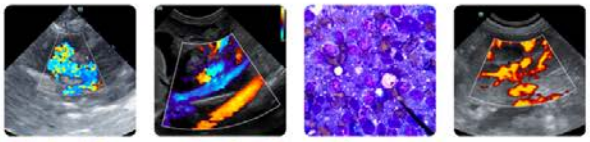


PATIENT

Teddy Garcia

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered Male

AGE

4 Years

WEIGHT

5.9 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Melissa Wilberger

HOSPITAL NAME

Wilvet South

REFERRING VET

Dr. Melissa Wilberger

INVOICE

72789

DATE

2/8/26

PRESENTING CLINICAL SIGNS

History of suspected inflammatory bowel disease (due to chronic diarrhea since rescued), diagnosed herpes respiratory virus URI in Feb 2025, and atopy. P maintained on cyclosporine, prednisolone, and tylosin for atopy and suspected IBD. Presented 2/6/2026 as O assuming URI flare occurred, and P not eating and requested outpatient SQF.

Abnormal PE/Chem/CBC/UA Results: P re-presented on 2/7/2026 with icterus, severe lethargy, and dehydrated. HCT 22.7%, rest of CBC wnl, Chem: ALT 558U/L, GGT 16 U/L, TBili 2.5 mg/dL, BUN 15mg/dL, albumin 2.3 mg/dL, K+ 3.1; UA: USG 1.050, bili 6 mg/dL, urobili 8mg/dL, protein 100mg/dL, pH 6.5. Blood smear pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

Both kidneys are of normal size and shape and exhibit appropriate cortico-medullary differentiation. There is mild pyelectasia present in left kidney, with anechoic contents. The renal pelvic fat is of normal echogenicity. There is no evidence of nephrolithiasis, mineralization, or hydronephrosis. The proximal ureters are not visible (normal). Left kidney measures 4.5 cm. Right kidney measures 4.5 cm.

Adrenal Glands

The left adrenal gland is identified in its normal location. It is of normal size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The left adrenal gland measures 3.5 mm at the caudal pole. The right adrenal gland is not distinctly visualized, but the region appears unremarkable.

Spleen

The spleen is of appropriate size (8.5 mm) 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.

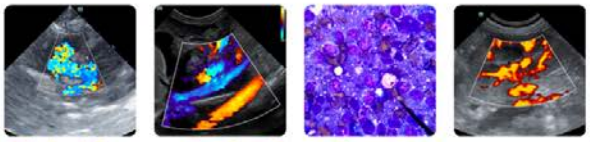
Liver

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is markedly distended with anechoic contents and a small amount of echogenic sludge. The wall is thickened to 2.0 mm without evidence of rupture. The cystic and common bile ducts are dilated to 7.3 mm and surrounded by hyperechoic omental fat.

Gastrointestinal

The stomach is moderately distended with fluid. The gastric wall is 2.4 mm with normal deviations due to rugal folds, and exhibits appropriate wall layering. The pylorus is of normal appearance.



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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 (1.1 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 no free fluid noted within the abdomen. There is hyperechoic, inflamed omental fat noted in the region of the common bile duct. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Mildly thickened gallbladder wall with sludge and dilated common bile duct with associated steatitis

SECONDARY FINDINGS

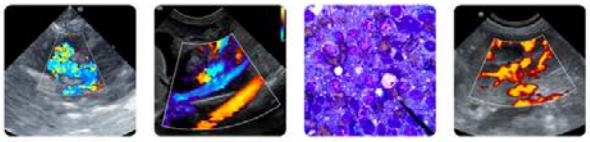
- Mild pyelectasia of the left kidney

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes in the gallbladder and common bile duct support a hepatic or post-hepatic cause for the elevated liver values, although concurrent hemolytic anemia is also possible. The distal aspect of the bile duct and duodenal papilla are not visualized, and so it is not clear whether there is a biliary obstruction present, or just inflammation (ie cholecystitis). The pyelectasia in the left kidney is likely incidental if the patient recently received fluid therapy, particularly given the lack of inflammatory change on urinalysis.

Recommended next steps include:

- Serial monitoring of the total bilirubin - continued rapid increases would increase concern for biliary obstruction
- Evaluation of pancreatic markers, to assess for the possibility of extrahepatic biliary obstruction secondary to pancreatitis. Although the pancreas appears normal, serum markers may become elevated prior to development of sonographic changes in acute pancreatitis.
- Recheck ultrasound with sedation, and/or CT scan, to further evaluate for the possibility of obstruction at the level of the duodenal papilla
- Cholecentesis with a 25G needle for cytology and culture could be performed, if the operator is comfortable with this procedure - the entire gallbladder should be drained using a 5 or 12 cc syringe. Approach through the hepatic parenchyma, either subcostally or intercostally, is recommended to minimize bile leakage.



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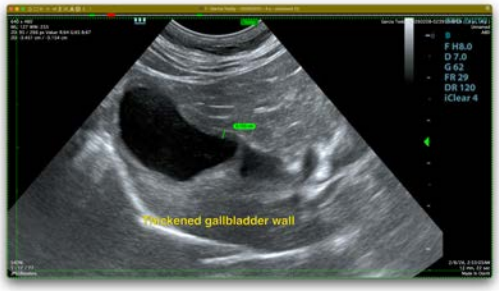
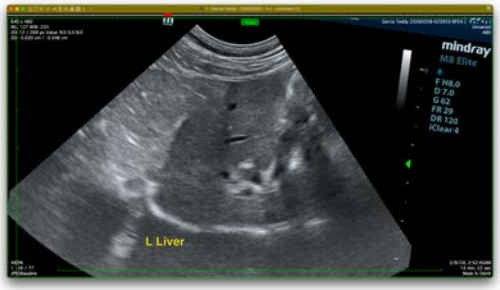
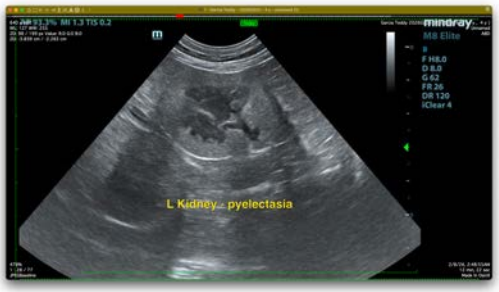
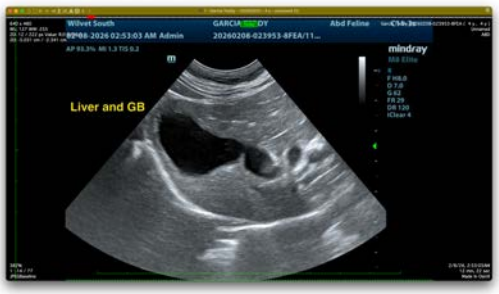
- Empiric treatment with a fluoroquinolone, metronidazole and ursodiol could be considered if cholecentesis is not feasible









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