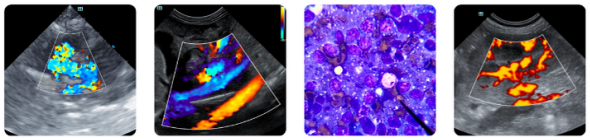




**PATIENT**

Mocha Benoit

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Spayed female

**AGE**

16 years

**WEIGHT**

2.3 kg

**INTERPRETED BY**

Dr. Alicia Angosto Guerrero

**IMAGING PERFORMED BY**

Matthew Olcha

**HOSPITAL NAME**

East Meadow VC

**REFERRING VET**

Dr. Olcha

**INVOICE**

71021

**DATE**

1/28/26

## PRESENTING CLINICAL SIGNS

- Weight loss, intermittent vomiting, excessive borborygmi, good appetite, normal behavior
- SDMA of 16 and USG of 1.023 with concurrent UTI, otherwise CBC/Chem/T4 unremarkable

## 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 have a normal appearance. No uroliths are identified. There is no ultrasonographic evidence of inflammatory or neoplastic changes.

The left kidney is normal in overall size, measuring 2.78×2.12 cm, with a cortical thickness of 0.32 cm measured in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. At the cranial pole, a triangular hyperechoic cortical area is identified, associated with a focal indentation of the renal contour, giving the appearance of focal flattening. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

The right kidney is normal in shape and size, measuring 3.02×2.21 cm, with a cortical thickness of 0.34 cm measured in the sagittal plane. The renal cortex is isoechoic relative 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*

The adrenal glands could not be visualized on this examination.

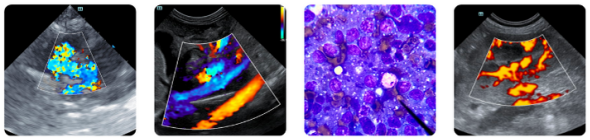
### *Spleen*

Splenic thickness is not provided in the original report. The splenic parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture, with no 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 homogeneous 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. The contents are predominantly anechoic. No dilation of the cystic duct or common bile duct is identified.





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### *Gastrointestinal*

The stomach is moderately distended with ingesta. Gastric mural thickness measures 0.97 mm, with preserved wall layering. The pylorus measurement is not provided.

Duodenal wall thickness measures 2.32 mm. Jejunal wall thickness ranges from 2.17–2.21 mm, with the following layer measurements: mucosa 1.40 mm, submucosa 0.48 mm, muscularis propria 0.25 mm. Ileal wall thickness measures 1.59 mm, with the following layer measurements: mucosa 0.79 mm, submucosa 0.63 mm, muscularis propria 0.34 mm. Wall layering is preserved throughout the evaluated intestinal segments. All intestinal segments are diffusely dilated, measuring up to 1.0 cm in luminal diameter, and contain abundant fluid and gas. Intestinal peristalsis appears increased. The ileocecal junction is not visualized.

The transverse colon wall thickness measures 0.62 mm and is markedly dilated with fluid content. The descending colon wall thickness measures 0.75 mm, with soft fecal material present.

### *Pancreas*

Visualization of the pancreas is markedly limited due to acoustic shadowing and artifact from gastrointestinal gas and ingesta. No overt pancreatic lesions are identified; however, concurrent pancreatitis cannot be confidently excluded based on this examination.

### *Peritoneal Cavity*

A mild volume of abdominal effusion is present within the rectovesical recess and between intestinal loops. Cranial mesenteric lymph nodes measure between 5.19–5.96 mm in thickness, are normal in shape, and mildly hypoechoic. Ileocecal lymph nodes are not visualized.

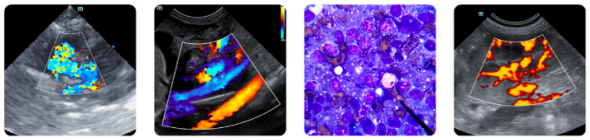
## ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Diffuse dilation of small and large intestinal segments (up to 1.0 cm) with fluid and gas.
- Increased intestinal peristalsis.
- Mild abdominal effusion.
- Mildly enlarged, mildly hypoechoic cranial mesenteric lymph nodes (5.19–5.96 mm).

SECONDARY FINDINGS

- Focal hyperechoic cortical lesion with contour indentation at the cranial pole of the left kidney.





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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This abdominal ultrasound examination is characterized by diffuse gastrointestinal dilation with fluid and gas, increased peristalsis, and preserved intestinal wall layering throughout, without a discrete obstructive lesion or focal mural mass. This pattern is most consistent with functional gastrointestinal disease, such as inflammatory enteropathy or motility-related disorder.

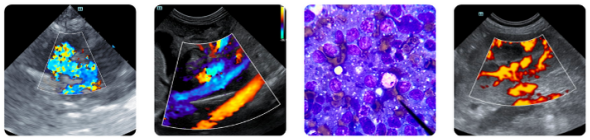
In a geriatric cat with chronic weight loss, intermittent vomiting, excessive borborygmi, preserved appetite, and normal behavior, this ultrasonographic appearance is most compatible with chronic enteropathy, including inflammatory bowel disease or early infiltrative disease such as low-grade alimentary lymphoma. Importantly, ultrasonography cannot reliably differentiate these entities when wall thickness and layering are preserved, and significant overlap is well recognized.

The mild abdominal effusion, in combination with mildly enlarged but morphologically normal cranial mesenteric lymph nodes, is considered nonspecific and may reflect reactive or inflammatory change secondary to gastrointestinal disease.

The focal hyperechoic, triangular cortical lesion with contour indentation at the cranial pole of the left kidney is most consistent with chronic focal renal scarring or prior infarction, and is considered an incidental finding.

Recommendations

- Review whether a gastrointestinal panel has already been performed. If not, a comprehensive gastrointestinal panel (including cobalamin, folate, and pancreatic markers, as clinically indicated) is recommended as an initial, noninvasive step in the evaluation of chronic gastrointestinal disease.
- Assess serum cobalamin concentration, and initiate supplementation if low or low–normal values are identified, as hypocobalaminemia is common in chronic enteropathies and may contribute to weight loss and gastrointestinal signs.
- Dietary management is recommended as an initial therapeutic trial, including a highly digestible, novel protein, or hydrolyzed diet, with close monitoring of clinical response.
- If clinical response to dietary and supportive management is incomplete or absent, gastrointestinal biopsy should be considered to obtain a definitive diagnosis and differentiate inflammatory bowel disease from low-grade alimentary lymphoma, recognizing that imaging findings alone cannot reliably distinguish these entities.
- Continue to monitor renal parameters and manage the concurrent urinary tract infection, given evidence of mild chronic renal change.





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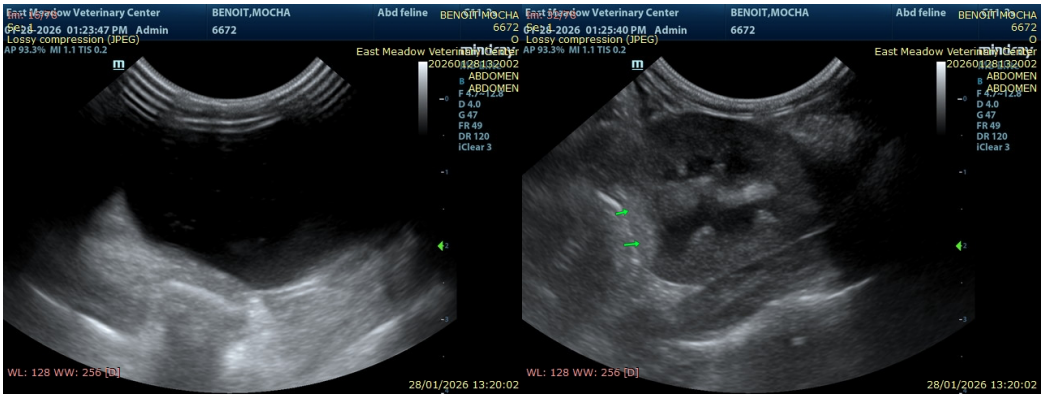


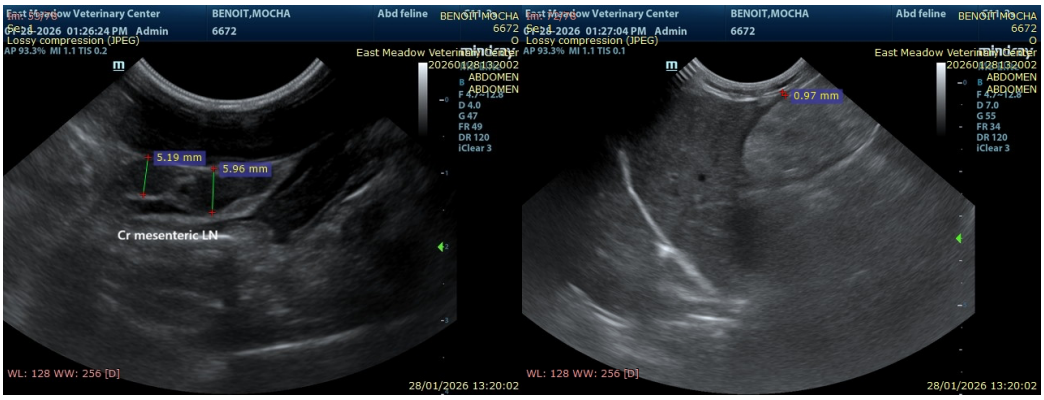


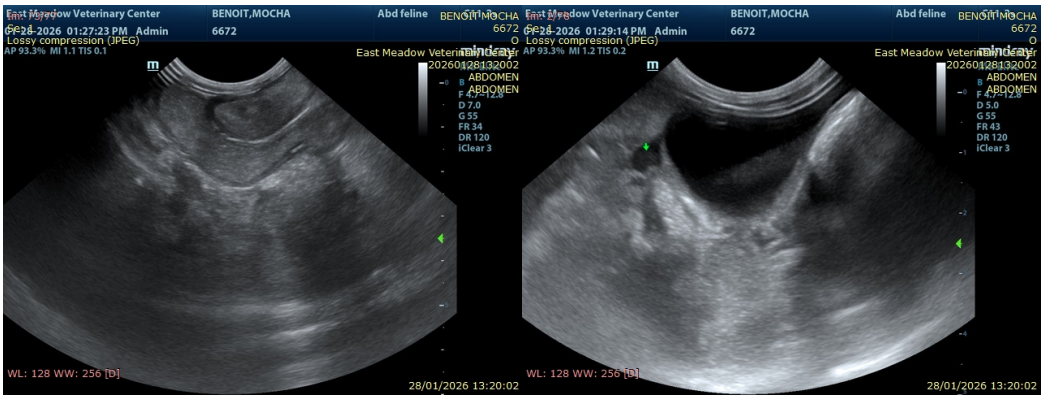

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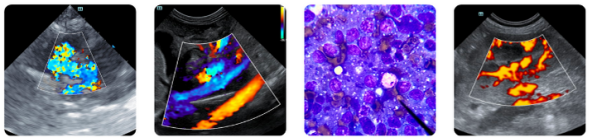

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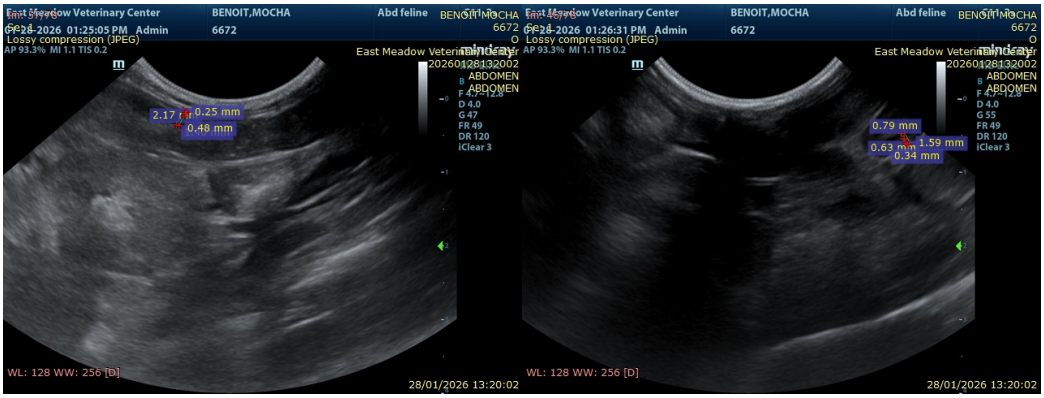


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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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