PATIENT

MaryG Lichtenstein

SPECIES

Feline

BREED

Siamese

SEX

Spayed Female

AGE

4 Years 10 Months

WEIGHT

7.6 lbs

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Animal Hospital of Lake Brandt

REFERRING VET

Dr. Smith

INVOICE

71780

DATE

11/13/25

PRESENTING CLINICAL SIGNS

P presented for ultrasound due to chronic elevation in bilirubin. Owner has numerous cats and used to be a breeder. She has had mycoplasma in her home and amyloidosis in her cats about 10 years ago. P has chronic URI's and intermittent inappetence.

Abnormal PE/Chem/CBC/UA Results: WBC 20.7, Mono 0.7, Eos 2.87, Bao0.1, Cl 105, Tbili 1.3, Uncon 0.7, Con 0.6, Tbili previously 2.8 in august 2025 Urinalysis usg 1.029, 1+ bili, 1+ protein

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.43 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.76 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.35 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.40 cm at the cranial pole and 0.32 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.67 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach is severely fluid distended. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. No evidence of a pyloric outflow tract obstruction is visualized. Motility subjectively appears diminished. Fluid can be observed flowing forward and backward into the dilated esophagus.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to moderate fluid/gas. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.25 cm. Jejunum wall measures 0.19 cm. Visualized peristalsis appears appropriate. The proximal duodenum is mildly to moderately fluid and gas distended. Some areas of distal jejunum have mild to moderate fluid and gas.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The left limb of the pancreas is prominent and hypoechoic as compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

Other

The distal esophagus is visualized at the level of the diaphragm. It appears prominent and distended with fluid and gas. Fluid can be seen passing forward and backward into the cardiac region of the stomach.

ULTRASONOGRAPHIC FINDINGS

- Pancreatic changes most consistent with pancreatic remodeling and possible chronic pancreatitis.
- Fluid distended esophagus and stomach with fluid passing back and forth, suggesting altered motility, and proximal fluid distention of the duodenum – This could represent an esophageal motility issue (megaesophagus, dysmotility, etc.), less likely a herniation, or potential severe dysmotility of the stomach and some areas of the intestinal tract. Correlate with feeding history. If not fasted, this can greatly affect the appearance in these areas.

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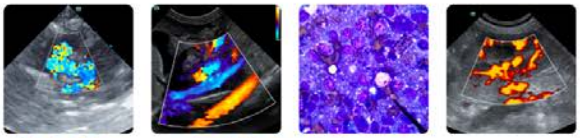

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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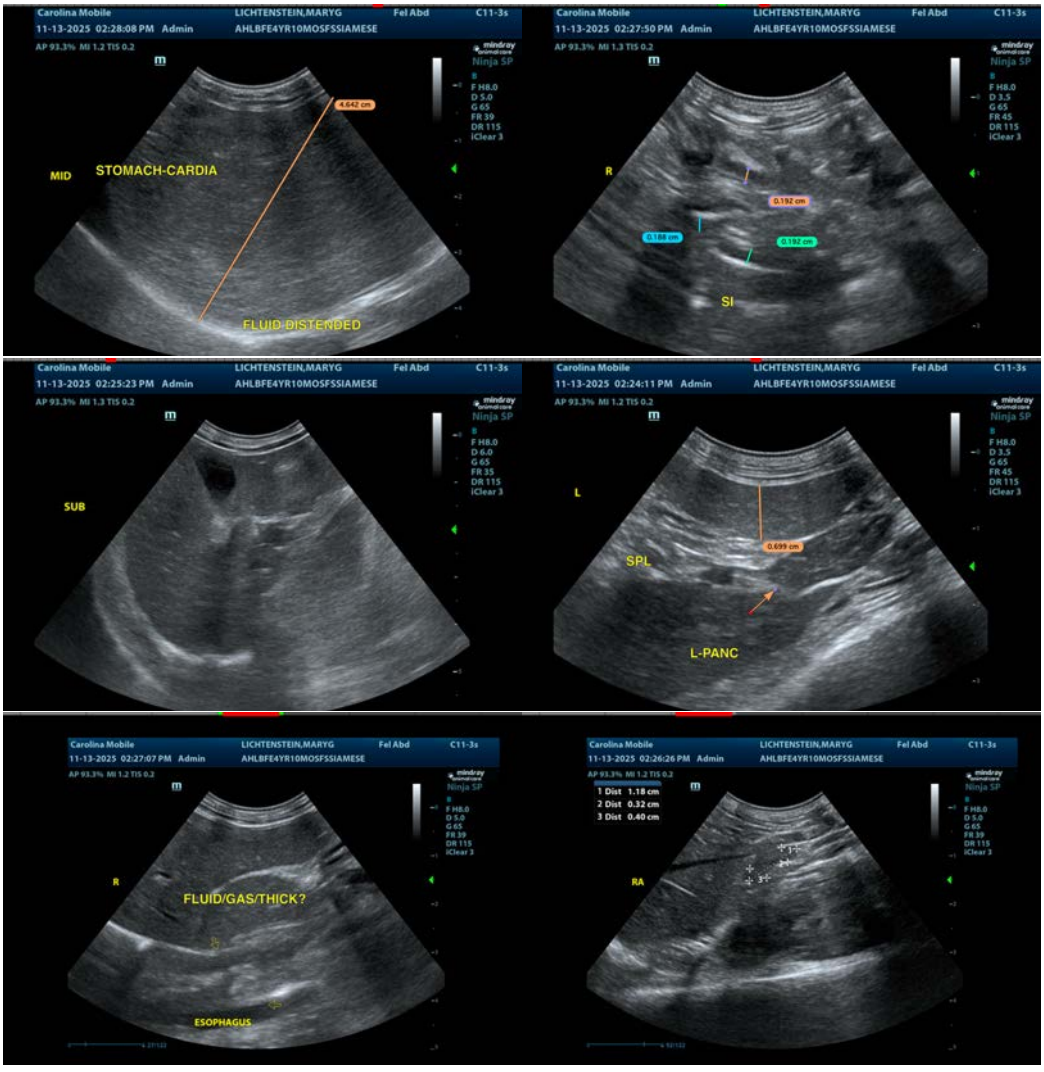
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the liver or biliary tract to explain the elevation in bilirubin reported. This does not rule out a primary hepatopathy. Consider a liver function test and screening for mycoplasma and evaluation of CBC (possibly with a pathologist review), trying to discern between hemolysis and primary hepatic icterus.

The stomach appears significantly fluid distended, as does the distal esophagus and some areas of small intestine. Correlate with feeding history. if the patient was non-fasted, this could greatly exacerbate this appearance. Recommend thoracic and abdominal radiographs to further evaluate for possible megaesophagus, esophageal lesion, etc. A barium study may be helpful for evaluation of possible dysmotility dilation, etc. Upper GI endoscopy may eventually be helpful in further evaluation and to evaluate for any gastrointestinal disease contributing to dysmotility.

The left limb of the pancreas is prominent and hypoechoic, most consistent with chronic remodeling and possible chronic pancreatitis. Correlate with a PLI level and consider treatment for chronic pancreatitis.



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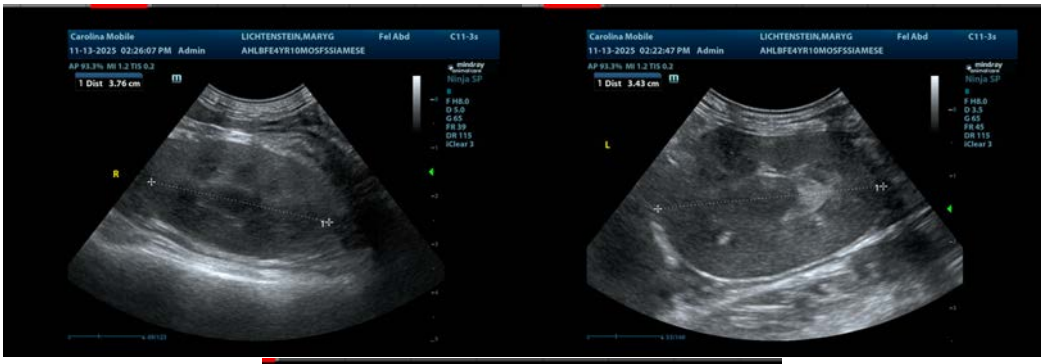

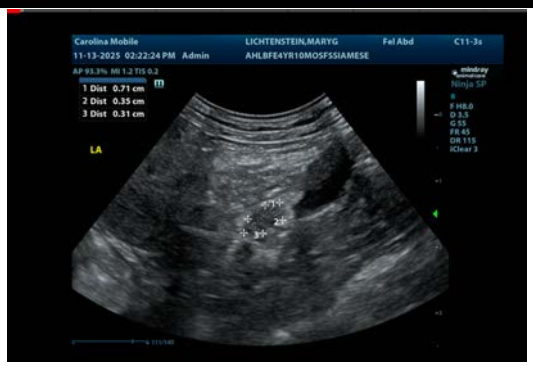

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

info@sonopath.com