



PATIENT

Pumpkin Wood

SPECIES

Feline

BREED

Domestic Medium Hair

SEX

Neutered male

AGE

10 years

WEIGHT

8.06 lbs

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Amy Isaac

HOSPITAL NAME

Valley West & Elk
Valley VH

REFERRING VET

Dr. Isaac

INVOICE

70889

DATE

1/22/26

PRESENTING CLINICAL SIGNS

- Chronic diarrhea for years per owner. Owner is noticing now that he has a lot of gas and abdominal pain. Not eating as well. Did better initially on the PR when started and then diarrhea worsened again. Has been on prednisolone 5 mg for years, 1 tablet twice a week. Recently increased to 3x a week. Now eating dry and canned ZD. Fortiflora daily.
- Calcium 11.4 Rest of CBC/Chem/UA normal Fecal PCR negative

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is thin and smooth. The urine is predominantly anechoic with scant suspended echogenic debris. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no sonographic evidence of inflammatory or neoplastic bladder wall changes.

The left kidney is normal in shape and size (3.94×2.23 cm). Cortical thickness measures 0.59 cm in the sagittal plane. The right kidney is normal in shape and size (4.04×2.32 cm). Cortical thickness measures 0.60 cm in the sagittal plane. In both kidneys, the renal cortex is markedly increased in echogenicity relative to the liver parenchyma. The corticomedullary ratio is abnormal, though corticomedullary distinction remains preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

The left adrenal gland is not visualized. The right adrenal gland is visualized and measures 0.20 cm at the cranial pole and 0.19 cm at the caudal pole, within normal limits.

Spleen

Splenic thickness is 0.74 cm. The splenic parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture without focal 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 to falciform fat, with normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder is normally distended. The wall is thin. Luminal contents are primarily anechoic with a small amount of biliary sludge. The common bile duct measures approximately 3.61 mm proximally, 2.91 mm mid-portion, and 1.91 mm distally.



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Gastrointestinal

The stomach is empty and folded. Gastric wall thickness measures approximately 1.87 mm, with preserved wall layering. The pylorus measures 2.30 mm. The duodenum measures 1.82 mm.

The jejunum measures approximately 2.13 mm, with preserved wall layering. Individual layers measure as follows: mucosa 0.92 mm, submucosa 0.58 mm, and muscularis propria 0.32 mm. The ileum measures approximately 1.36 mm, with preserved wall layering. Individual layers measure as follows: mucosa 0.33 mm, submucosa 0.45 mm, and muscularis propria 0.28 mm. The ileocecal junction is not visualized.

A segment of small intestine demonstrates marked focal wall thickening up to approximately 5.09 mm, with loss of normal wall layering. Due to the absence of cine loops clearly demonstrating the margins of this lesion and its continuity with adjacent normal bowel, the precise anatomic location and full extent of this abnormal segment cannot be definitively determined.

The colon measures 1.41 mm in wall thickness and contains small amounts of formed feces within the descending segment, with mild distal acoustic shadowing.

Pancreas

The pancreas measures approximately 6.99 mm in thickness. The right limb, body, and left limb appear normal. The pancreatic parenchyma is isoechoic to adjacent omental fat. The pancreatic duct measures approximately 1.52 mm in diameter. No sonographic evidence of active pancreatitis or pancreatic neoplasia is identified.

Peritoneal Cavity

No abdominal effusion or evidence of peritonitis is observed. Cranial mesenteric and ileocecal lymph nodes are not visualized. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Focal small intestinal wall thickening (up to 5.09 mm) with loss of normal wall layering.
- Renal cortical thickness is at the upper limits of normal bilaterally, with markedly increased cortical echogenicity.

SECONDARY FINDINGS

- Small amount of biliary sludge.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This abdominal ultrasound examination identifies a focal segment of markedly abnormal small intestine, characterized by severe wall thickening and loss of normal wall layering. The focal nature of the intestinal lesion, its degree of thickening (up to 5.09 mm), and the loss of normal mural stratification are not typical of mild inflammatory enteropathy or functional gastrointestinal disease. In this clinical context, these findings are highly suspicious for clinically significant intestinal pathology, with intestinal



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lymphoma representing a primary concern, particularly given the chronicity of signs and prior partial response followed by progression despite dietary modification and corticosteroid therapy. A focal intestinal neoplasm other than lymphoma is less likely but cannot be excluded based on ultrasonography alone.

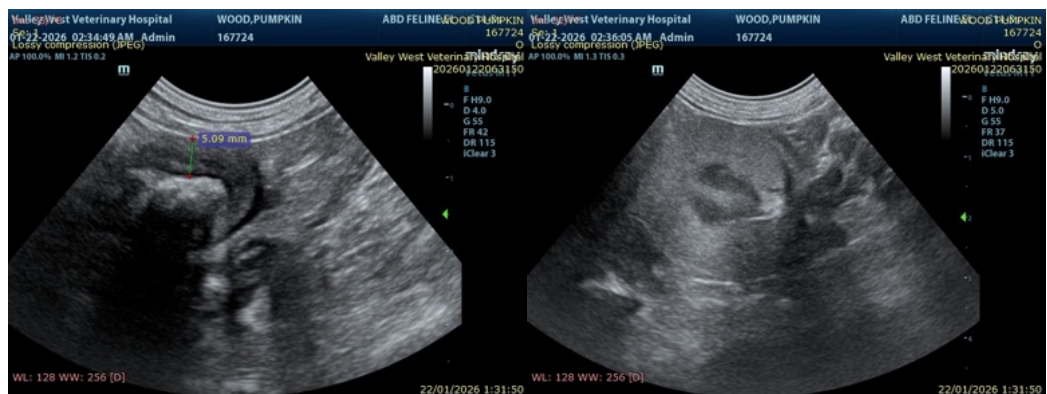
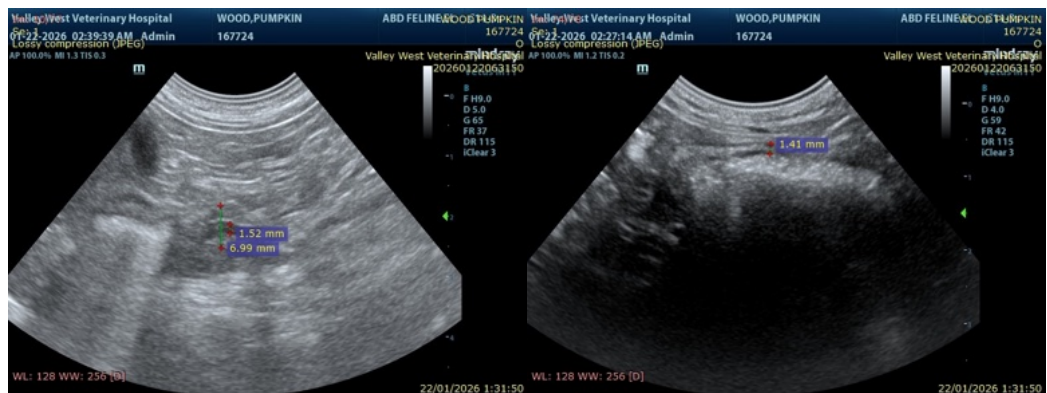
Interpretation is limited by the lack of complete cine documentation of the lesion, preventing precise localization and full assessment of its longitudinal extent; however, the abnormal appearance itself remains significant.

Renal findings are consistent with chronic renal changes.

Overall, the ultrasound findings significantly increase concern for focal intestinal neoplasia, most notably lymphoma, and warrant definitive diagnostic investigation.

Recommendations

- Definitive diagnostic sampling of the abnormal intestinal segment is strongly recommended.
- Interpretation and diagnostic planning should take into account the patient's ongoing corticosteroid therapy, which may reduce the diagnostic yield of intestinal biopsy, particularly for lymphoproliferative disease.
- Continue supportive gastrointestinal management as needed while pursuing definitive diagnosis, with close clinical monitoring.





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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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