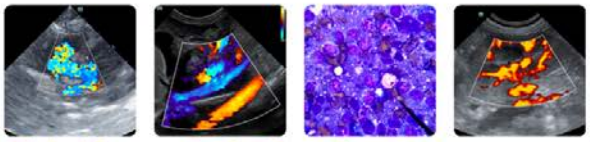


PATIENT

Peanut Lomeli

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed Female

AGE

3 Years

WEIGHT

12.81

INTERPRETED BY

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

IMAGING PERFORMED BY

Celia Galanti, DVM

HOSPITAL NAME

Craig Road Animal Hospital

REFERRING VET

Celia Galanti, DVM

INVOICE

72795

DATE

12/28/25

PRESENTING CLINICAL SIGNS

Previously presented on 12/11/2025: 3-year-old spayed female DSH presenting with 2-day history of lethargy and anorexia following recent weight loss. Physical exam notable for pale mucous membranes, mild dehydration, and historical umbilical hernia. Chemistry panel revealed significantly elevated liver enzymes (ALT 297, ALP 263) and hyperbilirubinemia (5.2 mg/dL) with icteric serum, consistent with hepatic lipidosis. Patient has been started on IV fluid therapy, gastroprotectants, and appetite stimulant with syringe feeding as needed. Owners are cost-constrained and declined abdominal ultrasound; plan is for 12-24 hours of supportive care with feeding tube placement if patient remains anorexic, and recheck chemistry in 24 hours.

Abnormal PE/Chem/CBC/UA Results: Updated bloodwork as of 12/26/2025 FeLV/FIV: negative CBC/Chem: anemia, (HCT 22.9), neutrophilia with monocytosis, elevated ALP (96), hyperbilirubinemia (6.5), hyperglycemia (213), hypoalbuminemia (1.9), hypocholesterolemia (58), hyponaremia (142), hypokalemia (2.9), hypochloremia (104)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. A large amount of echogenic luminal material is present, typical of mucus. The ureteral papillae, trigone and pelvic urethra (visualized to 2.0 cm) are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted.

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). Left measured 4.0 cm. Right measured 4.2 cm.

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. Left measures 3.6 mm. Right measured 4.0 mm.

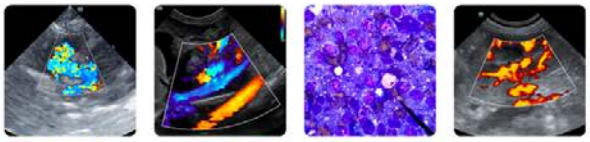
Spleen

The spleen is diffusely thickened, measuring 1.3 cm at the hilus. The capsular margins are regular and the parenchyma is normal. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.

Liver

The liver is diffusely hyperechoic and subjectively enlarged, with rounded margins 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.



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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.

The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. Intestinal motility appears normal.

The visible portions of the colon are of normal thickness (1.4 mm) with intact wall layering. The ileocecal junction is not seen.

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 scant free fluid noted throughout the abdomen, particularly in the region of the liver. There is hyperechoic, inflamed omental fat noted in the region of spleen. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Diffusely rounded, hyperechoic liver
- Mildly thickened spleen with associated steatitis
- Small amount of anechoic free fluid - suspect secondary to the low albumin, though an inflammatory cause cannot be excluded.

SECONDARY FINDINGS

- Mucoid bladder sediment - likely incidental, but urinalysis recommended if not recently performed, to rule out cystitis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Determining the definitive cause of this patient's clinical signs may be challenging on a limited budget. The diffusely hyperechoic spleen, rounded spleen may indeed be secondary to hepatic lipidosis, but may also reflect infiltrative disease such as lymphoma or FIP, or infectious / inflammatory disease. Similarly, the thickened, inflamed spleen may be due to inflammation (as might be seen with an infectious hemolytic anemia) or infiltrative disease such as lymphoma or FIP. Thus, if coagulation parameters are normal, fine needle aspiration of both the liver and spleen would be recommended for definitive diagnosis.

It is also not clear whether the hyperbilirubinemia is due to hemolytic anemia, primary hepatic disease, or both. The low albumin and cholesterol would support hepatic failure, but concurrent hemolysis cannot be excluded. The presence or absence of bilirubinuria would help further clarify this.

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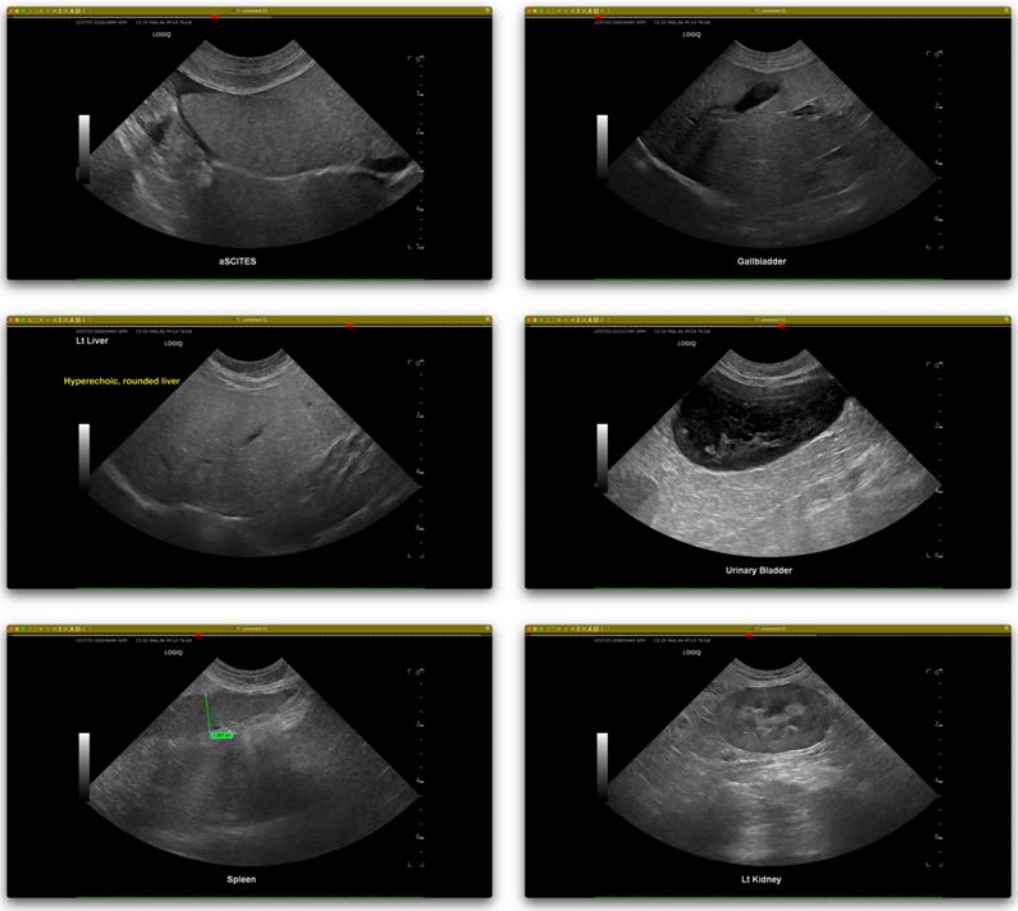
If an "empiric treatment" approach is desired, then treating for both infiltrative / inflammatory hepatic diseases, as well as infectious causes of anemia & splenitis, could be attempted with the following approach, and a guarded prognosis:

- Initiation of liver support therapies such as SAMe, Milk Thistle, Vitamin E and ursodiol
- Symptomatic management, as needed, for inappetence, nausea or diarrhea, including a feeding tube
- Broad spectrum antibiotic therapy, such as a combination of amoxicillin or amoxi-clav, in combination with a fluoroquinolone, is recommended. If recheck lab values in 1 week show significant improvement, then a 4-6 week total course of antibiotics is recommended. If there is no response to empiric antibiotic therapy, then treatment with corticosteroids (such as prednisone at 2mg/kg/day) could be attempted.



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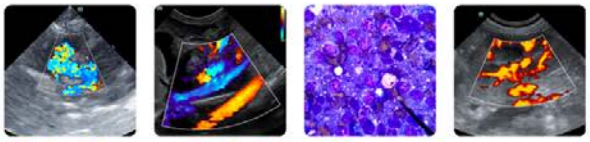

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@SonoPath.com