

**PATIENT**

Kali Brown

**SPECIES**

Feline

**BREED**

DMH

**SEX**

Spayed Female

**AGE**

10 Years

**WEIGHT**

3.83 kg

**INTERPRETED BY**

Tam Mengine, DVM,  
 DABVP (canine/feline  
 practice)

**IMAGING PERFORMED BY**

Crystal Hill

**HOSPITAL NAME**

Vet For Life Animal  
 Hospital

**REFERRING VET**

Dr. Bajaj

**INVOICE**

35580

**DATE**

11/23/25

**PRESENTING CLINICAL SIGNS**

History: Decreased appetite, lethargy, pale MM, decreased body weight past 3-4 weeks. Has been on Doxycycline.

Abnormal PE/Chem/CBC/UA Results: Abdominal rad report was normal. Anemia present HCT 18%, T.P greater than 99g/L, ALP 114 U/L, Total Bilirubin 13umol/L.

**PRESENTING CLINICAL SIGNS**

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is mildly distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted. Urethra visualized to 2.0 cm.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal). The left kidney is 3.9 cm in length. The right kidney is 3.7 cm in length.

**Adrenal Glands**

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The left adrenal gland height is 2.6 mm at the caudal pole. The right adrenal gland height 4.1 mm at the caudal pole.

**Spleen**

The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal. Thickness at the splenic hilus is normal at 6.0 mm.

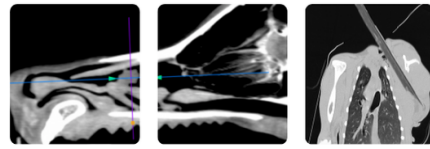
**Liver**

The liver is diffusely hyperechoic and subjectively enlarged, with sharp borders and a homogenous echotexture. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents and a small amount of freely moveable echogenic sludge. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

**Gastrointestinal**

The stomach is empty. The gastric wall is subjectively normal in thickness, and exhibits appropriate wall layering, but cannot be accurately measured due to normal deviations of the rugal folds. The pylorus is of normal appearance.



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The small bowel has diffuse changes to the normal 1:3 muscularis to mucosa ratio. Wall measurements are increased up to 2.4 mm for duodenum and 2.8 mm for jejunum. Overall wall layering is preserved. Intestinal motility appears normal.

The visible portions of the colon are of normal thickness, up to 1.4 mm, with intact wall layering. The ileocecal junction is visualized and appears normal.

**Pancreas**

The areas of the limbs and body of the pancreas are isoechoic to the surrounding mesenteric fat, with normal capsular appearance. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

**Free Abdomen**

There is no evidence of free fluid within the peritoneal cavity. The omentum and intra-abdominal fat are of appropriate echogenicity. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

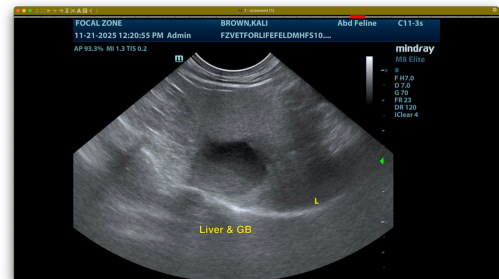
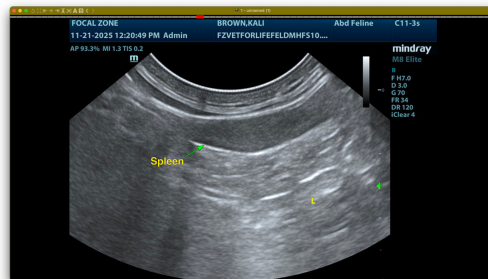
**ULTRASONOGRAPHIC FINDINGS**

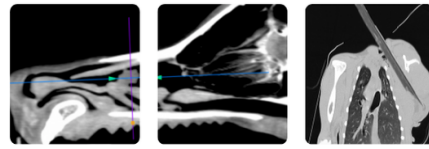
- Hyperechoic liver, and gallbladder with a small amount of sludge.
- Diffuse small bowel changes, typical of infiltrative bowel disease.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The appearance of the liver is nonspecific and might be seen with a reactive hepatopathy, inflammatory disease, hepatic lipidosis, or less likely infiltrative neoplasia. While gallbladder sludge can be an incidental finding, in the presence of a mildly elevated ALP and changes to the liver parenchyma, this may also be associated with cholangiohepatitis. The significance of the small intestinal changes is uncertain, given that there is no reported history of gastrointestinal signs. A full GI panel may be helpful in determining whether this pathology is significant, although intestinal biopsy would be needed for definitive diagnosis.

Fine needle aspiration of the liver would be recommended, if coagulation parameters are normal, for definitive diagnosis. It is possible that the elevated bilirubin is actually due to hemolysis and not indicative of hepatic disease. Serial monitoring of other liver values, including the bilirubin, is recommended to determine whether these values are increasing.





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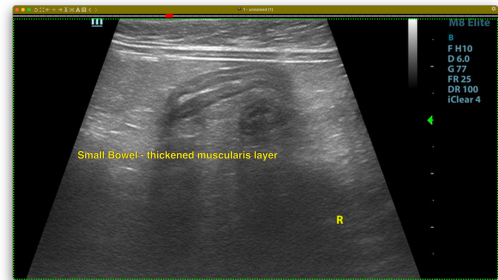
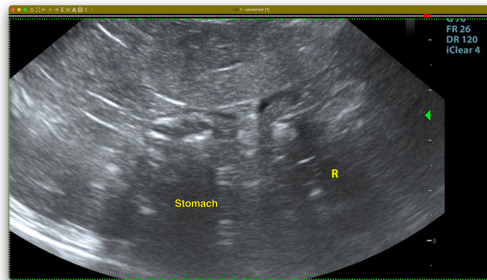
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Tam Mengine, DVM, DABVP (canine/feline practice)

info@SonoPath.com