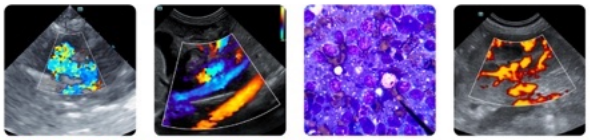


PATIENT

Pepper Sheets

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

3 years

WEIGHT

6.8 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Quinn Robinson RVT

HOSPITAL NAME

Hess Ridge AH

REFERRING VET

Dr. Frint

INVOICE

71036

DATE

1/28/26

PRESENTING CLINICAL SIGNS

- History of diarrhea/straining to defecate. Somewhat improved on supportive care (metronidazole, probiotics, prescription GI diet).
- Negative fecal Globulins 6.8, remainder of CBC/Chem 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, and there is no ultrasonographic evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 3.30×2.07 cm, with a cortical thickness of 0.42 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. Doppler color evaluation demonstrates a normal vascular pattern.

The right kidney is normal in shape and size, measuring 3.46×2.15 cm. Cortical thickness was not recorded. 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. Doppler color evaluation demonstrates a normal vascular pattern.

Adrenal Glands

Both adrenal glands are normal in shape and echogenicity. The left adrenal gland measures 0.24 cm at the cranial pole and 0.26 cm at the caudal pole. The right adrenal gland measures 0.23 cm at the cranial pole and 0.23 cm at the caudal pole.

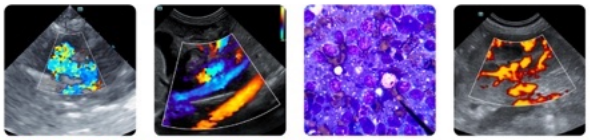
Spleen

Splenic thickness is 0.85 cm. The splenic parenchyma demonstrates normal echogenicity and a 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 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, and 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 distended with ingesta. Gastric mural thickness measures 0.85–1.21 mm, with preserved wall layering. The pylorus measures 2.52 mm.

Duodenal wall thickness measures 1.54 mm. Jejunal wall thickness ranges from 1.13–1.24 mm. The ileum measures 2.45 mm, with preserved wall layering. Layer measurements include mucosa 1.02 mm, submucosa 0.72 mm, and muscularis propria 0.70 mm.

The ileocecal junction is not visualized. A focally abnormal intestinal segment is identified, measuring approximately 4.18–4.36 mm in wall thickness, with loss of normal wall layering. The exact intestinal segment cannot be definitively identified, as neither the proximal nor distal margins of the affected segment can be clearly traced to adjacent normal bowel. Based on anatomic location, this segment most likely represents the transverse colon or proximal descending colon. Other portions of the colon appear within normal limits, which limits definitive segmental identification.

The ascending colon wall thickness measures 0.66 mm and contains pasty fecal material.

Pancreas

The evaluated pancreatic regions show no ultrasonographic evidence of overt inflammation.

Peritoneal Cavity

No abdominal effusion or signs of peritonitis are observed.

Multiple abdominal lymph nodes are mildly enlarged and hypoechoic:

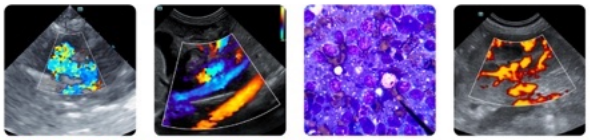
- Cranial mesenteric lymph nodes measure 7.92–8.99 mm in thickness. Ileocecal lymph nodes measure 4.61–6.30 mm in thickness. Caudal mesenteric lymph nodes measure 2.64–3.41 mm in thickness and are mildly hypoechoic.

The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

- Focal intestinal wall thickening (4.18–4.36 mm) with complete loss of wall layering, suspected colonic origin
- Mild to moderately enlarged, hypoechoic abdominal lymph nodes (cranial mesenteric, ileocecal, caudal mesenteric, pancreaticoduodenal).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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A focal segment of marked intestinal wall thickening (4.18–4.36 mm) with loss of normal wall layering is identified. Due to limitations in tracing the affected segment to clearly normal adjacent bowel, the exact intestinal location cannot be definitively determined on this examination.

Multiple abdominal lymph nodes are enlarged and hypoechoic. Although the cranial mesenteric lymph nodes appear more prominent, this is likely influenced by their normally larger baseline size. In the context of a young cat with large-bowel clinical signs, these findings are most consistent with reactive lymphadenopathy rather than definitive nodal neoplasia.

Overall, the findings support a clinically significant focal colonic process, with infectious, parasitic, or severe inflammatory/granulomatous colitis prioritized. Neoplasia (including lymphoma) is considered less likely given the patient's age and nodal appearance but cannot be excluded based on ultrasound alone.

Recommendations

- Prioritize less invasive diagnostics to evaluate for infectious or parasitic causes of focal colitis, given the patient's young age and large-bowel clinical signs. This may include repeat fecal examination and targeted fecal PCR testing: Giardia, *Tritrichomonas foetus*, and other enteropathogens (recognizing that single fecal tests may yield false-negative results).
- Intestinal biopsy is recommended if noninvasive testing is unrevealing or if clinical signs fail to resolve, and it is necessary to definitively differentiate severe inflammatory or granulomatous disease from infiltrative neoplasia.
- Clinical reassessment following targeted medical management based on diagnostic results is recommended, with consideration of repeat abdominal ultrasound to see progression.

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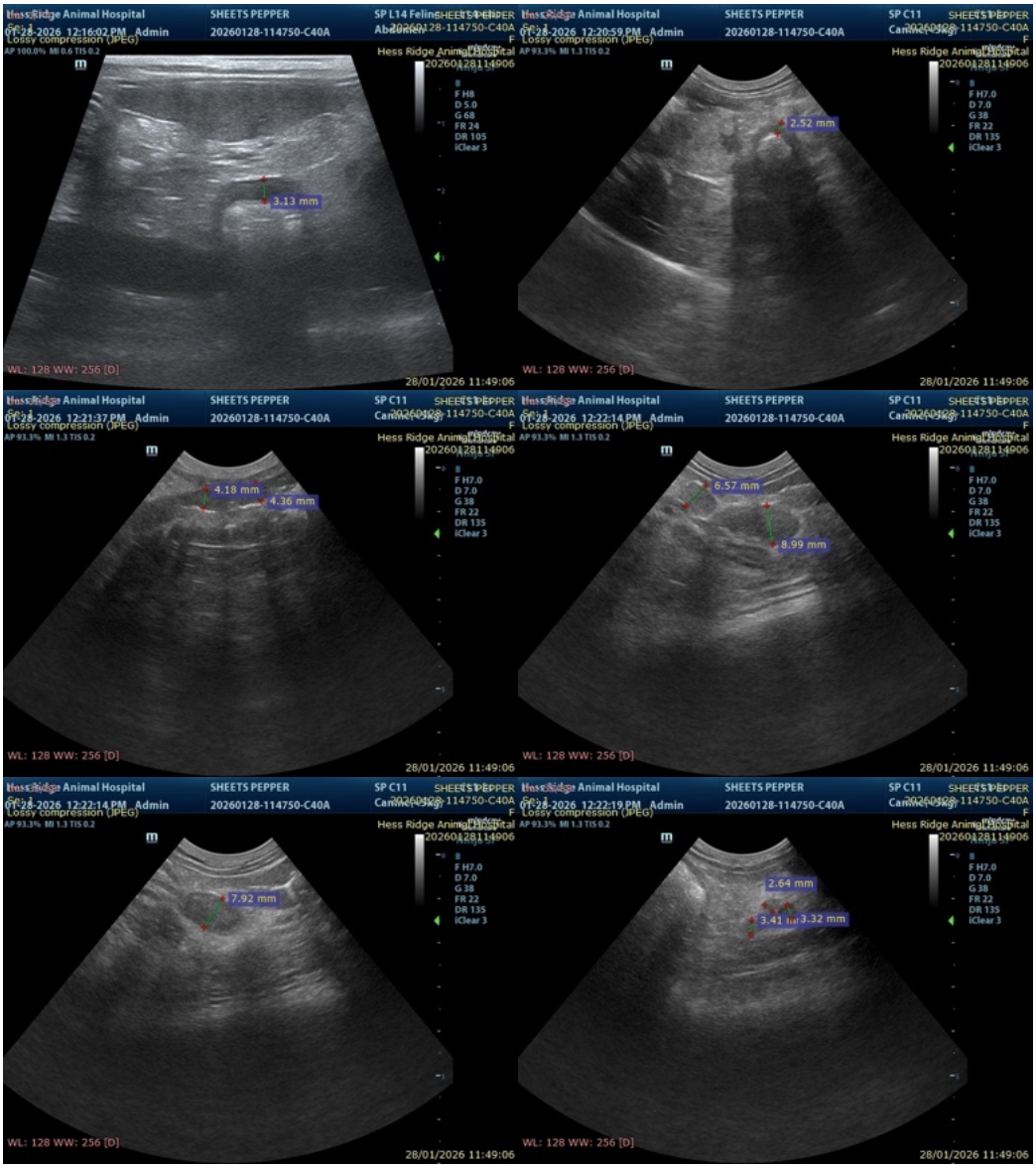

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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