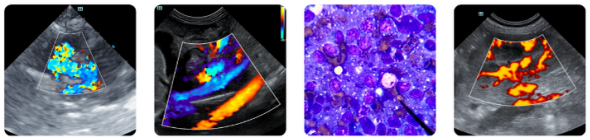


PATIENT

Alibaba Hepler

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

5 years

WEIGHT

11.4 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Amanda Hockenbrock

HOSPITAL NAME

Lewisburg Veterinary Hospital

REFERRING VET

Dr. Meghan Facer

INVOICE

11012

DATE

1/2/2026

PRESENTING CLINICAL SIGNS

Previously vomitting once per night o's changed food to sensitive/hairball and p has started vomiting more frequent p has also started to be more skittish over the last few works.

Abnormal PE/Chem/CBC/UA Results: Tense on palpation of cranial abdomen bloodwork – WNL.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The 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 ultrasonographic evidence of inflammatory or neoplastic disease.
The left kidney is normal in shape and size, measuring 3.95×2.53 cm, with a cortical thickness of 0.42 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 3.92×1.69 cm, with a cortical thickness of 0.39 cm in the sagittal plane.

Both kidneys: The renal cortex is mildly increased in echogenicity relative to the liver, resulting in increased corticomedullary distinction. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

The left adrenal gland measures 0.30 cm at the cranial pole and 0.31 cm at the caudal pole. The right adrenal gland is not visualized.

Spleen

Splenic thickness measures 1.14 cm. The splenic parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

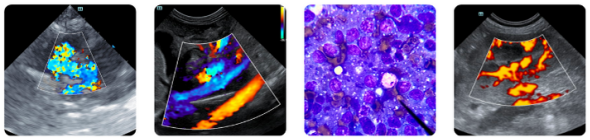
Liver

The liver is subjectively normal in size, with sharp margins and a regular contour. The hepatic parenchyma is uniform 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 primarily anechoic. No dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and mildly folded, with a mural thickness of 1.53 mm and preserved wall layering. The pyloric wall measures 2.59 mm.
The duodenum measures 1.76 mm.
The jejunum measures 1.99 mm, with the following wall layer measurements: mucosa 0.90 mm, submucosa 0.39 mm, and muscularis propria 0.35 mm.
The ileum measures 1.94 mm, with mucosa 0.80 mm, submucosa 0.53 mm, and muscularis propria



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0.49 mm; wall layering is preserved.
The ileocecal junction measures 2.63 mm, with a muscularis thickness of 0.99 mm.

No evidence of gastrointestinal obstruction, ileus, or foreign material is identified.
The colonic wall measures approximately 0.65 mm, with formed fecal material present in the descending colon.

Pancreas

The pancreas is not clearly visualized.

Free Abdomen

No abdominal effusion or evidence of peritonitis is observed. Cranial mesenteric and ileocecal lymph nodes appear unremarkable. The iliac trifurcation appears normal.

PRIMARY FINDINGS

- Mild relative prominence of the intestinal muscularis (ileum and ileocecal junction) with preserved wall layering (nonspecific).
- Mildly increased cortical echogenicity of the kidneys.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach and intestines demonstrate normal wall thickness and preserved layering throughout. While the ileal and ileocecal regions show relative muscularis prominence, the overall wall thickness remains within acceptable limits, and there is no loss of stratification, mass effect, or associated lymphadenopathy. This pattern is nonspecific but can be seen with early or mild chronic inflammatory enteropathy, functional gastrointestinal disease, or dietary intolerance. There is no ultrasonographic evidence to support infiltrative disease or neoplasia at this time.

The pancreas is not visualized; however, there are no secondary ultrasonographic signs (peripancreatic fat reaction, effusion, or regional lymphadenopathy) to support pancreatitis. Given the clinical signs of vomiting and cranial abdominal discomfort, pancreatitis cannot be excluded based on ultrasound alone, particularly in cats.

Renal findings include mildly increased cortical echogenicity of the right kidney, which may represent early or incidental chronic renal change and is unlikely to be clinically relevant to the presenting gastrointestinal signs.

Recommendations

- Institute a strict, single-source diet trial (novel protein or hydrolyzed), with no treats or dietary indiscretions.
- Continuing symptomatic management for vomiting as clinically indicated.
- Consider feline pancreatic lipase testing, recognizing the limited sensitivity of ultrasound for feline pancreatitis.
- Reassess vomiting frequency, appetite, behavior, and body weight over the next 2–4 weeks.
- If vomiting persists or worsens, or if weight loss develops, consider escalation to additional diagnostics (gastrointestinal panel, endoscopy with biopsies), acknowledging that current ultrasound findings do not mandate invasive testing.

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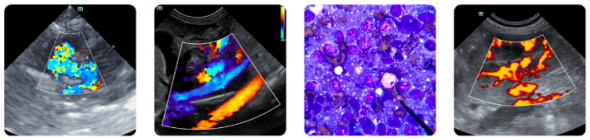

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Educational Teleconsultation Services™

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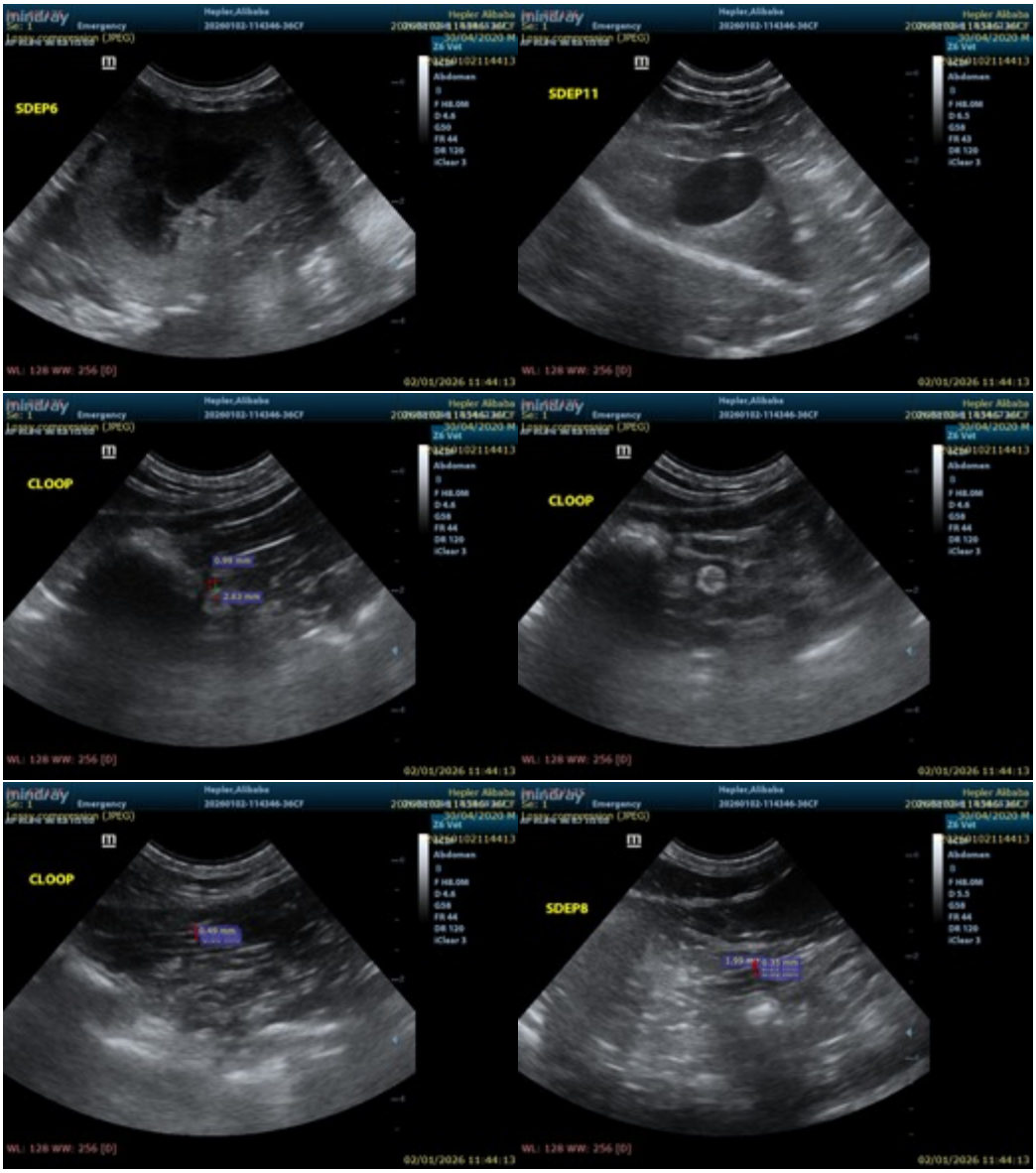

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com