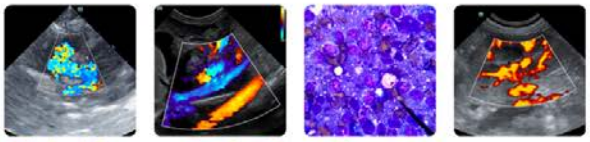


PATIENT

Posey Brown

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed Female

AGE

14 Years

WEIGHT

8.38 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Danielle Shemanski, DVM, MA

HOSPITAL NAME

Western New York Veterinary Services

REFERRING VET

Morgan Busby, DVM

INVOICE

74822

DATE

4/29/26

PRESENTING CLINICAL SIGNS

Concern for neoplasia or gall bladder obstruction. Mild neutrophilia, marked liver value elevations (ALT 258, ALP 1988, GGT 16, bilirubin 7.9). Anorexia over the last 3-4 days and vomiting. The vomiting has resolved since starting anti-nausea medication. Prior to that, she was having dry heaves with foamy bile almost every morning. She has been drinking water and urinating but has not been defecating. Owner reports a history of constipation. In the past month or two, she has had some biley, hairball-like vomit, which was unusual for her. CLINICAL SIGNS: Anorexia, Vomiting, Constipation. MEDICATIONS: Cerenia 8 mg SID, Mirtazapine 1.8 mg q3d, Clavamox 62.5 mg BID, Veraflox 25 mg SID, Ursodiol 62.5 mg BID, *Butorphanol 0.1 mL was given for abdominal discomfort noted during the exam.

Abnormal PE/Chem/CBC/UA Results: April 27, 2026 CBC: MCHC: 37.2 g/dL HIGH RDW: 29.6% HIGH Reticulocytes: 1.0 K/µL LOW Reticulocyte Hemoglobin: 12.8 pg LOW Neutrophils: 13.83 K/µL HIGH IDEXX SDMA: 15 µg/dL HIGH Blood Chem BUN: 44 mg/dL HIGH ALT: 258 U/L HIGH ALP: 1,988 U/L HIGH GGT: 16 U/L HIGH Bilirubin - Total: 7.9 mg/dL HIGH Urinalysis: Urine Protein: 100 mg/dL Blood/Hemoglobin: 250 Ery/µL Bilirubin: 6 mg/dL (Significant bilirubinuria) Urobilinogen: 12 mg/dL White Blood Cells: 14/HPF Red Blood Cells: >50/HPF (Significant hematuria) Non-Squamous Epithelial Cells: 3–5/HPF

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild 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.

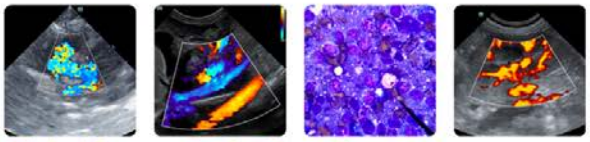
The left kidney has a normal shape and size (3.36 cm). Overall echogenicity is slightly hyperechoic with mildly reduced corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.78 cm). Overall echogenicity is slightly hyperechoic with mildly 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 0.46 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 0.47 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 (0.61 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 large in size with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in 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. There is a moderate amount of non-organized echogenic debris. The bile duct appears mildly dilated and tortuous proximally, measuring at 0.25 cm. It is lost to visualization distally.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm 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.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.25 cm. Jejunum wall measures 0.23 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 pancreas (particularly in the right limb) 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

There is a small amount of free abdominal fluid. There is no evidence of a significant lymphadenopathy. A prominent lymph node is visualized near the ileocecal junction measuring 0.40 cm. The omentum is mildly diffusely hyperechoic.

PRIMARY FINDINGS

- Prominent, hypoechoic right limb of the pancreas – Most consistent with chronic pancreatic remodeling or chronic pancreatitis.
- Large, hyperechoic liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.

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- Moderate gallbladder debris and mild proximal dilation of the bile duct – Evidence of an obstruction is not clearly visualized. Findings could be consistent with mild cholangitis. No significant wall thickening noted.
- Mild inflammatory type changes visualized associated with the small intestine.
- Free abdominal fluid – Recommend fluid analysis and cytology.

SECONDARY FINDINGS

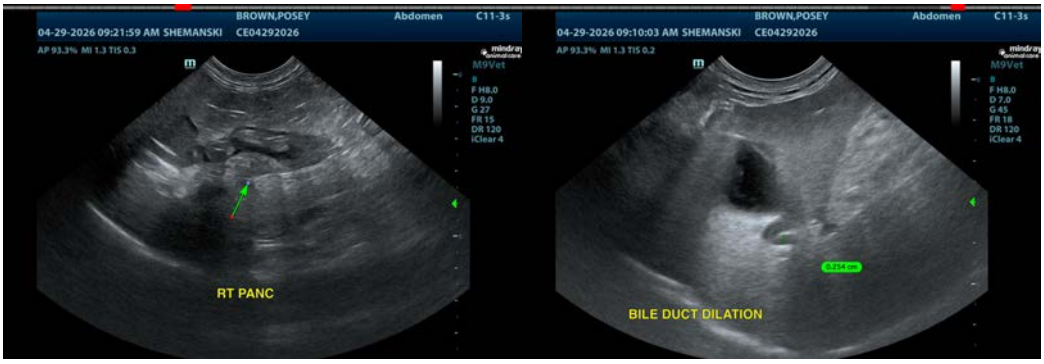
- Mild suspended echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Age related changes associated with both kidneys.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver is large and hyperechoic. These changes are concerning for a primary hepatopathy such as lipidosis, round cell neoplasia, etc. The gallbladder does not appear overtly obstructed but does have some intraluminal debris, and the proximal bile duct is dilated and tortuous. Visualization is lost distally. Recommend a fine needle aspirate of the liver (provided coagulation parameters are normal) to help differentiate between lipidosis, round cell neoplasia, etc., and empirical treatment for cholangiohepatitis and pancreatitis. If liver values are not improving, repeat imaging looking for progressive dilation of the bile duct could be considered. Additionally, placement of a feeding tube for nutritional support should be considered.

There are some mild inflammatory type changes visualized associated with the small intestine. This could also be consistent with early round cell neoplasia. You could consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate, looking for additional evidence of underlying small intestinal disease. If this is strongly suspected, you could consider a hydrolyzed protein prescription diet.

Ultimately, if the patient is not responding to therapy, biopsies of the liver, GI tract and pancreas may need to be considered. Additionally consider sampling of the free abdominal fluid for fluid analysis and cytology.



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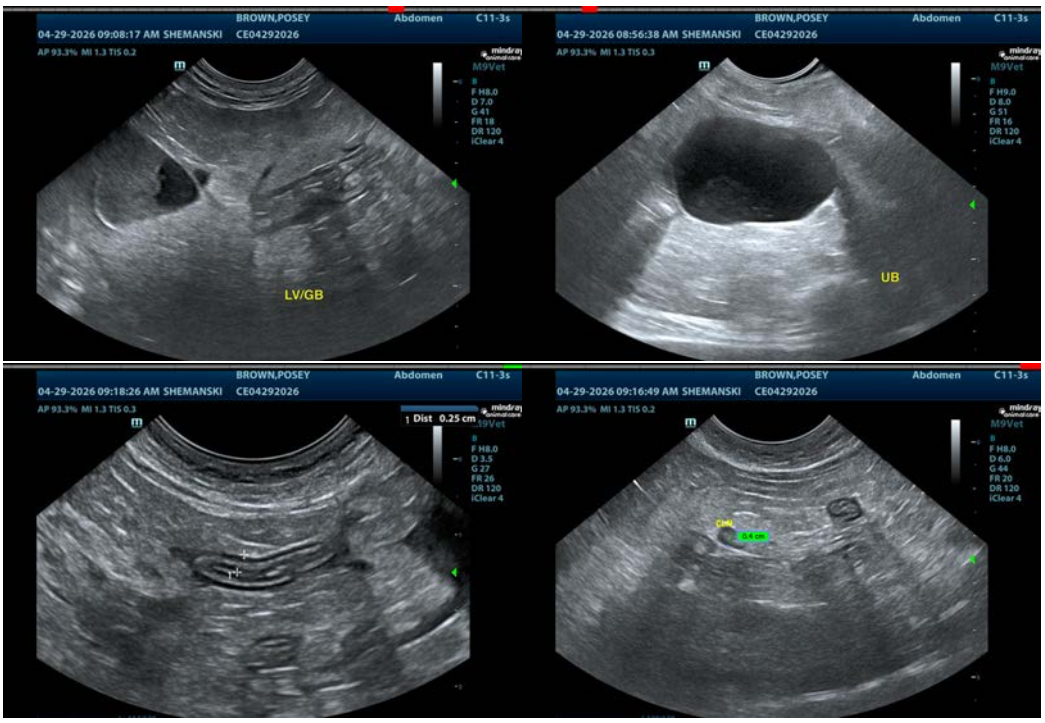

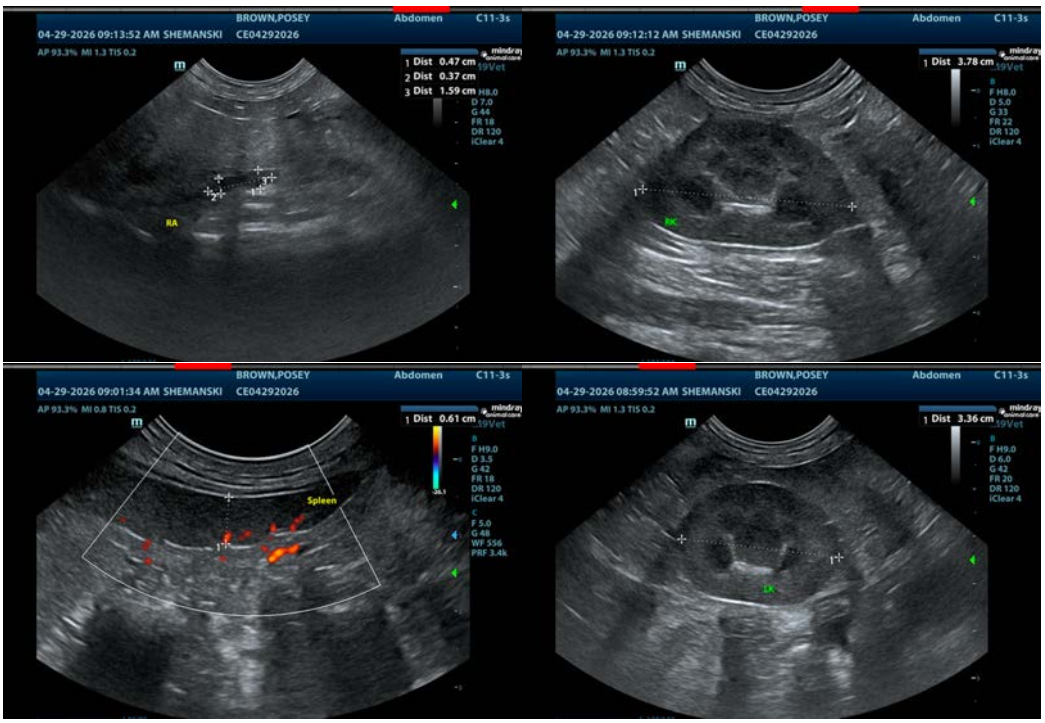

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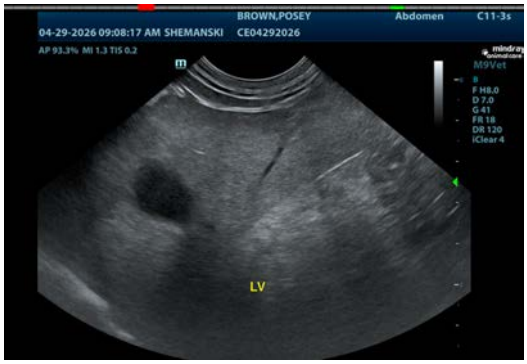

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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