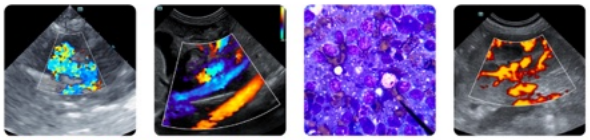


PATIENT

Jack Newman

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

15 years

WEIGHT

11.38 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Cathleen Whitcraft, DVM

HOSPITAL NAME

Craig Road AH

REFERRING VET

Dr. Whitcraft

INVOICE

70107

DATE

1/13/26

PRESENTING CLINICAL SIGNS

History: Long time managed diabetic. Over the last few months his apatite has decreased. Bloodwork has been unremarkable and glucose curve has been good.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the bladder wall appears thin and smooth. The urine is predominantly anechoic with scant suspended echoes. 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 3.90×3.15 cm, with a cortical thickness of 0.35 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 4.00×2.89 cm, with a cortical thickness of 0.40 cm in the sagittal plane. In both kidneys, the renal cortex is mildly hyperechoic relative to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

Both adrenal glands are visualized and demonstrate normal shape and echogenicity. Left adrenal gland: 0.32 cm (cranial pole), 0.40 cm (caudal pole). Right adrenal gland: 0.40 cm (cranial pole), 0.41 cm (caudal pole)

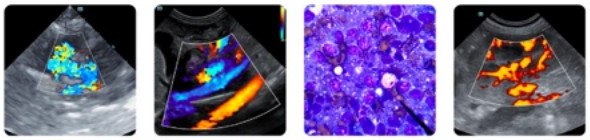
Spleen

Splenic thickness measures 0.62 cm. The splenic parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

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 normal echotexture. No hepatic lymphadenopathy is observed.

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



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Gastrointestinal

The stomach is empty and folded, with mural thickness ranging from 1.52 to 1.91 mm, and preserved wall layering.

The jejunum measures 2.12–2.45 mm, with approximate layer measurements as follows: mucosa: 1.17 mm, submucosa: 0.60 mm, muscularis propria: 0.65 mm.

The ileum measures 1.36 mm, with preserved wall layering mucosa: 0.35 mm, submucosa: 0.61 mm, muscularis propria: 0.28 mm

The ileocecal junction measures 2.70 mm, with a muscularis thickness of 0.86 mm.

Mild corrugation of selected small intestinal segments is observed, without associated focal mural thickening or loss of wall layering.

The colon (ascending segment) measures 0.64 mm, with preserved layering. Formed fecal material is present in the descending colon.

Pancreas

The pancreatic right limb (6.81 mm), body (6.89 mm), and left limb (6.46 mm) are visualized. The pancreatic margins are mildly irregular, and the parenchyma is diffusely hypoechoic relative to the adjacent omental fat. The pancreatic duct measures approximately 0.57–0.67 mm. No peripancreatic fat inflammation or abdominal effusion is identified.

Peritoneal Cavity

No abdominal effusion or sonographic evidence of peritonitis is observed. Cranial mesenteric and ileocecal lymph nodes are not visualized, and the surrounding regions appear unremarkable. The iliac trifurcation appears normal.

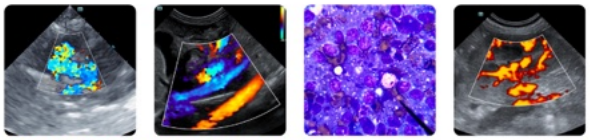
ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Mild pancreatic enlargement with hypoechoic parenchyma and mildly irregular margins. No peripancreatic fat inflammation or abdominal effusion.
- Moderate biliary sludge within a normally distended gallbladder.
- Gastrointestinal tract with preserved wall layering and no mass lesions.
- No abdominal lymphadenopathy.

SECONDARY FINDINGS

- Mild, diffuse bilateral renal cortical hyperechogenicity with preserved corticomedullary definition.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pancreatic ultrasonographic appearance is most compatible with chronic pancreatitis in cats; however, ultrasonography cannot reliably differentiate chronic disease from an acute exacerbation of chronic pancreatitis.

The kidneys are normal in size and shape but demonstrate mild, diffuse bilateral cortical hyperechogenicity with preserved corticomedullary definition, consistent with early or subclinical chronic kidney disease. These findings correlate with the mildly increased SDMA and proteinuria noted on laboratory evaluation and are commonly encountered in geriatric feline patients, particularly those with longstanding diabetes mellitus.

The hepatobiliary system is largely unremarkable, aside from moderate biliary sludge within a normally sized gallbladder, a common incidental finding in older cats with hyporexia and not suggestive of clinically significant biliary obstruction in the absence of ductal dilation or hepatic enzyme abnormalities.

No abdominal lymphadenopathy or effusion is identified.

The gastrointestinal tract demonstrates preserved wall layering and measurements largely within expected limits, without evidence of obstructive disease or mass lesions. Mild corrugation of selected small intestinal segments is noted, along with a mild relative prominence of the muscularis layer at the ileocecal junction. These findings are considered mild and nonspecific and may reflect reactive or functional changes, such as altered motility or low-grade inflammatory activity, particularly when interpreted in the context of concurrent pancreatic disease.

Overall, the imaging findings, in conjunction with the clinical and laboratory data, support a diagnosis of chronic pancreatitis, likely contributing to the patient's decreased appetite, with early chronic kidney disease as a concurrent comorbidity. No ultrasonographic evidence of gastrointestinal neoplasia, significant hepatobiliary disease, or acute abdominal pathology is identified at this time.

Recommendations

- Consider supportive medical management even in the absence of acute inflammatory signs.
- Consider serial monitoring of pancreatic markers (Spec fPL/PSL) if clinically indicated.
- Continue routine diabetic monitoring, as pancreatic inflammation may affect glycemic control over time.
- Monitor renal parameters (SDMA, creatinine, UPC, blood pressure) consistent with early-stage CKD management.

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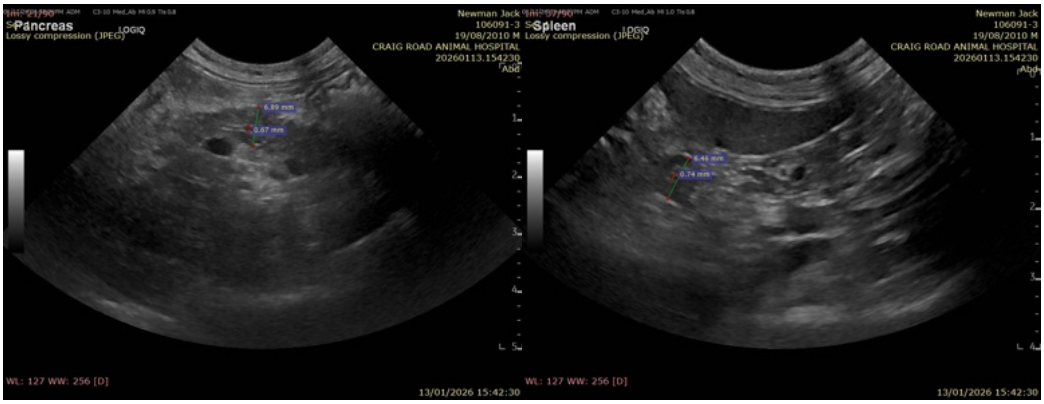

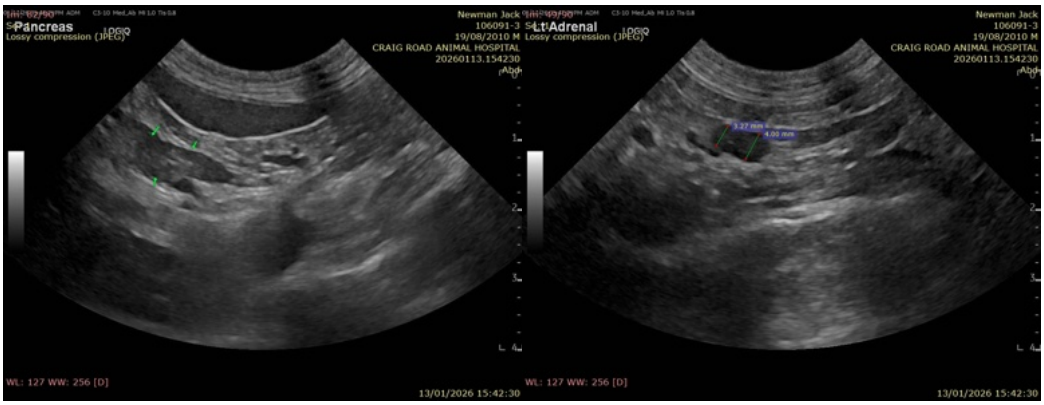

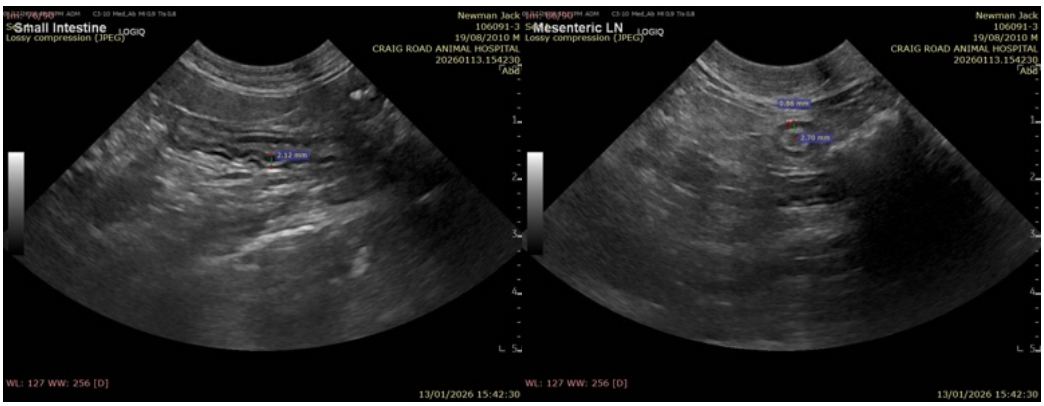

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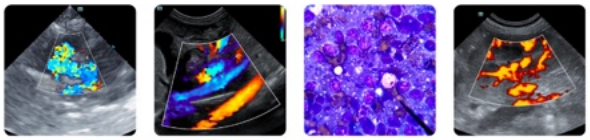

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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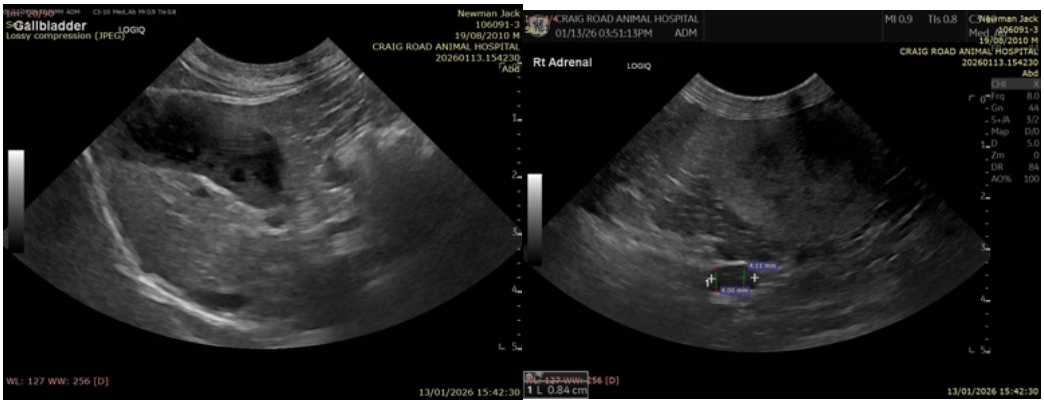

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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