



PATIENT

Updo PHVA

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

11 months

WEIGHT

6.6 lbs

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Dr. Meaghan Godwin

HOSPITAL NAME

Wellesley AH

REFERRING VET

Dr. Leal

INVOICE

70108

DATE

1/13/26

PRESENTING CLINICAL SIGNS

History: P has been having liquid stools since May 5 2025. P has had fecal floats done and they have been negative. P has had Forta Flora, psyllium husk, and various prescription food. P first started on EN both wet and dry. After 2 weeks poop was still the same. Stopped feeding the wet to see if it made a difference, no change. P was then tried on Biome for a month. No change, P still had liquid diarrhea. Tried hydrolyzed protein food. P stools were still very loose. The whole time the P has been on probiotics. For the last couple of months P has been on Purina Pro Plan Sensitive Skin and Stomach. At times P may have a day or two of very soft serve stools. Then still goes back to complete liquid. P is now crying when she poops in the litter box. Foster has stated cat is not very happy.
Abnormal PE/Chem/CBC/UA Results: CBC/chem/T4: pending Diarrhea PCR: pending

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 anechoic. The bladder neck and proximal urethra have a normal appearance. 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 2.90×1.98 cm, with a cortical thickness of 0.26 cm in the sagittal plane. The renal cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

The right kidney is normal in shape and size, measuring 3.24×1.71 cm, with a cortical thickness of 0.25 cm in the sagittal plane. The renal cortex is isoechoic compared 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: 0.25 cm (cranial pole), 0.23 cm (caudal pole).
- Right adrenal gland: 0.25 cm (cranial pole), 0.27 cm (caudal pole).

Spleen

Splenic thickness is 0.87 cm. The splenic parenchyma demonstrates normal echogenicity and 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 uniform and isoechoic relative to the falciform fat, with normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The gallbladder wall measures 0.96 mm and is thin. The gallbladder contents are anechoic. The common bile duct measures 1.86 mm, within normal limits.

Gastrointestinal

The stomach is empty and folded, with a mural thickness of 1.33 mm and preserved wall layering.

The duodenum measures 1.93 mm and appears within normal limits.

The jejunum measures 2.30–2.33 mm, with the following approximate layer measurements:

- Mucosa: 1.16 mm, Submucosa: 0.56 mm, Muscularis propria: 0.44 mm.

The ileum measures 1.69 mm, with preserved wall layering:

- Mucosa: 0.60 mm, Submucosa: 0.70 mm, Muscularis propria: 0.25 mm.

The ileocecal junction is not visualized.

The colon wall measures approximately 2.0–2.37 mm, with preserved layering. Luminal content is scant and semi-liquid, with some formed fecal material in the descending colon.

Pancreas

The pancreatic right limb (5.45 mm) and left limb (5.66 mm) are visualized and appear within normal limits. Pancreatic parenchyma is mildly hypoechoic relative to the adjacent omental fat. The maximum diameter of the pancreatic duct measures 1.23 mm. No sonographic evidence of active pancreatitis or pancreatic neoplasia is identified.

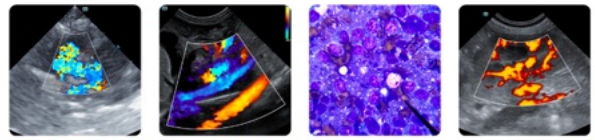
Peritoneal Cavity

No abdominal effusion or peritonitis is observed.

Cranial mesenteric lymph nodes measure approximately 3.87–4.15 mm, appear elongated, and are mildly hypoechoic.

Ileocecal lymph nodes are not visualized.

The pancreaticoduodenal lymph node measures 3.22×5.63 mm.



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ULTRASONOGRAPHIC FINDINGS

- Mild to moderate colonic wall thickening with preserved mural layering. Scant, semi-liquid colonic contents.
- Mild enlargement and hypoechogenicity of cranial mesenteric lymph nodes, morphologically normal and likely reactive.
- Small intestinal segments within normal limits, with preserved wall layering.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominal ultrasonography demonstrates mild to moderate colonic wall thickening with preserved mural layering, associated with mild enlargement and hypoechogenicity of the cranial mesenteric lymph nodes, which remain elongated and morphologically normal. The small intestine (duodenum, jejunum, and ileum) appears largely within normal limits, with preserved wall layering and measurements within expected ranges for a young feline patient. No focal intestinal masses, obstructive patterns, or loss of wall stratification are identified.

Given the patient's young age, chronic history of severe, refractory diarrhea, and failure to respond to multiple dietary trials and probiotic supplementation, the ultrasonographic findings are most consistent with a chronic inflammatory or infectious colonic process, rather than a primary neoplastic condition. In particular, chronic colitis or inflammatory enteropathy of juvenile onset is considered most likely. The presence of pain or vocalization during defecation further supports a colonic or distal gastrointestinal origin of the clinical signs.

Overall, when interpreted in conjunction with the clinical history, the ultrasonographic findings support a diagnosis of chronic colitis, with infectious etiologies (particularly *Tritrichomonas foetus*) remaining a major consideration in this age group. Definitive diagnosis will depend on pending fecal PCR results and clinical response to targeted therapy.

Recommendations

- Proceed with fecal diarrhea PCR testing, with particular attention to *Tritrichomonas foetus* and *Giardia* spp., given the patient's age and clinical presentation.
- Consider empirical antiprotozoal therapy if PCR results are positive or if clinical suspicion remains high despite negative results.
- If infectious causes are excluded and diarrhea persists, medical management for chronic colitis or inflammatory enteropathy (dietary fiber modulation, anti-inflammatory therapy) may be considered.
- Endoscopic evaluation and colonic biopsies may be pursued if clinical signs persist or worsen despite appropriate medical therapy, to further characterize the underlying inflammatory process.



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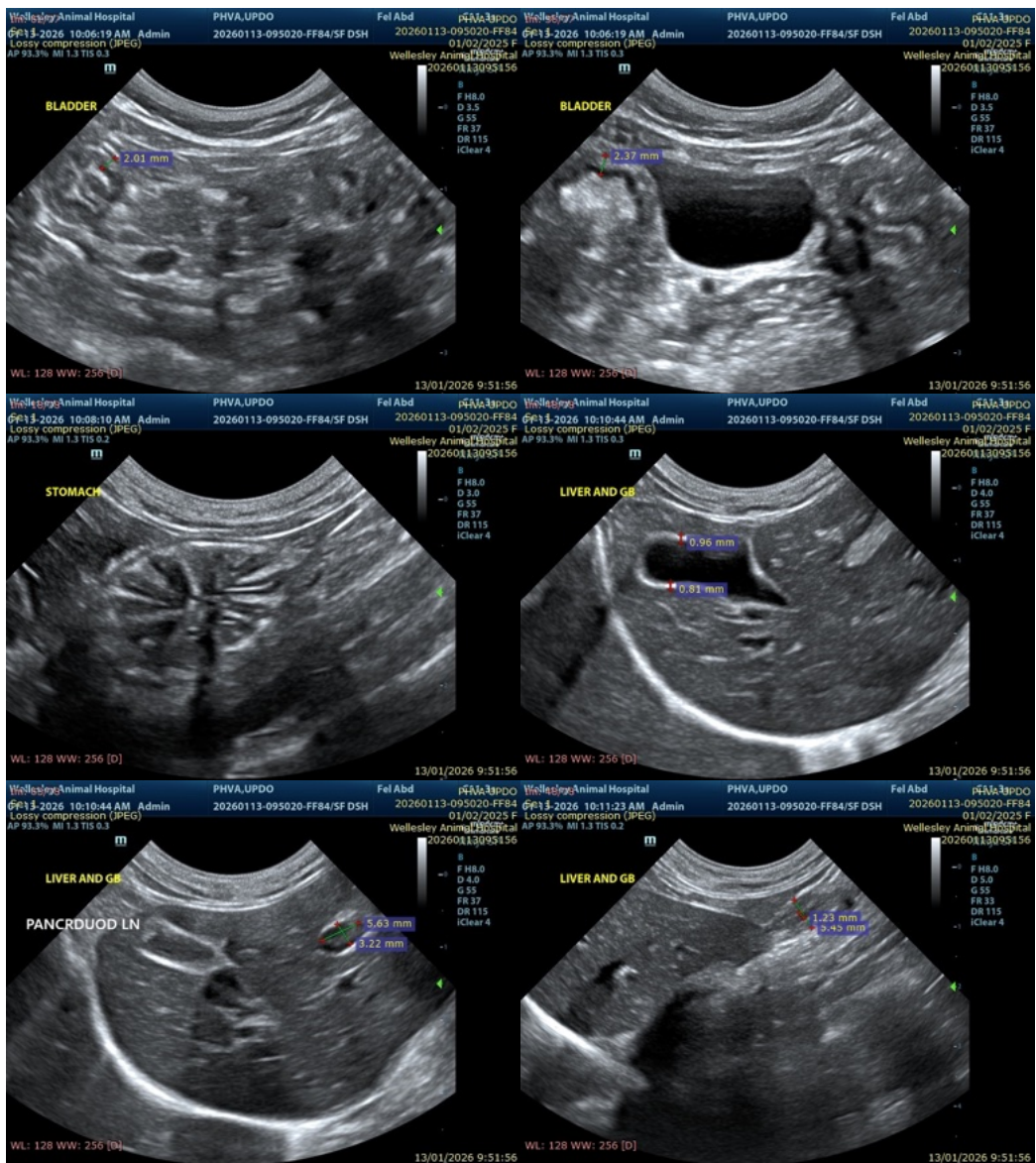
Dr. Leal

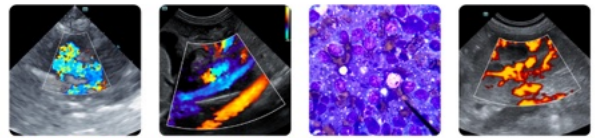
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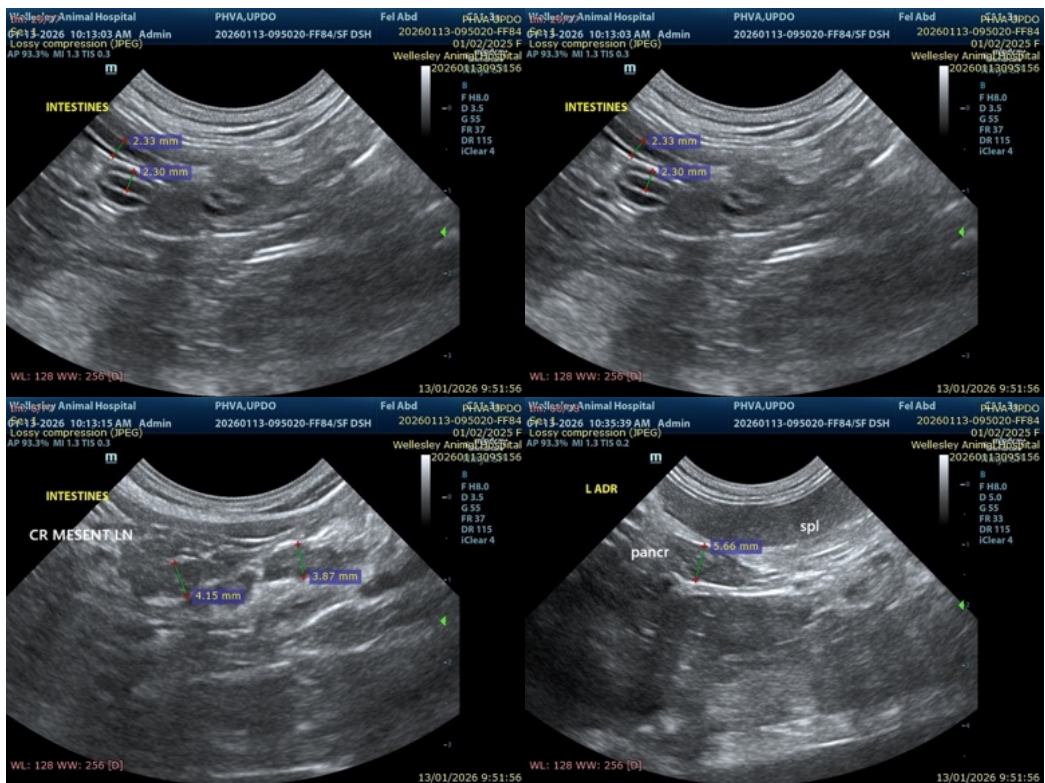
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

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