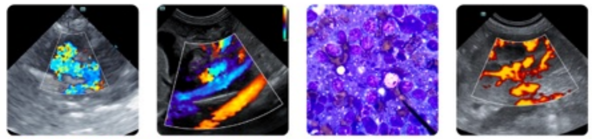


PATIENT
Zoey Gillette

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Spayed female

AGE
10 years

WEIGHT
11.8 lbs

INTERPRETED BY
Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY
Brandi Kurzowski

HOSPITAL NAME
Corfu VC

REFERRING VET
Dr. Garnder

INVOICE
70070

DATE
1/13/26

PRESENTING CLINICAL SIGNS

History: Presumptive diagnosis: Alimentary lymphoma. Extensive thickening of distal jejunum extending to ascending colon noted on palpation. Patient presenting with chronic vomiting and decreased appetite. Weight is stable. Differential diagnoses include infiltrative bowel disease. P did receive a dose of depomedrol at last visit in December 2025.
Abnormal PE/Chem/CBC/UA Results: 12/17/25 Chemistry : Glu 220mg/dL, BUN 12 mg/dL, Phos 3 mg/dL CBC Neut 10.3 k/uL

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 3.95×2.50 cm, with a cortical thickness of 0.47 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. A medullary rim sign is noted. 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 3.82×2.71 cm, with a cortical thickness of 0.53 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

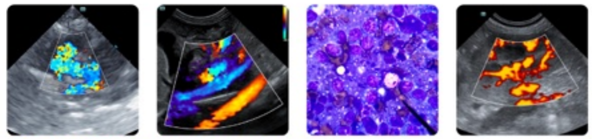
Both adrenal glands are not confidently visualized for detailed evaluation.

Spleen

Splenic thickness measures approximately 0.99 cm. The splenic parenchyma demonstrates normal echogenicity and a 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 a normal echotexture. No hepatic lymphadenopathy is observed.



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The gallbladder lumen is normally distended. The gallbladder wall measures approximately 1.31 mm and appears smooth. The contents are predominantly anechoic. No dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and folded, with a small amount of intraluminal fluid. Gastric mural thickness measures approximately 1.70 mm, with preserved wall layering. The pyloric wall measures approximately 2.34 mm.

Duodenal wall thickness measures approximately 1.66 mm. Jejunal wall thickness measures approximately 1.70–1.85 mm, with the mucosa measuring approximately 1.42 mm, the submucosa approximately 0.52 mm, and the muscularis propria approximately 0.17 mm. Ileal wall thickness measures approximately 1.43 mm. Individual wall layers are very thin and cannot be measured with high precision; however, normal wall layering is preserved.

The ileocecal junction is not visualized. No sonographic signs of inflammation, ileus, or foreign material are identified in the provided video clips.

The colonic wall measures approximately 1.06 mm, with formed fecal material present in the descending colon.

Pancreas

The visualized portion of the pancreas measures approximately 6.40 mm in thickness. The pancreatic parenchyma is isoechoic relative to the adjacent omental fat. The pancreatic duct measures approximately 0.92 mm in diameter. No sonographic evidence of active inflammation or neoplastic disease is identified.

Peritoneal Cavity

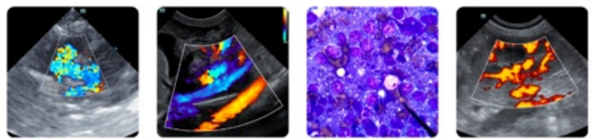
No abdominal effusion or sonographic signs of peritonitis are observed. Cranial mesenteric and ileocecal lymph nodes are not visualized; the surrounding regions appear unremarkable. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

- Medullary rim sign in the left kidney (nonspecific, often incidental).
- Mild gallbladder wall thickness (within acceptable limits) without biliary obstruction.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominal ultrasonography does not demonstrate imaging findings consistent with alimentary lymphoma. The gastrointestinal tract appears within normal limits, with preserved wall layering



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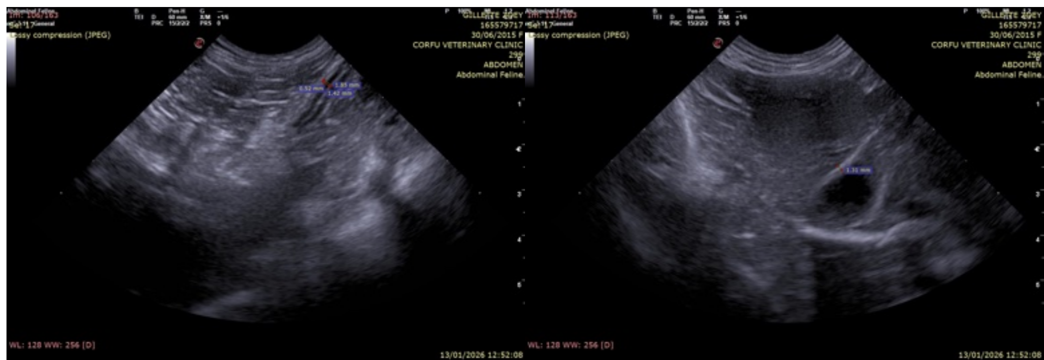
throughout and no evidence of focal or diffuse intestinal thickening, mass formation, or abdominal lymphadenopathy.

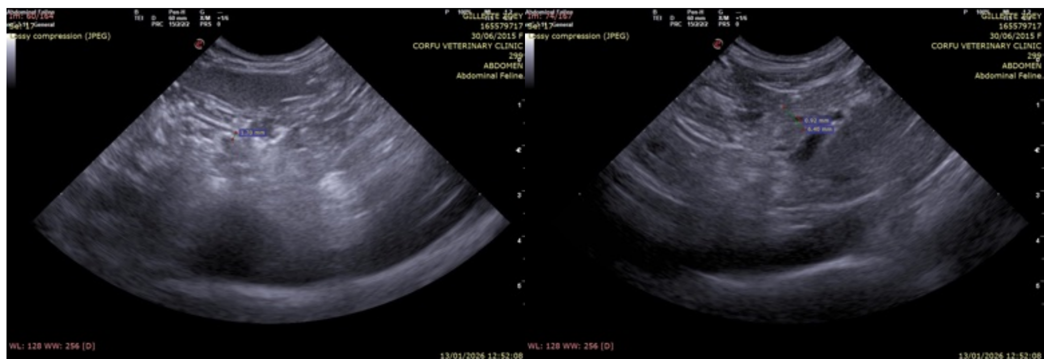
Based on the provided images and video clips, no active infiltrative intestinal disease is identified at this time. However, given the patient's history of chronic gastrointestinal signs and prior administration of corticosteroids, it is acknowledged that the ultrasonographic appearance of intestinal disease may be altered.

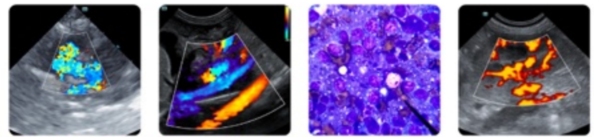
Overall, the abdominal ultrasound examination is largely unremarkable. Clinical information regarding whether alimentary lymphoma has been histologically confirmed, or whether the patient is currently undergoing treatment for lymphoma, is not available. Therefore, the absence of ultrasonographic abnormalities may reflect either a lack of active infiltrative disease or a treatment response, and findings should be interpreted in the appropriate clinical context.

Recommendations

- Clinical correlation is recommended, particularly in light of prior corticosteroid administration, which may transiently alter ultrasonographic findings.
- If gastrointestinal signs persist, worsen, or recur, further diagnostic evaluation may be considered, including measurement of serum cobalamin and folate concentrations and, if clinically indicated, endoscopic or full-thickness intestinal biopsies to definitively differentiate inflammatory bowel disease from alimentary lymphoma.
- Repeat abdominal ultrasonography may be considered if corticosteroids are discontinued or if clinical suspicion for infiltrative intestinal disease remains.







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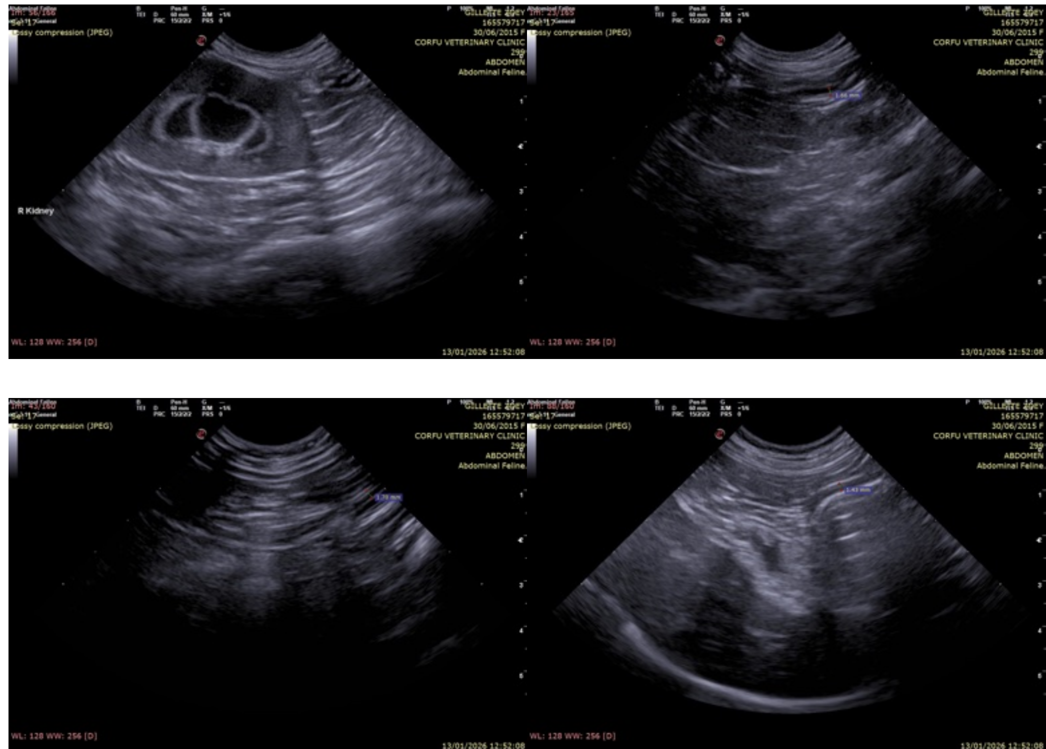

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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