.

Gastrointestinal

The stomach was normal in thickness and layering and contained a moderate amount of fluid. 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

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

ULTRASONOGRAPHIC FINDINGS

- Cholangitis pattern with no overt evidence of EHBDO
- Low-grade pancreatitis
- Peritoneal effusion, small volume
- Interstitial nephritis, mild
- Mild splenomegaly with scalloping capsule contour - ddx benign causes (EMH, splenitis, etc) vs potential for emerging round cell neoplasia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of the icterus may be a combination of hepatic and pre-hepatic causes given the newly developing anemia. The presence of peritoneal effusion is concerning for more significant pathology within the abdomen.

Hepatic causes include cholangiohepatitis, hepatic lipidosis, FIP and lymphoma. Sampling of the liver would be needed for further evaluation.

A FNA of the liver with a 25G needle could be considered if there is normal coagulation profile. A screening FNA of the spleen could be done at the same time to assess for emerging round cell neoplasia.

Pre-hepatic causes would include hemolysis (IMHA). Secondary IMHA is the most common type in cats. Secondary IMHA can be caused by infectious agents (FIP, Felv, FIV, Mycoplasma, or potentially any infectious trigger), drug reactions, inflammatory conditions, and/or neoplasia. In some cases of

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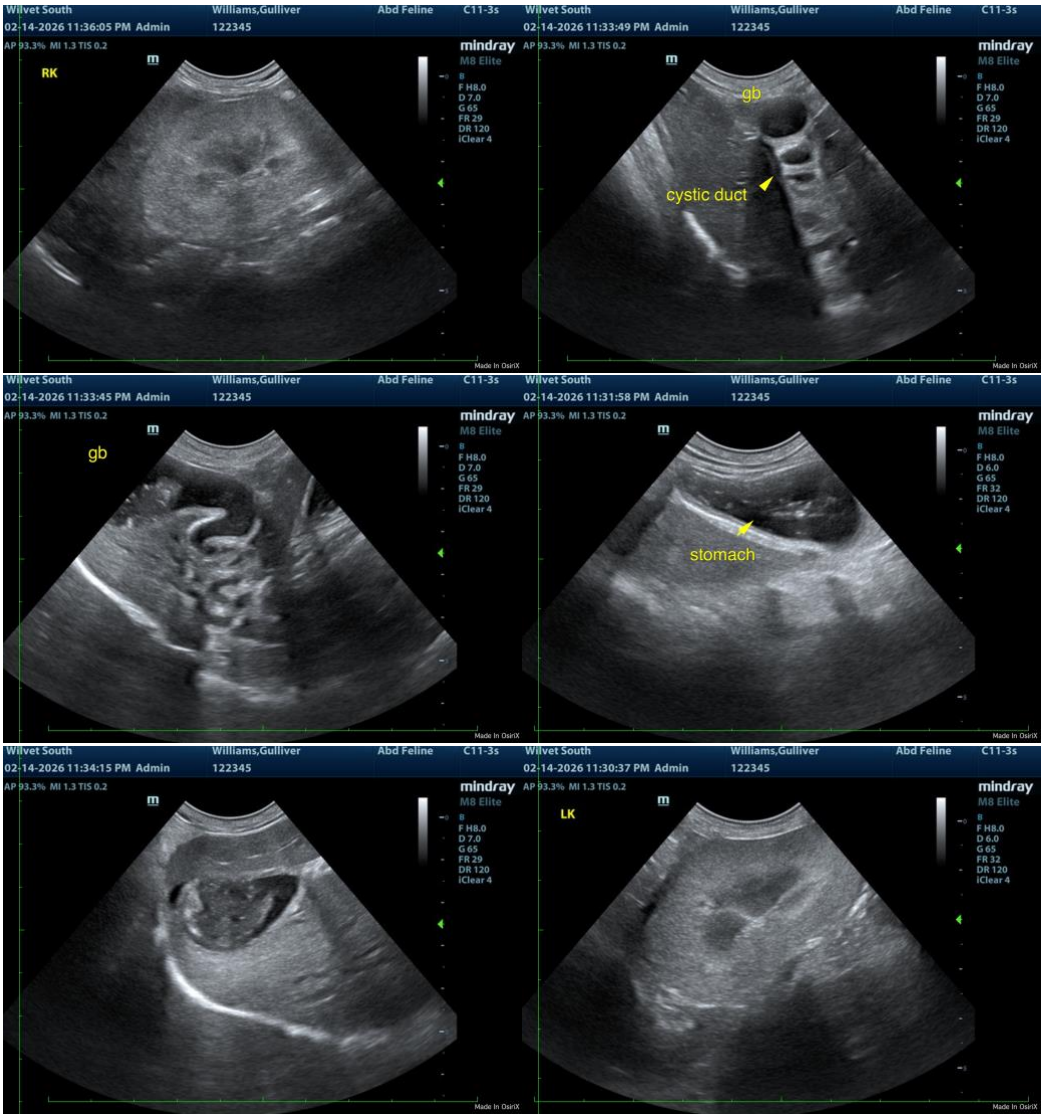
IMHA the antibodies will target the RBC precursors in the bone marrow, causing a non-regenerative IMHA.

Further testing could include any or all the following, depending on severity: saline agglutination test and/or Coombs testing, CBC with path review, Anemia PCR panel and/or any other infectious disease testing.

I would recommend IVF, electrolyte management and supportive care pending further diagnostics. The prognosis is currently guarded, pending Gulliver's response to supportive care and results of further diagnostics.



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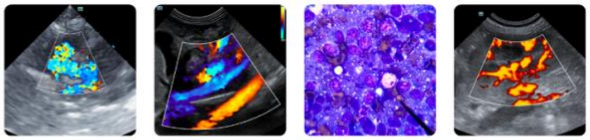

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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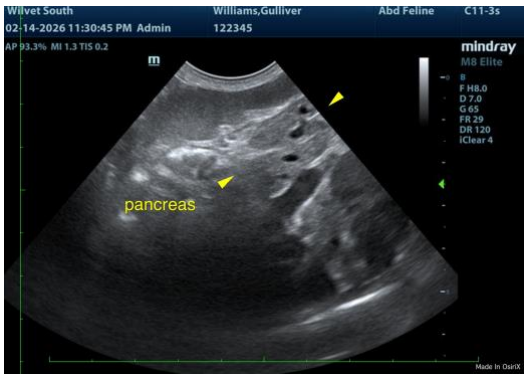

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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