



PATIENT

Champagne
Kershner

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

9.5 yrs

WEIGHT

6.21 kg

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. Alyssa Carver

HOSPITAL NAME

Animal Emergency
Hospital Volusia

REFERRING VET

Dr. Alyssa Carver

INVOICE

15764

DATE

12/30/22

PRESENTING CLINICAL SIGNS

Champagne is a 9 Y MC DSH who presented for lethargy, anorexia, jaundice. O notes p lost 8 lbs. rDVM concerned about cholangitis. P has not been eating for 3-4 days.

Abnormal PE/Chem/CBC/UA Results: TBILI- 8.0, ALP- 792, GGT- 23, BUN- 41.5 8% DEHYDRATED

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. 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 changes was noted.

The area of the aortic trifurcation was free of pathology.

Normal size was present in the kidneys. Minor areas of asymmetrical renal capsule contour were noted along with mild nonuniform cortex. Caudal left kidney solitary ill-defined cortical cyst was present. Mild loss of corticomedullary border demarcation was noted. No evidence of pyelectasia. The left kidney measured 3.7 cm in length. The right kidney measured 4.6 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. The spleen measured 0.83 cm width at the level of the hilus.

Liver/ Gallbladder

The liver exhibited generalized enlargement with symmetrical to mild rounded hepatic contour. Normal to mildly mixed echogenic hepatic parenchyma echogenicity exhibiting moderate coarse echotexture was present. No hepatic masses or nodule were noted. The gallbladder was non-distended in size containing primarily anechoic content. The proximal common bile duct was mildly dilated and tortuous without overt post hepatic obstruction. The common bile duct measured 0.15 cm diameter. The mildly dilated proximal common bile duct did not appear to extend to the level of the duodenal papilla and was not overt consistent with post-hepatic obstructive criteria.

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.



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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.

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

Pancreas

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The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

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Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

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ULTRASONOGRAPHIC FINDINGS

- Hepatopathy
- Nondistended gallbladder with mild proximal nonobstructive common bile duct dilation
- Sonographically unremarkable gastrointestinal tract - possible mild gastroenteritis / inflammatory gastroenteropathy pattern
- Subjective heterogeneous pancreas - possible patient variant potential for concurrent low-grade pancreatitis possible
- Nonspecific chronic renal changes with cortical infarcts and discrete left kidney cortical cyst

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall hepatobiliary presentation is nonspecific although primary concern for cholangitis / cholangiohepatitis is warranted. Alternative hepatopathy including vacuolar hepatopathy, emerging lipidosis, infectious / immune-mediated disease, or less likely occult neoplasia are all potentials.

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Assuming normal clotting status and with vitamin K pretreatment, hepatic FNA cytology is warranted for further assessment primarily to potentially identify inflammatory cell type if present and rule out the less likely potential for occult neoplasia. A GI panel to include PLI/TLI/Cobalamin/Folate as well as three view chest radiographs to assess for or rule out occult disease as a contributing factor to the patient's weight loss is recommended.

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Empirically, hospitalization with cholangiohepatitis protocol, as-needed gastrointestinal support, and continued monitoring of hepatic and clinical response would be reasonable. No evidence of post hepatic obstructive criteria.

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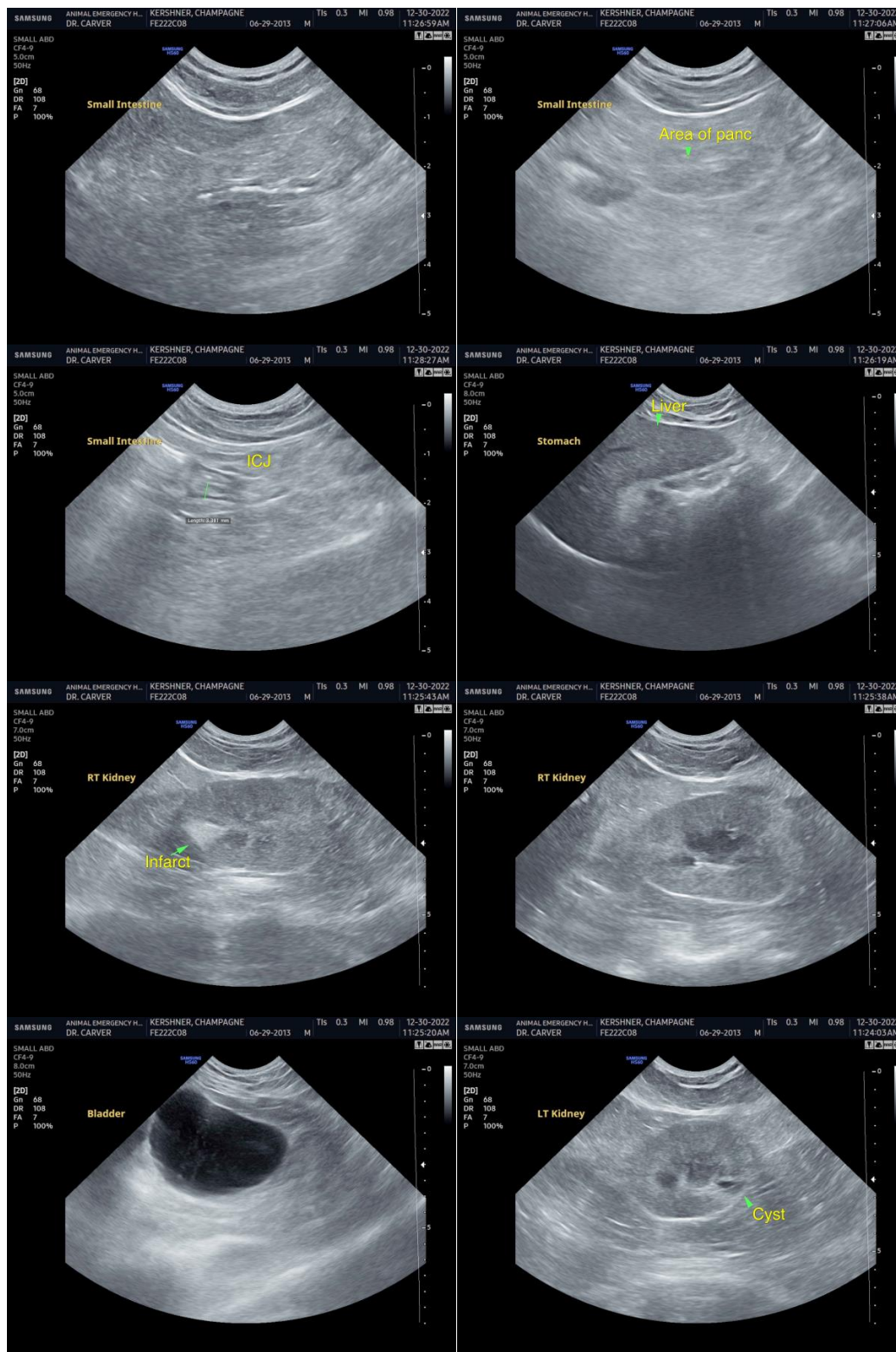
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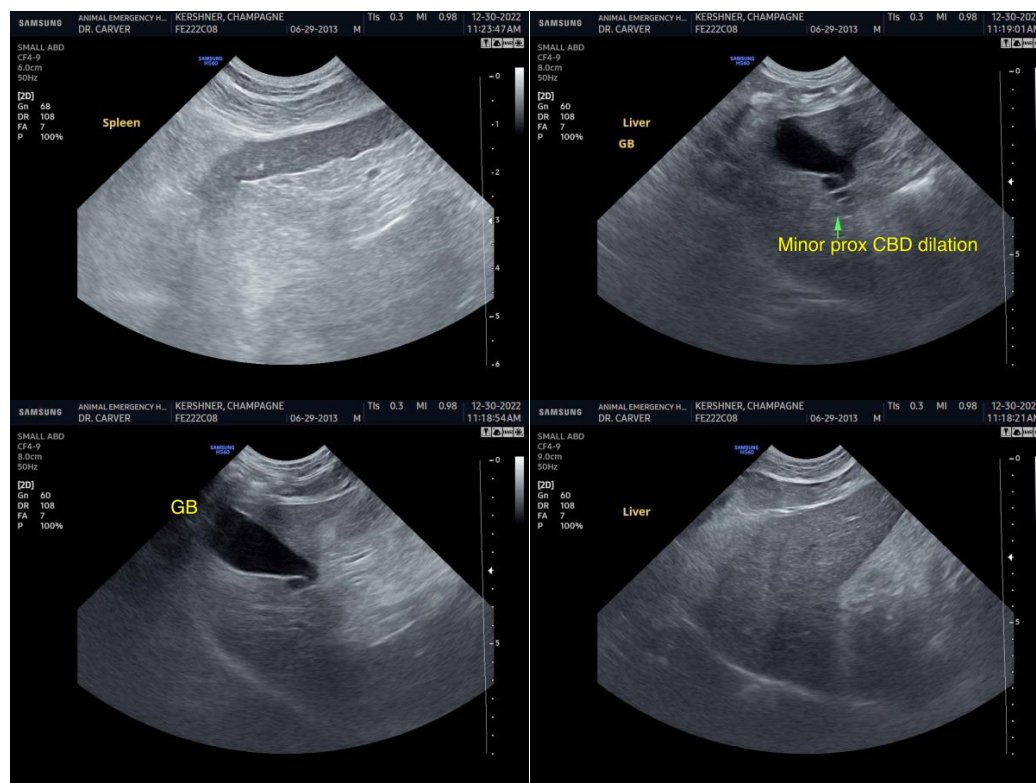
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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