



PATIENT

Sookie Animals in Distress

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

15 years

WEIGHT

10.06 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Pamela Bay

HOSPITAL NAME

For Cats Only VC

REFERRING VET

Dr. Bay

INVOICE

70359

DATE

1/21/26

PRESENTING CLINICAL SIGNS

- Weight loss

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is thin and smooth. The urine contains moderate suspended echogenic material, resulting in a turbid appearance. The bladder neck and proximal urethra are normal. No uroliths are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic changes.

Left kidney: Normal in shape and size, measuring 3.44×2.63 cm, with cortical thickness of 0.42 cm in the sagittal plane.

Right kidney: Normal in shape and size, measuring 3.25×2.12 cm, with cortical thickness of 0.47 cm in the sagittal plane.

In both kidneys, the renal cortex is mildly increased in echogenicity relative to the liver, resulting in mildly increased corticomedullary distinction. Corticomedullary architecture is preserved. No pyelectasia, nephroliths, or hydronephrosis are identified. Color Doppler evaluation demonstrates normal perfusion.

Adrenal Glands

Both adrenal glands are normal in shape and echogenicity. The left adrenal gland measures 0.32 cm at the cranial pole and 0.31 cm at the caudal pole. The right adrenal gland measures 0.28 cm at the cranial pole and 0.29 cm at the caudal pole.

Spleen

Splenic thickness measures 0.88 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 uniform and isoechoic relative to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder is normally distended. The gallbladder wall measures 0.84 mm. The contents are primarily anechoic, with a very small amount of biliary sludge. No dilation of the cystic duct or common bile duct is identified.



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Gastrointestinal

Stomach: Empty and folded, with mural thickness of 1.23 mm and preserved wall layering.

Pyloric region: Measures 1.90 mm and contains a small amount of partially digested ingesta.

Jejunum (typical segments): Wall thickness 1.80 mm, with preserved layering (mucosa 1.26 mm, submucosa 0.30 mm, muscularis propria 0.21 mm).

Ileum: Wall thickness 0.94 mm, with preserved layering.

Ileocecal junction: Measures 2.05 mm, with muscularis thickness of 0.52 mm.

Additionally, one segment of small intestine, most consistent with jejunum, demonstrates marked mural thickening measuring 5.03–5.42 mm, with complete loss of normal wall layering. The longitudinal extent of this lesion is estimated at approximately 4 cm, though precise measurement is limited by bowel curvature. Mild hyperechogenicity of the adjacent omentum is present. No obstructive pattern is identified.

Colon: Wall thickness 0.83 mm, with a small amount of fecal material in the descending segment.

Pancreas

The pancreatic body and limbs measure up to 5.60 mm and appear normal. The pancreatic parenchyma is isoechoic relative to adjacent omental fat. The pancreatic duct measures 1.24 mm. No ultrasonographic evidence of pancreatitis or focal pancreatic lesions is identified.

Peritoneal Cavity

No abdominal effusion or evidence of peritonitis is observed.

Cranial mesenteric lymph nodes measure 0.68 cm and 1.07 cm in thickness and are hypoechoic and mildly heterogeneous. Ileocecal lymph nodes measure approximately 3.02–3.4 mm and are hypoechoic.

The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Focal jejunal segment with severe mural thickening (5.03–5.42 mm) and complete loss of wall layering.
- Mild hyperechogenicity of adjacent omentum.
- Cranial mesenteric lymphadenopathy (hypoechoic, mildly heterogeneous).

SECONDARY FINDINGS

- Mildly increased renal cortical echogenicity bilaterally.
- Turbid urine with suspended echogenic material.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This abdominal ultrasound reveals a focal, markedly abnormal segment of small intestine, most consistent with jejunum, characterized by severe mural thickening and complete loss of normal wall layering, extending over an estimated 4 cm length and associated with mild regional omental hyperechogenicity. These findings are highly suspicious for an infiltrative intestinal process, with intestinal neoplasia considered the primary concern, particularly alimentary lymphoma. No ultrasonographic evidence of intestinal obstruction is present at this time.

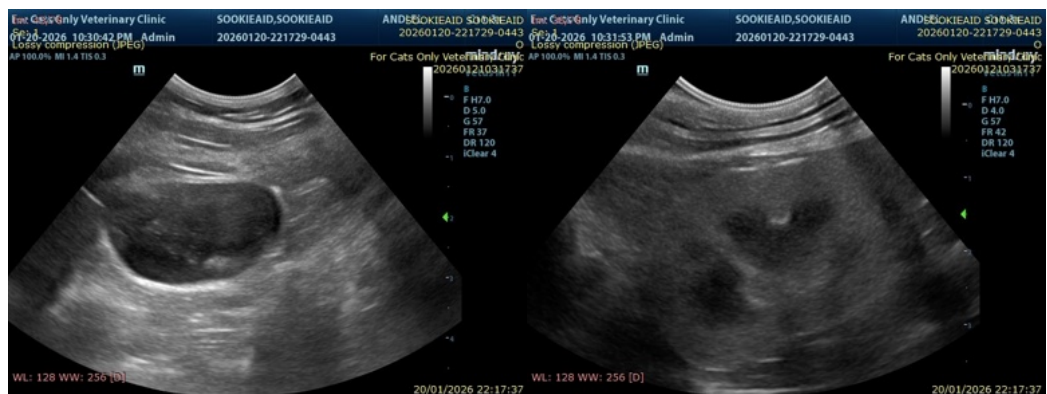
While focal severe enteritis or granulomatous disease could theoretically produce similar ultrasonographic changes, the degree of wall thickening, complete loss of stratification, focal nature of the lesion, and the patient's advanced age and weight loss make a benign inflammatory enteropathy substantially less likely.

The presence of regional cranial mesenteric lymphadenopathy, which is hypoechoic and mildly heterogeneous, further supports involvement of the local lymphatic drainage and increases concern for a neoplastic process, although reactive lymphadenopathy cannot be entirely excluded.

The mildly increased renal cortical echogenicity is a nonspecific, likely age-related finding and is of uncertain clinical significance in the absence of additional abnormalities. Correlation with renal laboratory parameters is recommended. The turbid appearance of the urine is most consistent with benign suspended debris or fine sediment and may be influenced by urine concentration or hydration status; this is considered incidental given the otherwise normal urinary tract.

Recommendations

- Definitive tissue diagnosis is recommended, with intestinal biopsy considered the most appropriate next step.
- Ultrasound-guided fine-needle aspiration of the affected lymph nodes can be considered as an alternative, although may not be definitive.
- If biopsy is declined, close clinical monitoring with supportive care may be pursued, recognizing that progression is likely if the lesion is neoplastic.





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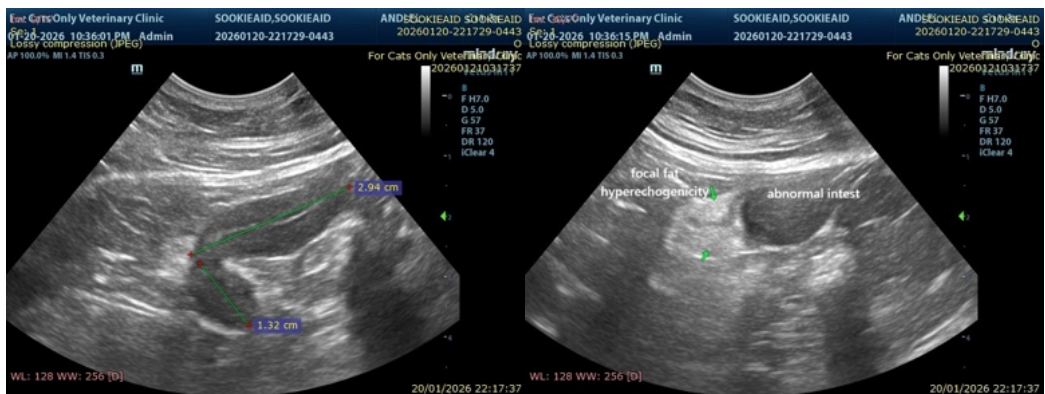
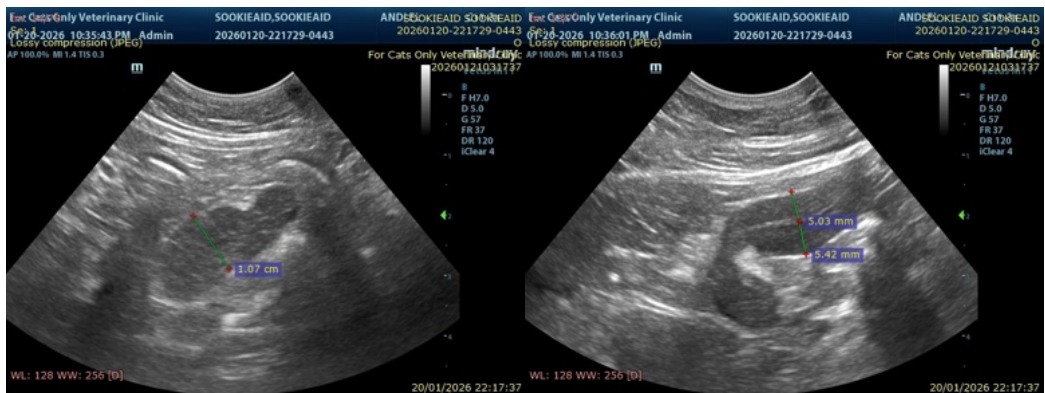
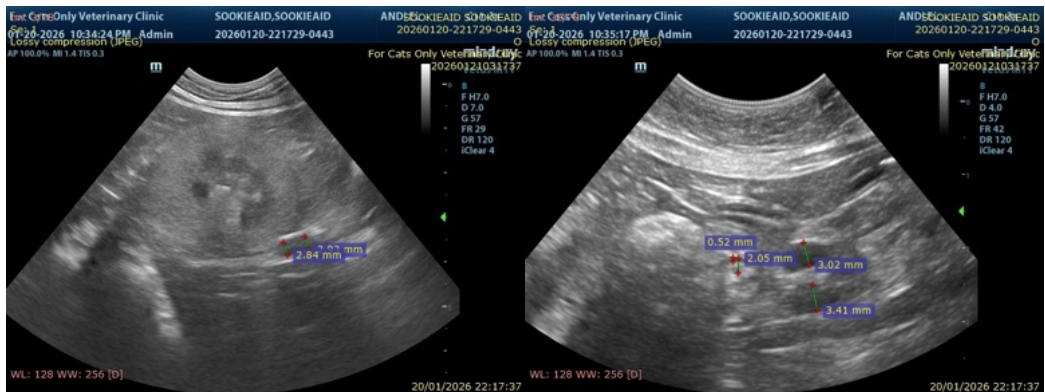
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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