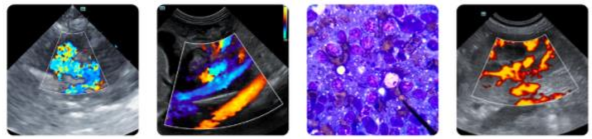


PATIENT
O2 Levy

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
7 Years

WEIGHT
5 kg

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

IMAGING PERFORMED BY
Lindsay Powell, CVT

HOSPITAL NAME
Hershey AEC

REFERRING VET
Dr. Leann Murphy

INVOICE
36852

DATE
12/12/25

PRESENTING CLINICAL SIGNS

History: significant weight loss - 6 lbs over several weeks. Hyporexia, Hypersalivation/foaming for at least 2 weeks. Jaundice noticed recently. FIV positive on prior testing.

Abnormal PE/Chem/CBC/UA Results: Eyes: Mildly icteric sclera Oral Cavity: Mild icterus of oral tissues; MM tacky, moderate tartar/gingival erythema Abdominal: Small column of stool palpable in colon Integument: Icteric inner pinna, prolonged skin tent, dry scales moderate on dorsum MS: Generalized muscle wasting over dorsum DX RDVM: 12/4/25 Chem: Creat 0.6 L, BUN 12 L, TP 9.3 H, Globulin 6.2 H, ALP 378 H, ALP 277 H, Tbili 5.1 H CBC: Retics 2.6 L, Eos 0.03K L Idexx triple SNAP test: Neg for FeLV, HW, Positive for FIV 12/6/25 Tbili 3.1 H 12/11/25 Tbili 5.7 H BP: 150 mm Hg (Doppler) EPOC: BUN 5 L, Glucose 140 H PCV/TS: 34/8.8 (icteric serum) CBC: Eos 0.13K L Chem15: BUN 5 L, Glob 5.5 H, A:G ratio 0.6, ALT 290 H, ALP 231 H, Tbili 5.7 H panc lipase: 0.9 UA: USG 1.030, bilirubin 2+, urobilinogen 3+

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Moderate nondependent accumulated particulate sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes was noted.

The area of the aortic trifurcation was free of pathology.

The left kidney was borderline prominent in size. Mild hyperechoic cortex hypertrophy, mildly enhanced corticomedullary border demarcation, and adequate medullary volume were noted. Pinpoint hyperechoic medullary foci were present. The left kidney measured 4.5 cm.

The right kidney was borderline prominent in size. Mild hyperechoic cortex hypertrophy, mildly enhanced corticomedullary border demarcation, and adequate medullary volume were noted. Pinpoint hyperechoic medullary foci were present. The right kidney measured 4.8 cm.

Adrenal Glands

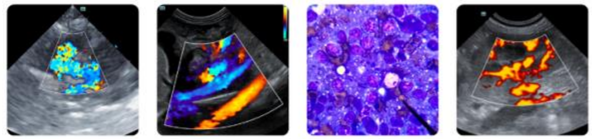
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.38 cm.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.44 cm.

Spleen

The spleen was mildly enlarged (1.3 cm width at the level of the mid spleen), exhibiting 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



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The liver presented subjective borderline to mildly enlarged in size. The parenchyma of the liver was subjectively increased in echogenicity compared to the spleen and renal cortices. The echotexture of the liver parenchyma was uniform with a mild coarse echotexture. The capsule of the liver was symmetrical in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with primarily anechoic luminal content. The cystic and common bile ducts were normal.

The gallbladder was non distended in size with normal wall, without evidence of inflammation or edema. Mild congealed cranial lumen debris was noted. The proximal common bile duct revealed mild tortuous dilation, not visualized to the level of the duodenum, without overt post hepatic obstruction.

Gastrointestinal

The stomach presented intact subjective mildly thickened wall. The stomach was collapsed without evidence of retained ingesta, fluid, or foreign material. The gastric body wall measured 0.36 cm.

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 ileus, obstruction or foreign material. The jejunum wall measured 0.23 cm. The duodenum wall measured 0.25 cm.

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 overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Hyperechoic liver- inflammation, lipidosis, cholestasis, vacuolar changes, and neoplasia are all potentials.
- Nondistended gallbladder with mild gallbladder debris.
- Mild proximal common bile duct dilation- no evidence of posthepatic obstruction.
- Splenomegaly- sedation (if clinically applicable), hyperplasia, hematopoiesis, inflammation, neoplasia.
- Overall normal gastrointestinal tract with borderline thickened stomach wall, empty gastrointestinal tract lumen.
- Normal area of pancreas.

Secondary Findings

- Bilateral interstitial nephrosis renal pattern.
- Urinary bladder sediment.

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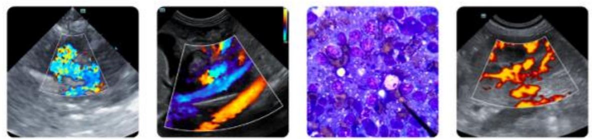

Clinical Sonography & Telecytology

Educational Teleconsultation Services™

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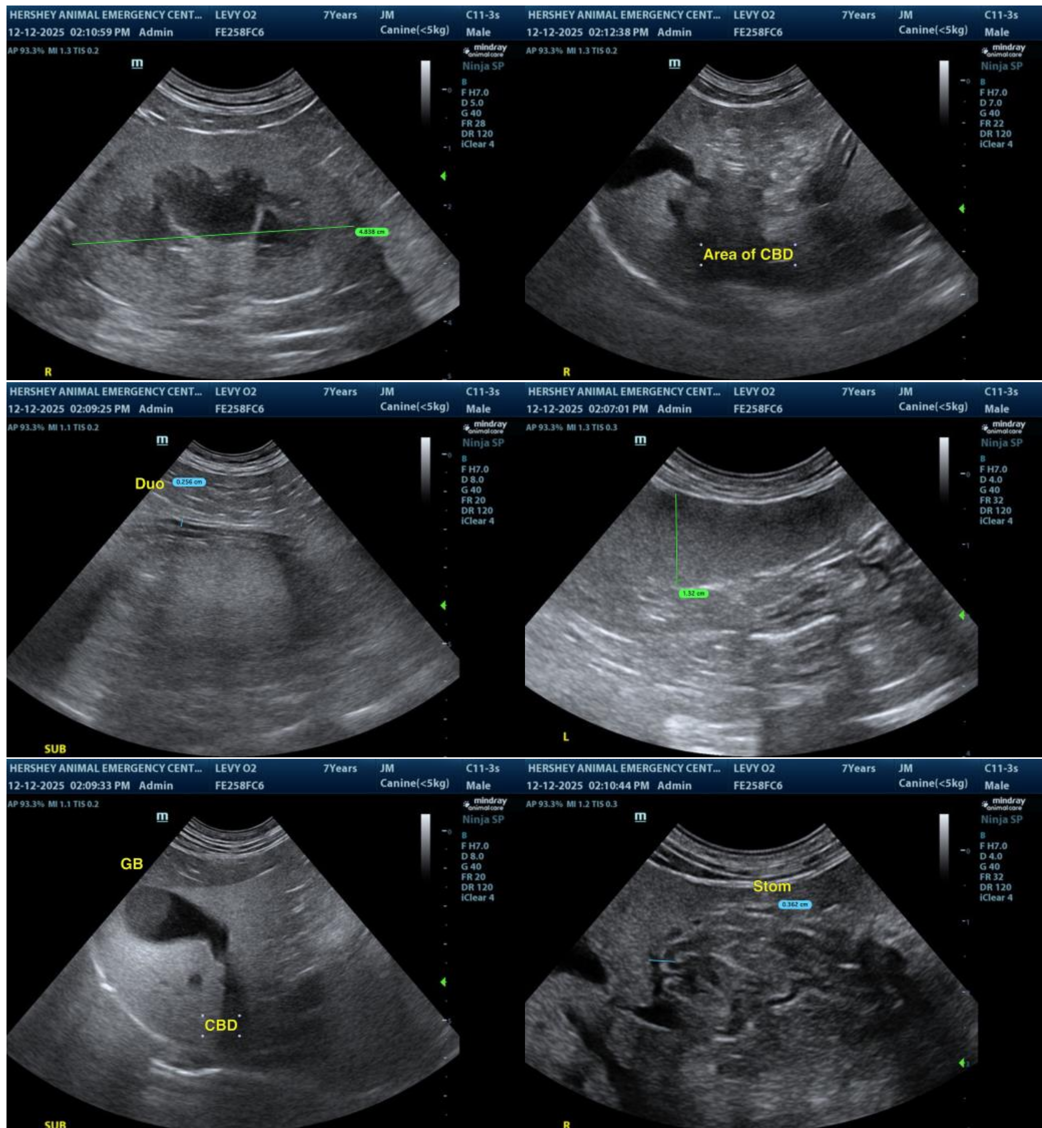
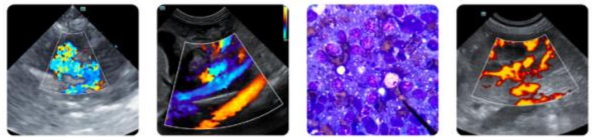
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status and using a 25-gauge needle with vitamin K pretreatment, hepatosplenic FNA cytology is warranted for further assessment. A GI panel to include PLI/TLI/Cobalamin/Folate to assess for nonstructural or occult gastrointestinal or pancreatic disease, i.e., triaditis. If hepatic inflammation is present. Empirical therapy for cholangiohepatitis/lipidosis with concurrent gastrointestinal support and clinical monitoring, pending hepatosplenic sampling, would be reasonable.





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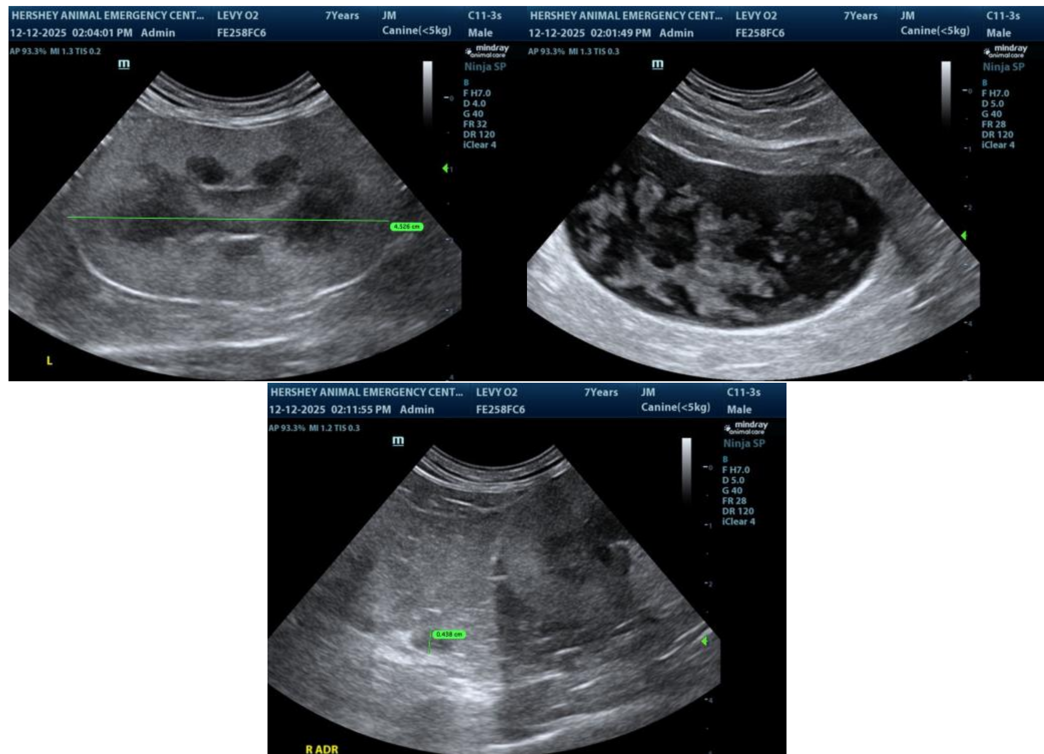

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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