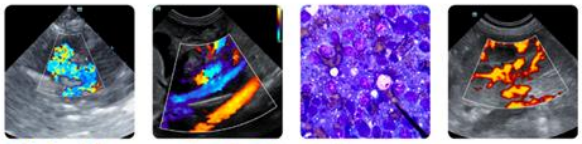


PATIENT
Sterling Feaser

SPECIES
Feline

BREED
DSH

SEX
MN

AGE
10yr

WEIGHT
4.13kg

INTERPRETED BY
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY
Melissa Randolph

HOSPITAL NAME
Shores Veterinary Emergency Center

REFERRING VET
Julia Kerr

INVOICE
23552

DATE
01/14/2026

PRESENTING CLINICAL SIGNS

*1/12 history: Ate small amount yesterday but today not interested in food at all. Drinking water normally. For the past 2-3 days owner hasn't really seen him frequent the box but has not seen any urinary accidents in the house. About 1 week ago his meows started to become hoarse and more quiet. Does have a cat and dog housemate but they are fine and all get along other than normal play. food change 2 weeks ago. 1/12 was sent home with mirataz transdermal ointment and denamarin advanced. *1/14 history: continued anorexia since 1/12. will sniff at food and then back away. owner noting P licking his lips, nausea, and drooling. owner noting lethargy. this morning owner noted P having increased respiratory effort. is urinating small amounts. possible no defecation in 1-2 days. owner has been using the mirataz transdermal ointment. owner has not given the denamarin. prior history of right eye enucleation. *concern for biliary obstruction, hepatic mass, cholangiohepatitis, hepatic lipidosis, anemia, neoplasia, other

Abnormal PE/Chem/CBC/UA Results: *PE: temp 98.6, vocalizing, tries to lay lateral, dull/depressed, cranial abdominal organomegaly; slight jaundice of internal aspects of pinna rads 1/12: Increased radiopacity in the cranial abd, most likely liver 1/12: pH 7.437, Na 146, K+ 3.5, ica ++ 1.12, lactate 3.94 1/12: hct 22%, hgb 7.6, rbc 5.15, plt 34,000 1/12: BUN 41.7, creat 0.7, calcium 7.5, ALT 232, ALP 229, ggt 11, t bili 0.9 1/12 u/a: urine red, cloudy, protein 3+ (300), pH 7.0, usg 1.025, leukocytes 2+(250), rbc > 100/hpf, wbc<5/hpf, bacteria none to rare, ca oxalate crystals 2-4/hpf 1/14: ALT 308, ALP 259, ggt 11, t bili 4.4 1/14: ica ++ 1.08, lactate 12.02, BUN 78 1/14: pcv 24% ts 6.6 1/14: urine golden yellow color

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with mild non-dependent particulate sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with mild increased cortex echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 4.3 cm in length. The right kidney measured 4.7 cm in length.

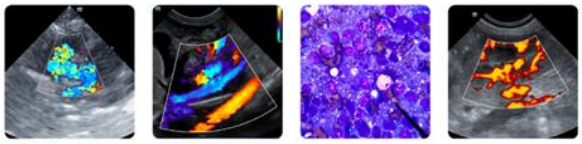
The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left and right adrenal glands were not definitively visualized. No obvious pathology was present in the area of the bilateral adrenal glands.

Spleen

The spleen was mildly enlarged with mild asymmetrical to scalloped medial capsule contour and homogenous, mildly hypoechoic splenic parenchyma. No visualized masses or nodules were present. The spleen measured 1.4 cm in width at the level of the mid spleen.



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Liver/Gallbladder

Moderate to marked hepatomegaly with areas of rounded to mild asymmetrical hepatic capsule contour. Non-homogenous, non-uniform to hypoechoic hepatic parenchyma exhibiting variable coarse echotexture. Normal vascular volume without evidence of congestion. The gallbladder was mildly distended in size with mildly thickened hyperechoic gallbladder wall. The gallbladder contained anechoic bile with non-dependent, non-organized bile sediment. The cystic duct and common bile duct exhibited mild dilation with common bile dilation measuring 0.42 cm in diameter. Concurrent cystic and common bile duct mucus. The common bile duct was not definitively visualized to the level of the duodenum.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of mechanical/metabolic ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The area of the pancreas was sonographically normal.

Free Abdomen

No omental masses or overt lymphadenopathy was present.

Pockets of mild volume perihepatic to peritoneal effusion present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Enlarged non-homogenous hypoechoic liver.
- Mild distended to inflamed gallbladder, cystic duct, and visualized common bile duct with gallbladder and ductal sediment / mucus.
- Normal gastrointestinal tract/ area of pancreas.
- Mild hypoechoic splenomegaly
- Minor volume peritoneal effusion

Secondary

- Bilateral chronic renal changes with urine sediment.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Acute on chronic hepatopathy is favored with acute on chronic significant cholangiohepatitis or occult neoplasia as primary differentials. The concurrent splenomegaly may indicate incidental or reactive hyperplasia, hematopoiesis, inflammation, or potential concurrent splenic neoplasia. Definitive

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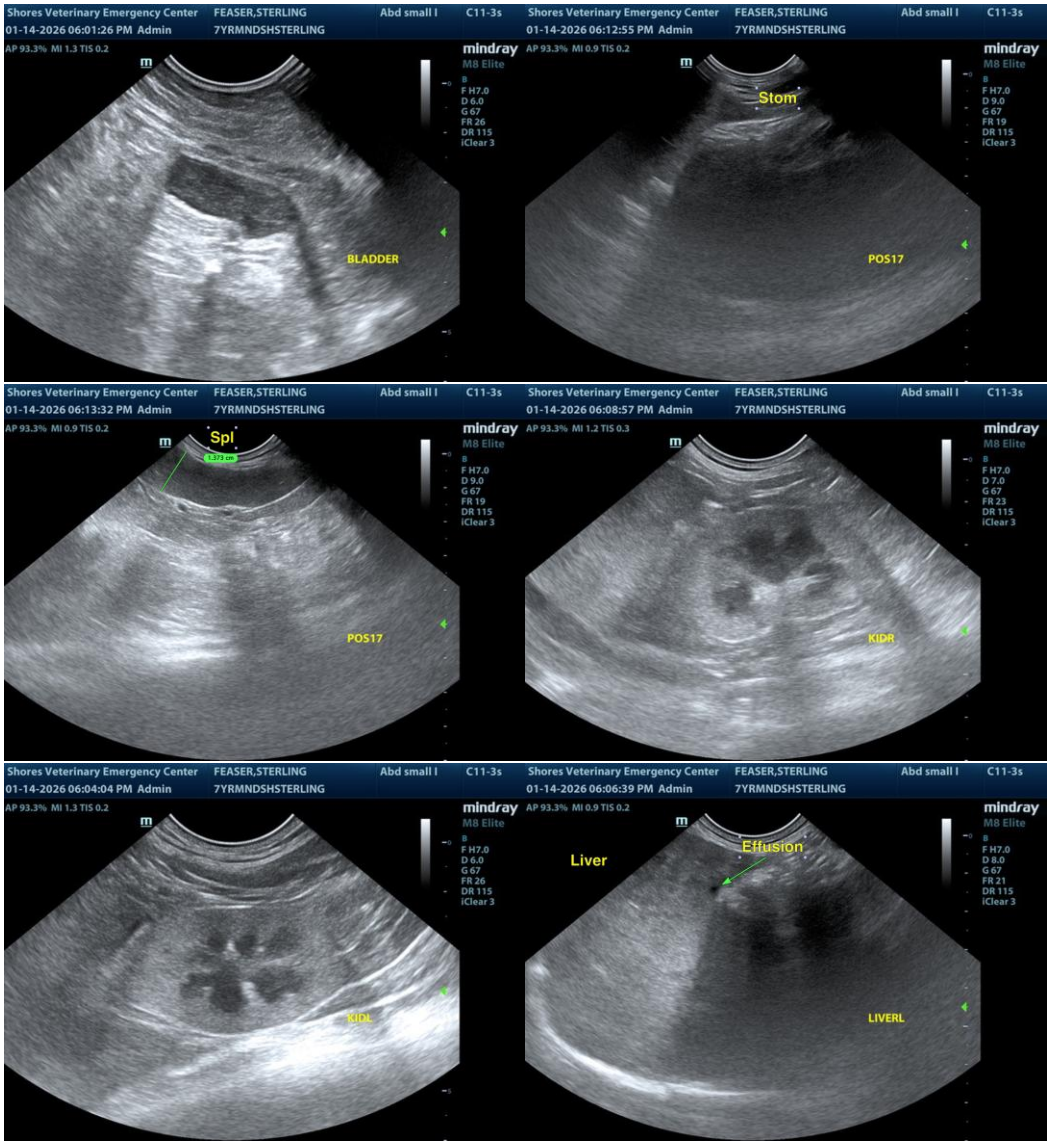
evidence of post-hepatic obstruction was not obvious.

Assuming normal clotting status, using a 25ga needle, hepatosplenic FNA cytology +/- C/S is warranted for further clarification.

Hospitalization with acute on chronic significant cholangiohepatitis therapy with clinical and as needed sonographic monitoring if evidence of progressive hepatopathy, icterus, or peritoneal effusion would be reasonable.



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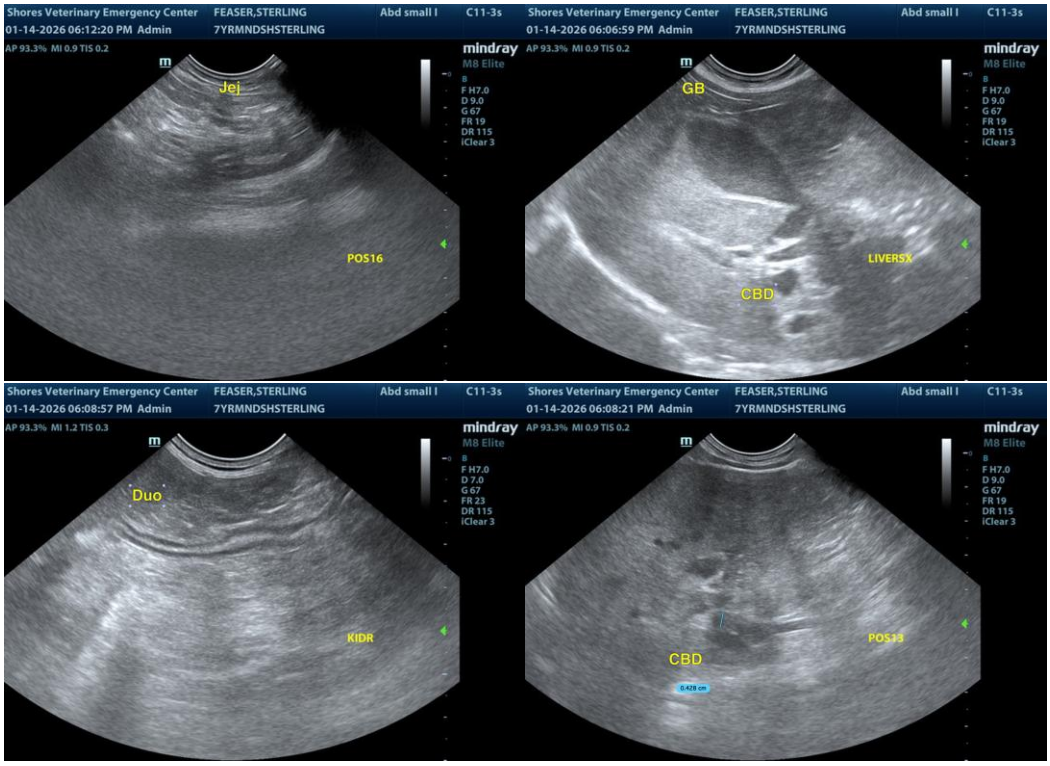

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
info@sonopath.com