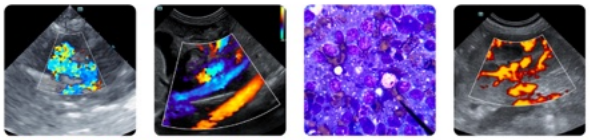


PATIENT

Bindi Staggs

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed femlae

AGE

10 years

WEIGHT

11.9 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Grace Jayne CVT

HOSPITAL NAME

Ark AH

REFERRING VET

Dr. Penraat

INVOICE

70358

DATE

1/21/26

PRESENTING CLINICAL SIGNS

- Bindi presented today for a dental procedure. The owner mentioned that she has been vomiting bile daily for years.
- Albumin 4.2 Sodium 161 Albumin: Globulin Ratio 1.3 Monocytes 0.492 Platelets 450

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. Normal appearance of the bladder neck and proximal urethra. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.87x2.29 cm, and the thickness of the cortex is 0.40 cm, in the sagittal plane. The cortical is isoechogenic compared to liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths or hydronephrosis. Doppler color shows normal pattern.

The right kidney is normal in shape and size: 4.01x2.13 cm, and the thickness of the cortex is 0.38 cm, in the sagittal plane. The cortical is isoechogenic compared to liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths or hydronephrosis. Doppler color shows normal pattern.

Adrenal Glands

The left adrenal gland is partially visualized and measures 0.32 cm. The right adrenal gland measures 0.29 cm at the cranial pole and 0.27 cm at the caudal pole. No adrenal enlargement or focal abnormalities are identified.

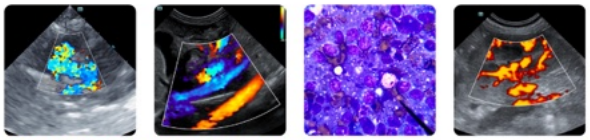
Spleen

Splenic thickness is 0.65 cm. The 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 edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic. No evident dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

Stomach: Empty and folded, with mural thickness measuring 1.86 mm and preserved wall layering.

Pylorus: Wall thickness 2.67 mm.

Duodenum: Wall thickness 1.66 mm.

Jejunum: Wall thickness 3.64 mm. Individual layers measure: mucosa 2.50 mm, submucosa 0.73 mm, muscularis propria 0.51 mm.

Ileum: Wall thickness 4.11 mm. Individual layers measure: mucosa 1.31 mm, submucosa 0.89 mm, muscularis propria 1.63 mm.

Ileocecal junction: Measures 4.88 mm, with muscularis thickness of 2.62 mm.

Wall layering is preserved throughout the gastrointestinal tract.

Colon: Wall thickness 0.74 mm, with formed feces present in the descending segment.

Pancreas

The pancreas measures 5.81 mm in thickness. The pancreatic parenchyma is slightly hypoechoic relative to adjacent omental fat. The pancreatic duct measures 1.04 mm. No ultrasonographic evidence of active pancreatitis or focal pancreatic lesions is identified.

Peritoneal Cavity

No abdominal effusion or evidence of peritonitis is observed. Cranial mesenteric lymph nodes measure approximately 7–8.24 mm. Ileocecal lymph nodes are not clearly visualized. The iliac trifurcation has a normal appearance.

ULTRASONOGRAPHIC FINDINGS

- Jejunal, ileal, and ileocecal wall thickening with preserved layering.
- Disproportionate thickening of the muscularis propria, most notable in the ileum and ileocecal junction.
- Mild enlargement of cranial mesenteric lymph nodes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This abdominal ultrasound demonstrates mild-to-moderate small intestinal wall thickening, most notably involving the jejunum, ileum, and ileocecal region, with preserved wall layering and disproportionate thickening of the muscularis propria, particularly at the ileum and ileocecal junction. This ultrasonographic pattern is most consistent with chronic inflammatory enteropathy, such as

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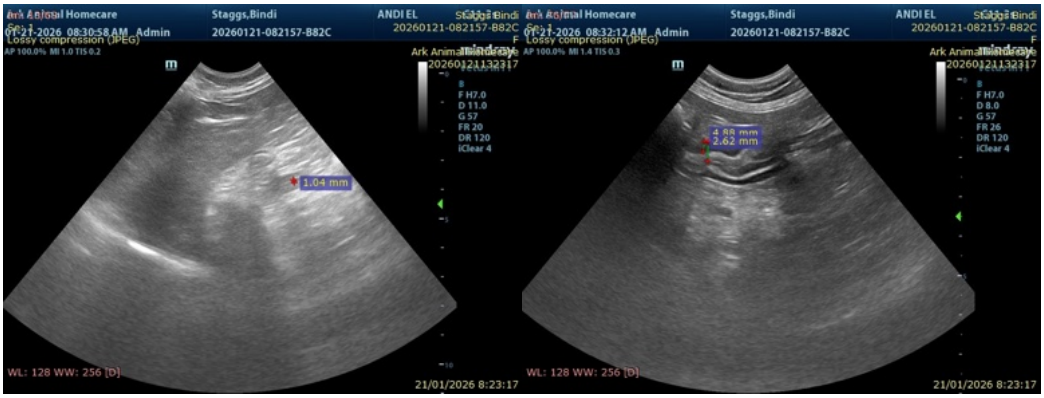
lymphoplasmacytic enteritis, and is commonly reported in cats with long-standing gastrointestinal signs. However, it is acknowledged that ultrasonographic overlap exists between chronic inflammatory bowel disease and low-grade alimentary lymphoma, and definitive differentiation cannot be achieved based on imaging alone.

The stomach does not show significant mural thickening or loss of layering, which is notable given the history of daily bilious vomiting for years. This clinical history, in combination with the largely unremarkable gastric ultrasound findings, supports a functional or chronic inflammatory gastric disorder, such as bile reflux–associated gastritis or chronic gastritis, rather than a primary obstructive or infiltrative gastric disease.

Overall, the imaging findings support a chronic enteropathy, with low-grade alimentary lymphoma remaining an important differential diagnosis.

Recommendations

- Initial medical management for chronic enteropathy is reasonable, including dietary modification (novel protein or hydrolyzed diet) and symptomatic therapy.
- Complete GI panel with serum cobalamin concentration is recommended if not already assessed, with supplementation if deficiency is identified.
- Given the long-standing history of bilious vomiting, medical management for chronic gastritis or bile reflux may be considered.
- Intestinal biopsies may be considered if clinical signs progress, fail to respond to medical management, or if additional systemic abnormalities develop, recognizing the known overlap between inflammatory enteropathy and low-grade lymphoma on ultrasound.



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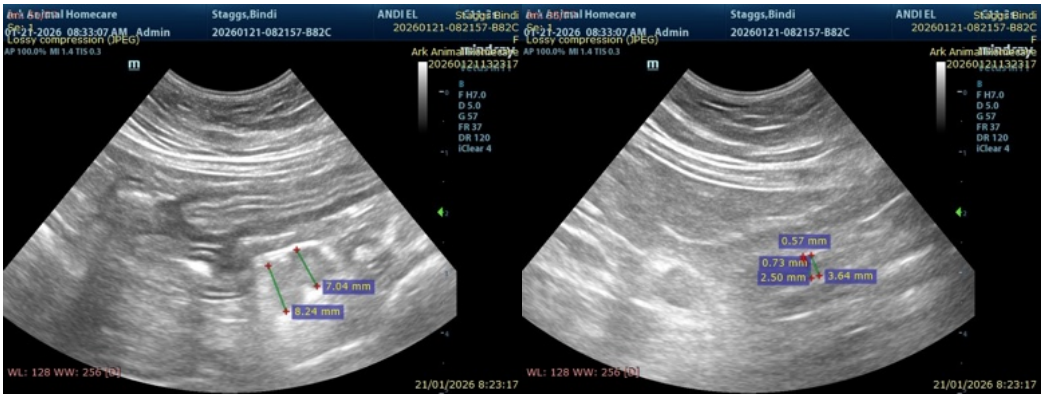

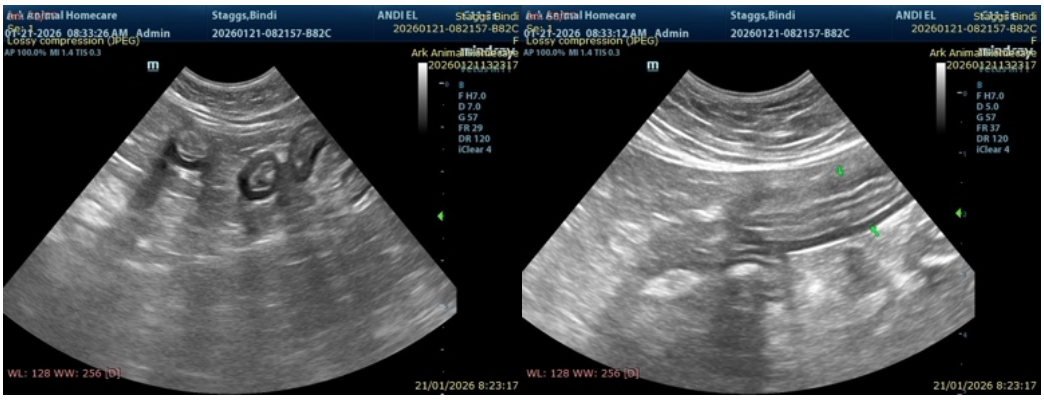

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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