



PATIENT

Ron Howard Smith

SPECIES

Feline

BREED

Domestic Medium Hair

SEX

Neutered male

AGE

13 years

WEIGHT

9 lbs

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Mark Reser

HOSPITAL NAME

Harvest Hills VH

REFERRING VET

Dr. Reser

INVOICE

70864

DATE

1/22/26

PRESENTING CLINICAL SIGNS

- Chronic vomiting and diarrhea, daily for past year. Is on z/d food for past 10 months and had trials of metronidazole and fortiflora that did not improve. Having weight loss also, about 10% body weight in year
- PE normal except cat is thinner. Prev. labs 10 months ago showed no abnormalities. Sending off TAMU panel and repeating cbc/chem/T4 today

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is 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 (3.63×2.05 cm). Cortical thickness measures 0.35 cm in the sagittal plane. Cortical echogenicity is isoechoic to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler evaluation demonstrates a normal perfusion pattern.

The right kidney is normal in shape and size (3.79×2.44 cm). Cortical thickness is not recorded. Cortical echogenicity is isoechoic to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler evaluation demonstrates a normal perfusion pattern.

Adrenal Glands

Both adrenal glands are normal in shape and echogenicity. The left adrenal gland measures 0.25 cm at the cranial pole and 0.23 cm at the caudal pole. The right adrenal gland measures 0.32 cm at the cranial pole and 0.34 cm at the caudal pole.

Spleen

Splenic thickness is 0.68 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 gallbladder wall measures approximately 1.46 mm. Luminal contents are primarily anechoic with a small amount of biliary sludge. No dilation of the cystic duct or common bile duct is identified.



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Gastrointestinal

The stomach contains ingesta. Gastric wall thickness measures approximately 1.66 mm, with preserved wall layering.

The pylorus measures approximately 2.48 mm.

The duodenum measures approximately 1.52 mm and contains small amounts of undigested food.

The jejunum measures approximately 2.90 mm, with preserved wall layering. Individual layers measure as follows: mucosa 1.94 mm, submucosa 0.46 mm, and muscularis propria 0.32 mm.

The ileum measures approximately 1.49 mm, with preserved layering. Individual layers measure as follows: mucosa 0.32 mm, submucosa 0.71 mm, and muscularis propria 0.39 mm.

The ileocecal junction measures approximately 3.32 mm, with the muscularis layer measuring 1.21 mm.

All intestinal segments contain ingesta and demonstrate increased peristalsis, consistent with a non-fasted state.

The colon measures approximately 0.51 mm in wall thickness and contains soft fecal material within the descending segment.

Pancreas

The pancreas measures approximately 6.39–6.89 mm in thickness. The pancreatic parenchyma is slightly hypoechoic relative to the adjacent omental fat. The pancreatic duct measures approximately 1.83 mm in diameter. No sonographic evidence of active pancreatitis or pancreatic neoplasia is identified.

Peritoneal Cavity

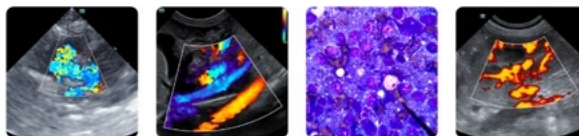
No abdominal effusion or evidence of peritonitis is observed.

The cranial mesenteric lymph nodes measure approximately 4.6–5.02 mm, and the ileocecal lymph nodes measure approximately 2.35–2.45 mm; all are normal in shape and echogenicity.

The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

- Mild jejunal wall thickening with mucosal prominence and preserved layering.
- Thickened ileocecal junction with muscularis prominence
- Mild pancreatic enlargement with slight hypoechoogenicity and mild pancreatic duct dilation.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

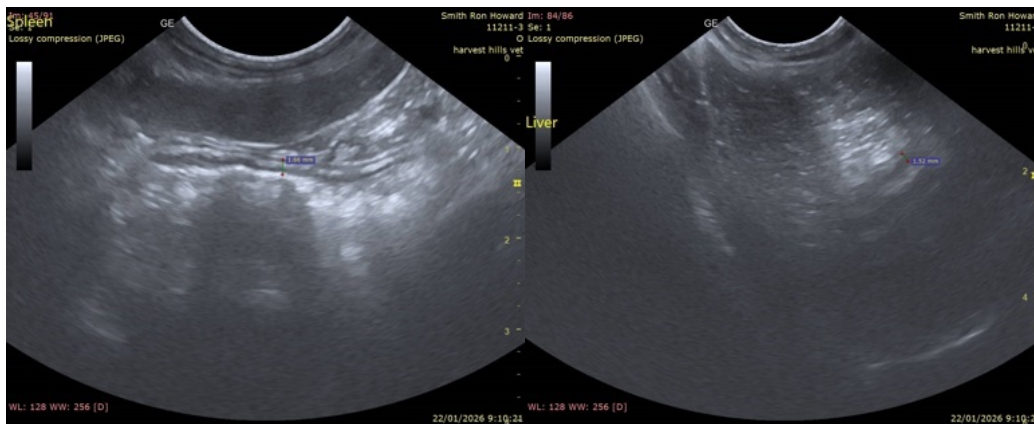
The small intestine shows mildly increased jejunal wall thickness, with relative prominence of the mucosal layer and preserved wall layering throughout. The ileocecal junction demonstrates increased wall thickness with muscularis prominence, while regional lymph nodes remain within normal size and echogenicity. These findings are nonspecific and lie within the recognized ultrasonographic spectrum shared by chronic inflammatory enteropathies, particularly lymphoplasmacytic enteritis, and small-cell (low-grade) alimentary lymphoma in cats. The substantial overlap in mural thickness, layer distribution, and lymph node appearance between these entities limits the discriminatory value of ultrasonography alone.

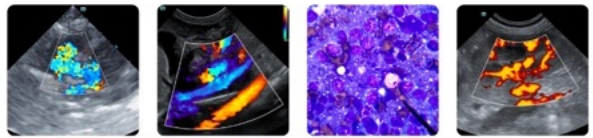
Interpretation of the gastrointestinal tract is further limited by the non-fasted state, with ingesta present throughout the stomach and intestines and increased peristalsis. This may influence mural measurements.

The pancreas is mildly enlarged, with parenchyma slightly hypoechoic to surrounding fat and a mildly dilated pancreatic duct. In the absence of peripancreatic fat inflammation, free fluid, or focal lesions, these findings are nonspecific and may represent chronic or subclinical pancreatic change.

Recommendations

- Interpret ultrasound findings in conjunction with pending diagnostics (especially TAMU GI panel).
- Correlate pancreatic findings with fPLI, recognizing the nonspecific nature of the ultrasonographic changes.
- Given the chronicity of signs, weight loss, and failure to respond to dietary and antimicrobial trials, intestinal biopsies should be strongly considered for definitive diagnosis.
- Continue close clinical monitoring, with therapeutic decisions guided by histopathology and response to targeted treatment.





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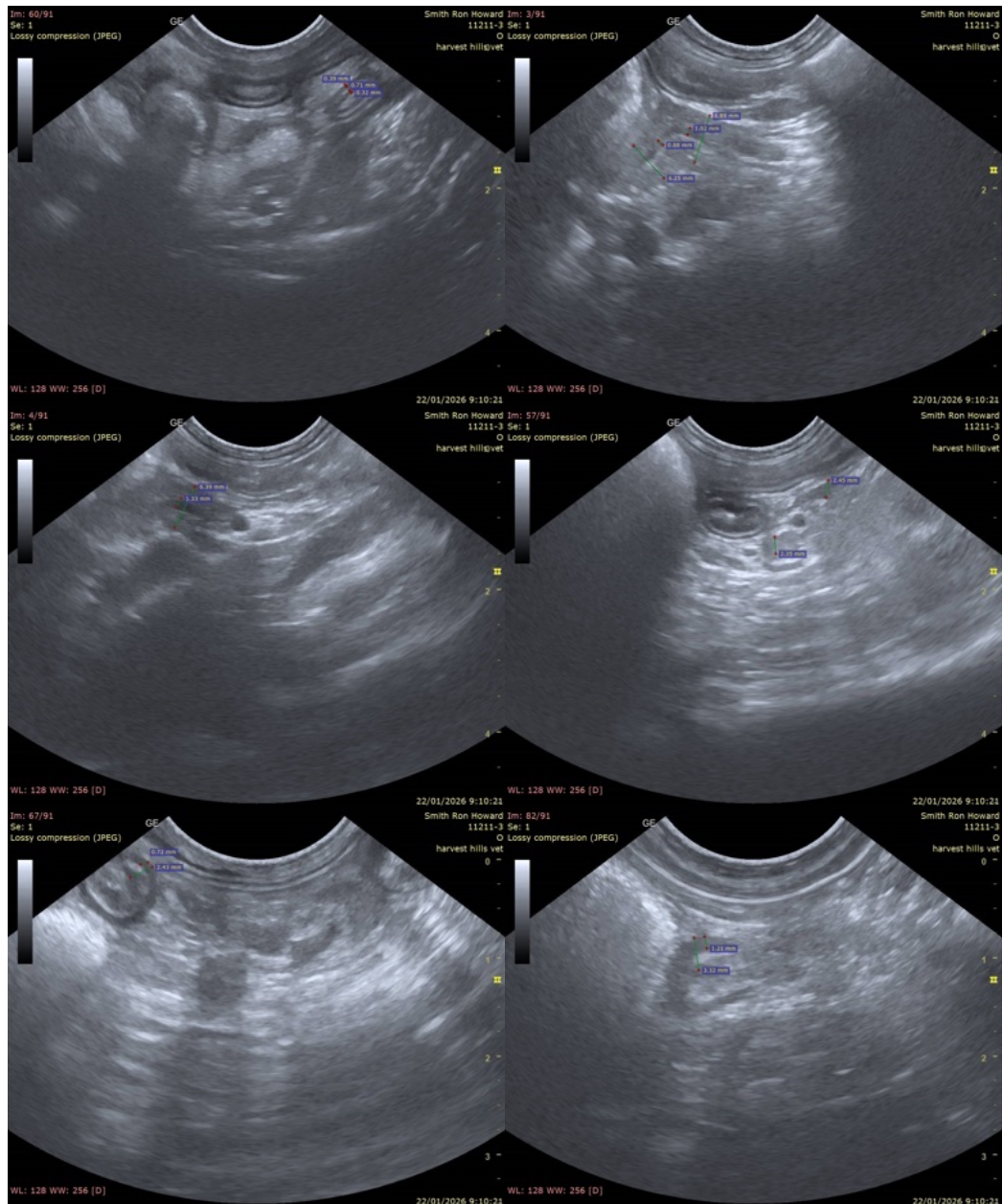
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.
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