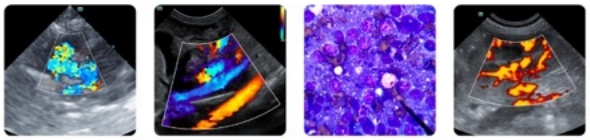


PATIENT

Willow Offenbacker

SPECIES

Feline

BREED

British Shorthair

SEX

Spayed female

AGE

11 years

WEIGHT

5.76 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Ugorji

HOSPITAL NAME

Craig Road AH

REFERRING VET

Dr. Ugorgi

INVOICE

70029

DATE

1/12/26

PRESENTING CLINICAL SIGNS

History: Willow is a 12-year-old FS British Shorthair presenting for vomiting, hematochezia with diarrhea, lethargy, and chronic weight loss. Owner reports good appetite, eats eagerly and receives additional feedings at work, yet continues to lose weight. Vomiting occurred 2 days ago (hairball after eating) and occurs about once weekly, often after eating too fast. Hematochezia with diarrhea and tenesmus was noted yesterday at work with 2 defecations. Owner notes mild behavior change with decreased early morning activity but remains ambulatory and interactive. History of IVDD diagnosed April 2025. Owner has been adding water to food to support hydration and weight gain. Stool sample provided today. No explicit changes in drinking or urination reported. No current coughing noted since relocating from Chicago where occasional coughing resembling asthma occurred historically.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the urinary bladder wall appears thin and smooth. The urine is anechoic. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no sonographic evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 3.55×1.76 cm, with a cortical thickness of 0.33 cm in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler demonstrates a normal perfusion pattern.

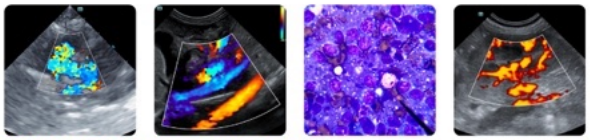
The right kidney is normal in shape and size, measuring 3.75×1.70 cm, with a cortical thickness of 0.29 cm in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler demonstrates a normal perfusion pattern.

Adrenal Glands

Both adrenal glands demonstrate normal shape and echogenicity. The left adrenal gland measures approximately 0.22 cm at both the cranial and caudal poles. The right adrenal gland measures approximately 0.22 cm at the cranial pole and 0.27 cm at the caudal pole.

Spleen

Splenic thickness measures 0.58 cm. The splenic parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.



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Liver

The liver is subjectively normal in size, with sharp margins and a regular contour. The hepatic parenchyma is homogeneous and isoechoic relative to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The gallbladder wall is thin, and the contents are predominantly anechoic with a very small amount of biliary sludge. No dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and folded, with a mural thickness of approximately 1.32 mm and preserved wall layering. The pyloric wall measures approximately 3.70 mm, with the muscularis layer measuring approximately 1.38 mm.

Duodenal wall thickness measures approximately 1.98 mm. Jejunal wall thickness measures approximately 3.00 mm, with the mucosa measuring approximately 1.79 mm, the submucosa approximately 0.88 mm, and the muscularis propria approximately 0.18 mm. Ileal wall thickness measures approximately 1.46 mm, with the mucosa measuring approximately 0.63 mm, the submucosa approximately 0.68 mm, and the muscularis propria approximately 0.26 mm. Wall layering is preserved throughout. The ileocecal junction measures approximately 3.19 mm, with a muscularis thickness of approximately 1.32 mm. No sonographic signs of obstruction, ileus, or foreign material are identified.

The colonic wall measures approximately 0.60 mm, with formed fecal material present in the descending colon.

Pancreas

The pancreas measures approximately 4.74 mm in thickness. Pancreatic parenchyma is isoechoic relative to the adjacent omental fat. The pancreatic duct measures approximately 1.01 mm in diameter. No sonographic evidence of active inflammation or neoplastic disease is identified.

Peritoneal Cavity

No abdominal effusion or sonographic signs of peritonitis are observed. Cranial mesenteric lymph nodes measure approximately 6.60–7.55 mm in thickness and appear mildly rounded and hypoechoic while maintaining an elongated shape. The ileocecal lymph nodes are not visualized; however, the surrounding regions appear unremarkable. The pancreaticoduodenal lymph node measures approximately 4.02×2.97 mm and demonstrates normal shape and echogenicity. The iliac trifurcation appears normal.

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ULTRASONOGRAPHIC FINDINGS

- Mild diffuse small intestinal wall thickening.
- Disproportionate muscularis thickening at the ileum and ileocecal junction, with preserved wall layering.
- Ileocecal junction thickening with prominent muscularis layer.
- Mild enlargement of cranial mesenteric lymph nodes, mildly rounded and hypoechoic.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominal ultrasonography demonstrates mild small intestinal wall thickening with preserved wall layering, characterized by disproportionate muscularis thickening at the ileum and ileocecal junction. Moderate enlargement and hypoechogenicity of the cranial mesenteric lymph nodes are also present.

This pattern is commonly associated with chronic inflammatory enteropathy in cats, particularly lymphoplasmacytic inflammation. These changes likely reflect chronic muscularis hyperplasia and altered intestinal motility secondary to longstanding inflammation. However, similar muscularis-predominant thickening may also be observed in early small-cell intestinal lymphoma. Due to significant overlap in ultrasonographic appearance, a definitive differentiation between chronic inflammatory enteropathy and early small-cell intestinal lymphoma cannot be achieved based on imaging alone.

Recommendations

- Measurement of serum cobalamin and folate is strongly recommended.
- Endoscopic intestinal biopsies are recommended as the next diagnostic step to differentiate chronic inflammatory enteropathy from early small-cell intestinal lymphoma.
- Dietary management with a novel protein or hydrolyzed diet and anti-inflammatory therapy may be considered. Cobalamin supplementation is recommended if deficiency is identified. If intestinal biopsies are planned, initiation of corticosteroid therapy should be deferred until histopathologic sampling has been completed.
- Follow-up abdominal ultrasonography is recommended to monitor intestinal wall thickness and lymph node size.

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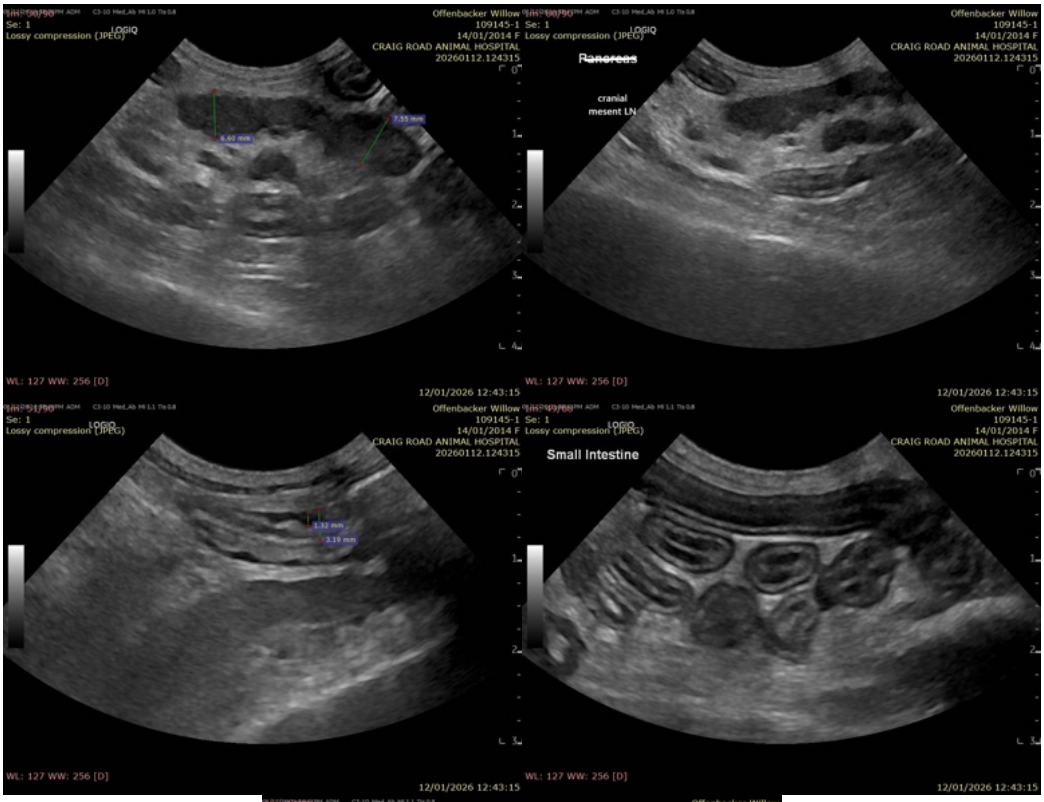

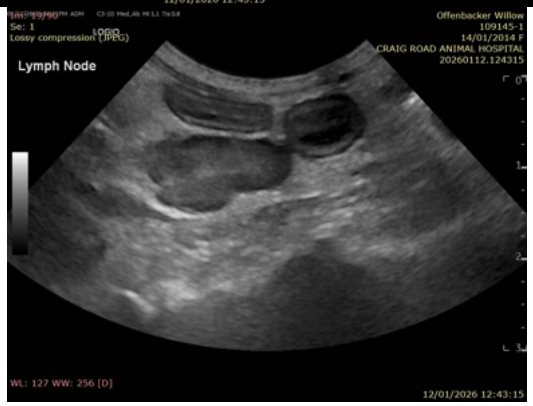

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

info@SonoPath.com