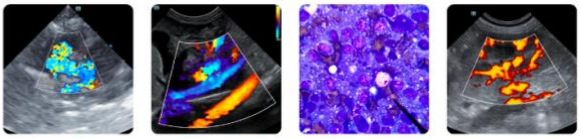


PATIENT

Pelos Quiroz

SPECIES

Feline

BREED

Maine Coon

SEX

Neutered Male

AGE

14 Years

WEIGHT

10

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

IMAGING PERFORMED BY

Dr. Solitaire Goldfield DVM

HOSPITAL NAME

Craig Road Animal Hospital

REFERRING VET

Dr. DeJesus

INVOICE

13469

DATE

01/29/26

PRESENTING CLINICAL SIGNS

- Acute on set behavior change, anorexia. Historic hepatobiliary mass

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary border demarcation was also present. The left kidney measured 3.5 cm in length. The right kidney measured 4.4 cm in length.

Adrenal Glands

The left and right adrenal glands were not definitively visualized.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver & Gallbladder

The liver revealed subjective generalized hepatomegaly with primarily symmetrical to areas of mild asymmetrical hepatic capsule contour and heterogenous parenchyma with parenchymal remodeling. Possible mild to lobar biliary tree dilation. No distinct mass or nodules were evident.

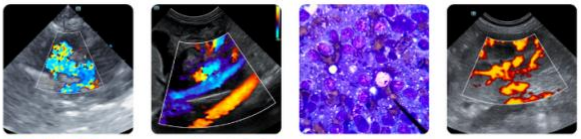
The gallbladder was distended in size with mildly thickened hyperechoic wall. Primarily anechoic bile in the gallbladder with minor bile sediment. The common bile duct exhibited marked generalized dilation with thickened bile duct wall extending from the gallbladder to an approximate level of the duodenum. The common bile duct contained anechoic content with mild nonmineralized mucoduct. The common bile duct dilation measured up to 2.1 cm.

Gastrointestinal

The stomach presented overtly normal intact wall layering. Mild gastric stasis with retained fluid was present.

Indistinct yet suspect mild thickened duodenum wall with normal intact visualized jejunum wall. The duodenum wall measured 0.31 cm wall width. The jejunum wall measured 0.23 cm wall width. Mild nonobstructive duodenojejunal ileus.

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



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Pancreas

The left pancreatic limb was mildly prominent in size with mild capsule asymmetry and heterogeneous remodeled to hypoechoic parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia. Indistinctly visualized yet suspect concurrent right pancreatic duct dilation.

Free Abdomen

No obvious visualized significant or swollen mesenteric lymphadenopathy or peritoneal effusion was present. Increased peri-hepatobiliary to cranial abdomen omental echogenicity.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Hepatopathy exhibiting possible lobar biliary tree dilation.
- Marked diffuse common bile duct/pancreatic duct dilation with mucoduct.
- Mild thickened duodenum wall with generalized mild nonobstructive gastrointestinal ileus.
- Chronic/chronic active pancreatitis pattern with remodeling.
- Mild peri-hepatobiliary to cranial abdomen to mildly inflamed omentum.

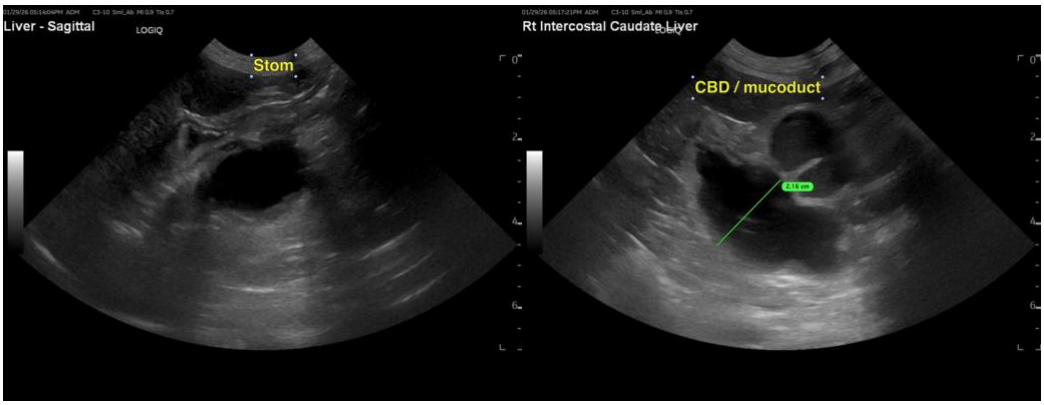
Secondary Findings

- Bilateral chronic renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Severe chronic hepatobiliary inflammation and post-hepatic obstruction, secondary to potential non-obvious mass, mucus or other obstructive pathology are possible. Correlation with recheck lab work is recommended.

Further assessment may include (assuming normal clotting status) hepatic FNA cytology using a 25-gauge needle and a GI panel to include PLI, TLI, cobalamin and folate. No evidence of mechanical gastrointestinal obstruction. Surgical exploratory is likely indicated. If not possible, empirical therapy for severe cholangiohepatitis and concurrent chronic pancreatitis with gastrointestinal support and clinical/sonographic monitoring would be more conservative.



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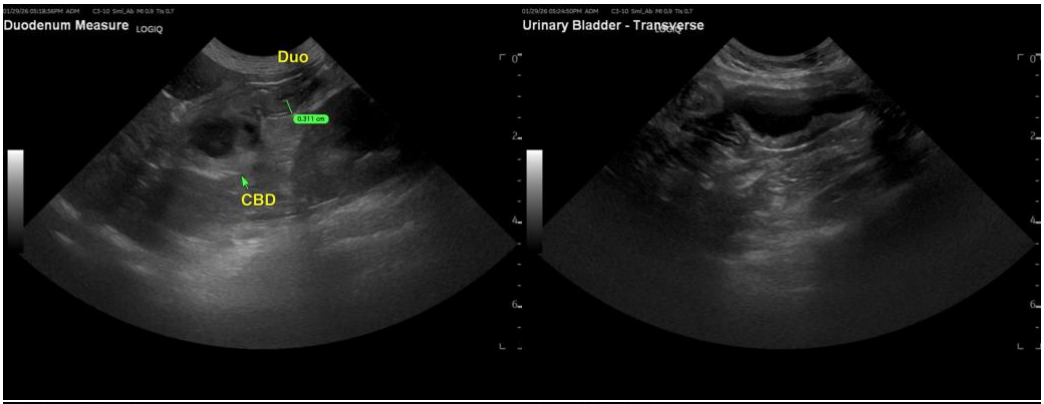

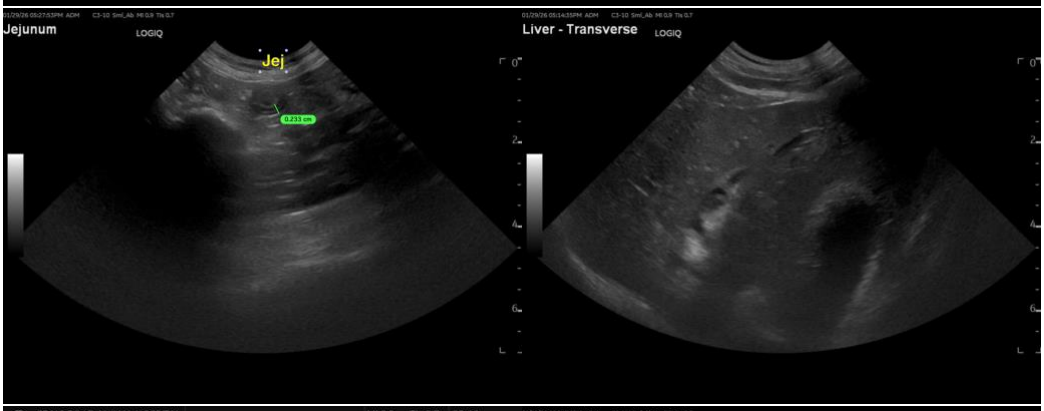

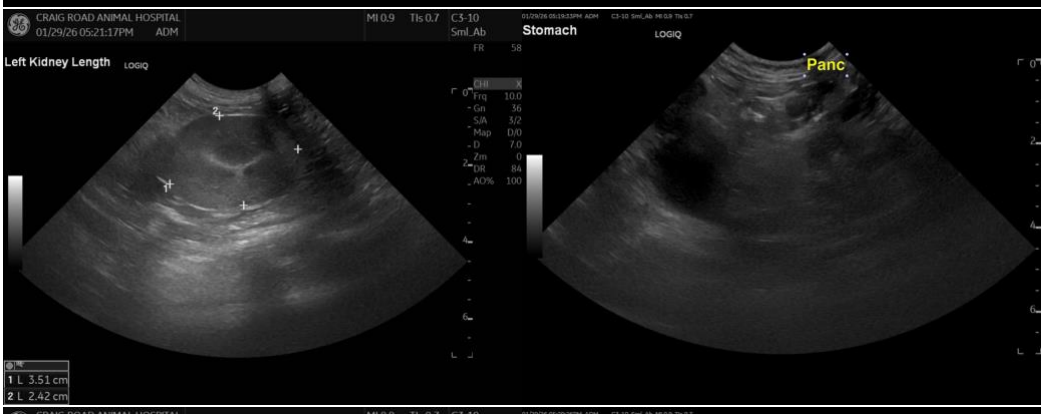

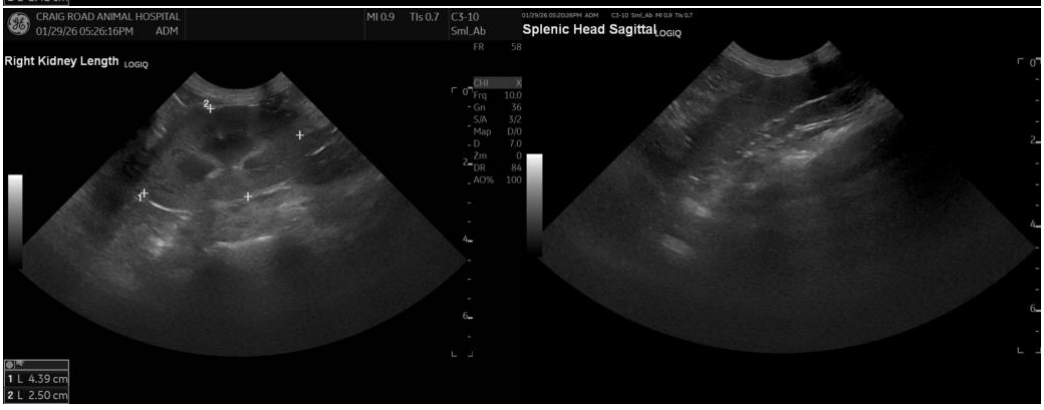

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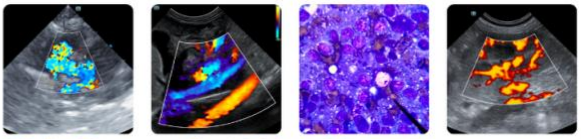

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com