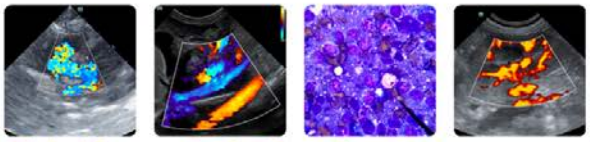


PATIENT

Gus Churby

SPECIES

Feline

BREED

DLH

SEX

Castrated Male

AGE

11 Years

WEIGHT

9.6 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Shane Stafford

HOSPITAL NAME

West Newton Animal Clinic

REFERRING VET

Dr. Shane Stafford

INVOICE

73722

DATE

3/17/26

PRESENTING CLINICAL SIGNS

Gus is an 11-year-old neutered male domestic longhair cat presented for persistent lethargy, inappetence, and intermittent vomiting. He was initially evaluated at an emergency clinic on 3/14/26 for similar signs and tested FIV positive, receiving cefovecin, Orbax, and transdermal mirtazapine. Despite treatment, clinical signs have persisted.

Abnormal PE/Chem/CBC/UA Results: Lethargic and anorexic with occasional mucus vomiting but continued to drink water. On exam he was non-febrile, mildly dehydrated, with a grade II/VI left parasternal systolic murmur, epaxial muscle atrophy. The abdomen was soft and non-painful with no palpable masses or effusion. Icteric serum with hyperglobulinemia and hyperbilirubinemia. Prior CBC showed neutropenia and mild thrombocytopenia. Total T4 and NT-proBNP was normal. Given the presence of icterus and hyperglobulinemia in this FIV-positive cat, differentials include hepatobiliary disease, inflammatory or neoplastic GI disease, infectious disease, and dry FIP. Abdominal ultrasound is requested to further evaluate the liver, biliary system, and other abdominal organs to determine the underlying cause of the icterus.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with a large amount of primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris. In some views the debris is dense enough to interfere with clear visualization of the bladder wall. A small mass effect cannot be ruled out but seems less likely. Consider repeat evaluation if the echogenic debris can be cleared.

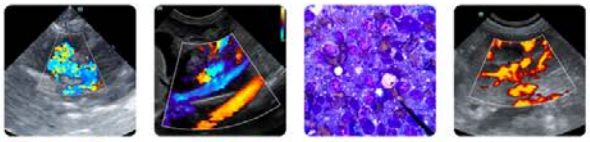
The left kidney has a normal shape and size (4.24 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.34 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 0.52 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 0.31 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.



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Spleen

The spleen is subjectively normal in size (0.86 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 large, with normal echogenicity and 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.

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 contains minimal luminal contents. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

Some of the visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Duodenum wall measures 0.30 cm. Jejunum wall measures 0.24 cm. Visualized peristalsis appears appropriate. Some sections of bowel appear mildly corrugated, most consistent with an enteritis type pattern.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. The ascending, transverse, and descending colon appear significantly fluid and gas distended. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is prominent and mottled 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.

ULTRASONOGRAPHIC FINDINGS

- Large amount of suspended echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Pancreatic changes most consistent with chronic pancreatic remodeling.
- Subjectively large liver – Findings could be consistent with anatomic variation, mild congestion, infiltrative disease, fatty infiltrates, etc.
- Mild enteritis type pattern visualized associated with the small intestine.

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- Diffusely fluid and gas distended colon – Findings are suggestive of significant diarrhea.

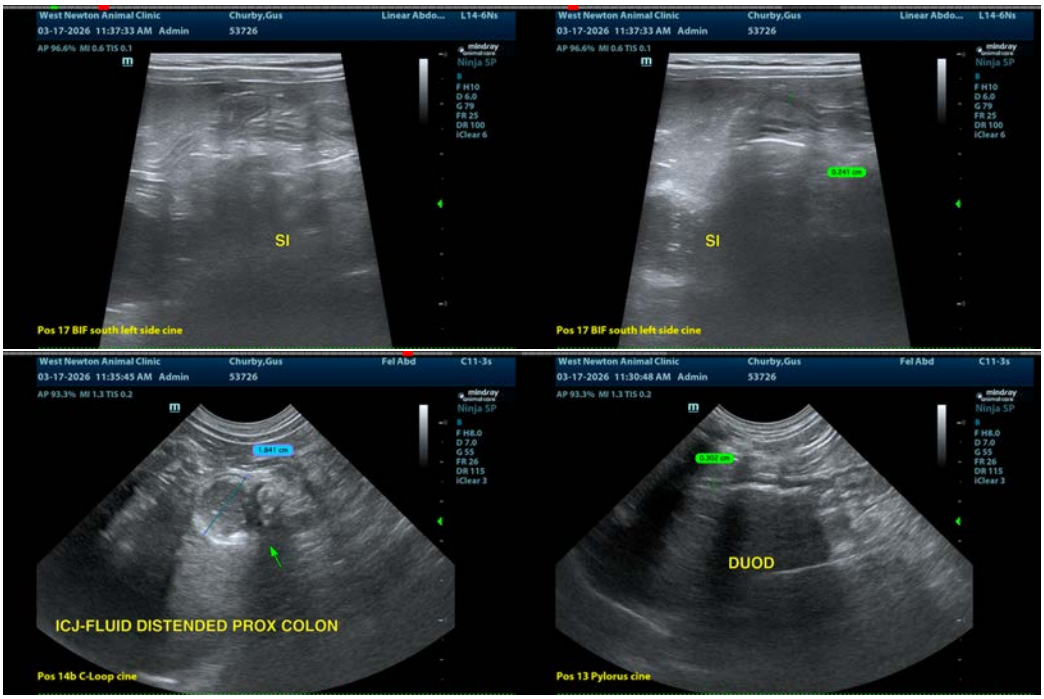
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes observed associated with the liver and gallbladder are mild. Findings could be normal for this individual, although primary hepatic disease can be present and significant despite a relatively normal appearing liver on ultrasound. It is unusual to see an elevation in bilirubin with no evidence of anemia and normal liver enzymes. Consider rehydration of this individual and reassessment of values on a non-hemolyzed sample to confirm the presence of true icterus. If this is present you could consider a liver function test and a fine needle aspirate of the liver for further evaluation (provided coagulation parameters are normal).

There is a large amount of suspended echogenic debris in the urinary bladder. In some areas this interferes with full evaluation of the bladder wall, and a small mass effect cannot be ruled out. Correlate with urinalysis and culture. Consider follow up evaluation to reevaluate in the future, looking for any evidence of progression of these findings.

Some sections of small intestine appear mildly corrugated, possibly consistent with underlying enteritis. No focal lesions are observed, although this cannot be definitively ruled out. No evidence of an obstructive pattern is visualized.

The colon appears significantly fluid and gas distended. In some areas this obscures clear visualization of other abdominal structures. Correlate with patient's current clinical signs, as diarrhea would be expected. Consider empirical treatment for gastroenterocolitis. If symptoms are persistent and primary gastrointestinal disease is suspected, you could consider further evaluation. Additionally, you could consider repeat imaging in the future, looking for the development of new lesions.



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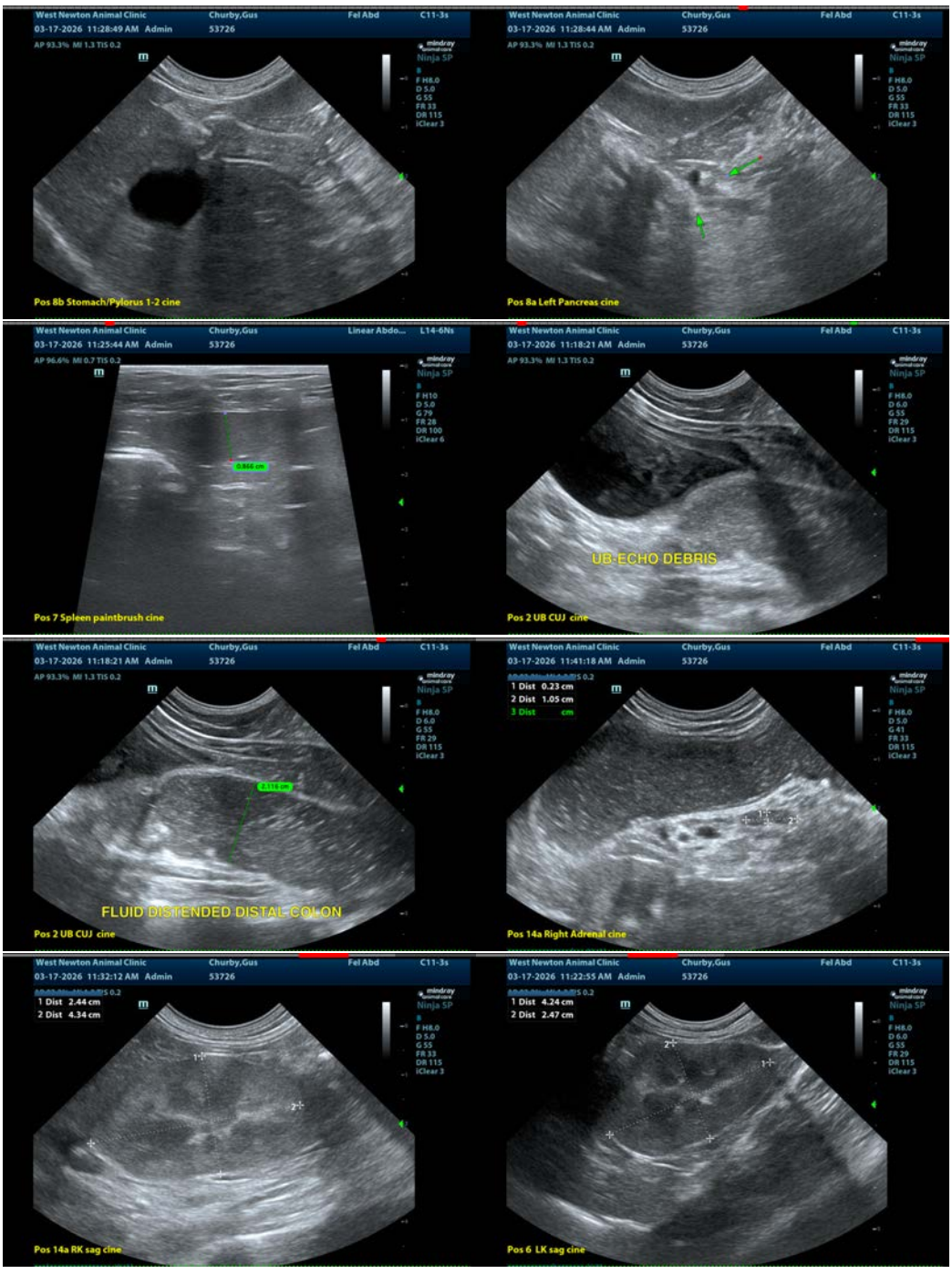

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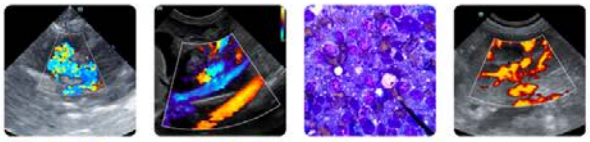

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@sonopath.com