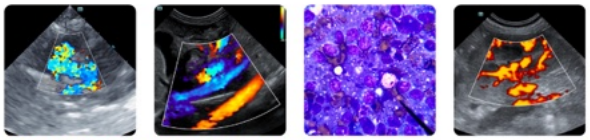


PATIENT

Cooper Najjar

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed Female

AGE

10 years

WEIGHT

10.5 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Christina Miller, DVM

HOSPITAL NAME

Seven Fields VH

REFERRING VET

Dr. Miller

INVOICE

71066

DATE

1/29/26

PRESENTING CLINICAL SIGNS

- Presented for increased drinking on 1/26/2026. Overall e/d normally. Vomits anywhere from a few times a week to going a week or two without vomiting. Mostly hairballs per owner. Takes over the counter hairball supplement. Fed canned food with boiled chicken or turkey or plain salmon. No other daily medication or monthly preventatives. Lost 1 lb since previous weight in June of 2024.
- Physical exam was fairly unremarkable. Bloodwork revealed CBC wnl, ALT elevation (549 U/L), T. bili 1.0 mg/dL, BUN 37, Creat 1.6, SDMA 10. USG 1.026. Normal UA. T4 1.4.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended. The urinary 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 3.36×2.21 cm. Cortical thickness is 0.31 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. No pyelectasia, nephroliths, or hydronephrosis are identified. Color Doppler evaluation demonstrates a normal vascular pattern.

The right kidney is normal in shape and size, measuring 3.64×2.40 cm. Cortical thickness is 0.30 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. No pyelectasia, nephroliths, or hydronephrosis are identified. Color Doppler evaluation demonstrates a normal vascular pattern.

Adrenal Glands

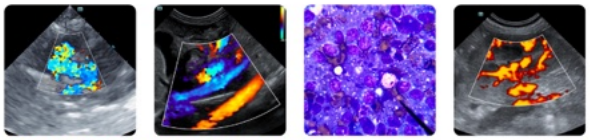
The left adrenal gland measures 0.28 cm at the cranial pole and 0.30 cm at the caudal pole. The right adrenal gland could not be reliably measured.

Spleen

Splenic thickness measures 0.65 cm. The splenic parenchyma has normal echogenicity and a fine homogeneous echotexture, without focal parenchymal abnormalities. The splenic capsule is smooth and regular. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size, with sharp margins and a regular contour. Hepatic parenchyma is homogeneous and isoechoic relative to falciform fat, with a normal echotexture. No hepatic lymphadenopathy is identified.



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The gallbladder lumen is moderately distended. The gallbladder wall is thin. The gallbladder contents are primarily anechoic. The common bile duct measures 2.45 mm proximally, tapering to 2.17 mm, 1.90 mm, and 1.79 mm distally.

Gastrointestinal

The stomach is partially empty and contains ingesta, with preserved wall layering and a mural thickness of 1.47 mm. The pylorus measures 3.38 mm.

Duodenal wall thickness measures 2.03 mm. Jejunal wall thickness measures 2.21 mm, with mucosa measuring 0.85 mm, submucosa 0.79 mm, and muscularis propria 0.29 mm. Ileal wall thickness ranges from 2.49–2.91 mm, with mucosa measuring 0.64 mm, submucosa 0.64 mm, and muscularis propria 0.99 mm. Wall layering is preserved. The ileocecal junction measures 2.50 mm, with muscularis measuring 1.09 mm.

The colonic wall measures 0.79 mm and is largely empty.

Pancreas

Pancreatic thickness ranges from 4.37–5.02 mm. Pancreatic parenchyma is mildly hypoechoic relative to the adjacent omental fat. The pancreatic duct measures 1.10 mm. No ultrasonographic evidence of active peripancreatic fat inflammation is identified.

Peritoneal Cavity

No abdominal effusion or ultrasonographic evidence of peritonitis is observed.

The cranial mesenteric lymph nodes are enlarged, measuring up to 1.65 cm, rounded, hypoechoic, and associated with increased perinodal fat echogenicity.

The ileocecal lymph nodes measure 2.22–2.27 mm and have normal shape and echogenicity.

The iliac trifurcation appears normal.

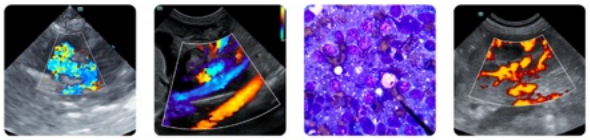
ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Enlarged cranial mesenteric lymph nodes, rounded and hypoechoic, with increased perinodal fat echogenicity.

SECONDARY FINDINGS

- Mild pancreatic parenchymal hypoechogenicity with mild pancreatic duct dilation.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominal ultrasonography identifies marked cranial mesenteric lymphadenopathy, characterized by rounded, hypoechoic lymph nodes with increased perinodal fat echogenicity, which is strongly suggestive of clinically significant gastrointestinal-associated disease.

Intestinal wall thicknesses are largely within expected limits for cats; however, layer analysis reveals abnormal muscularis prominence, particularly at the ileum. In this segment, the muscularis propria exceeds the thickness of the mucosa, resulting in an increased muscularis-to-mucosa ratio. This pattern is not typical of normal feline small intestine and is most commonly associated with chronic enteropathy, including inflammatory bowel disease or small cell (low-grade) lymphoma. At the ileocecal junction, the muscularis comprises a disproportionately large component of the total wall thickness, further supporting chronicity.

Importantly, the presence of preserved wall layering throughout the gastrointestinal tract indicates a chronic, infiltrative, or inflammatory process rather than an acute or aggressive transmural disease, and ultrasonography alone cannot reliably distinguish between inflammatory and neoplastic etiologies.

The liver appears structurally normal, with no focal lesions or biliary obstruction identified. In this context, the marked ALT elevation and mild hyperbilirubinemia are most consistent with a reactive hepatopathy, likely secondary to chronic gastrointestinal disease, rather than primary hepatic pathology.

Mild pancreatic parenchymal hypoechogenicity with minimal ductal dilation, in the absence of peripancreatic fat reactivity, is most compatible with chronic or secondary pancreatic involvement, potentially as part of a feline chronic enteropathy / pancreatobiliary axis.

Recommendations

- Targeted sampling of cranial mesenteric lymph nodes.
- A complete gastrointestinal panel (including cobalamin, folate, and pancreatic lipase) is recommended to further characterize the suspected chronic enteropathy and guide medical management.
- Further gastrointestinal investigation: Additional diagnostics such as intestinal biopsies (endoscopic or full-thickness) may be required for definitive diagnosis.
- Correlation with hepatic enzyme elevation.
- Medical management pending diagnosis: Empirical therapy should be approached cautiously and ideally deferred until cytologic or histologic diagnosis is obtained, given the markedly different management strategies for inflammatory enteropathy versus early low-grade lymphoma.

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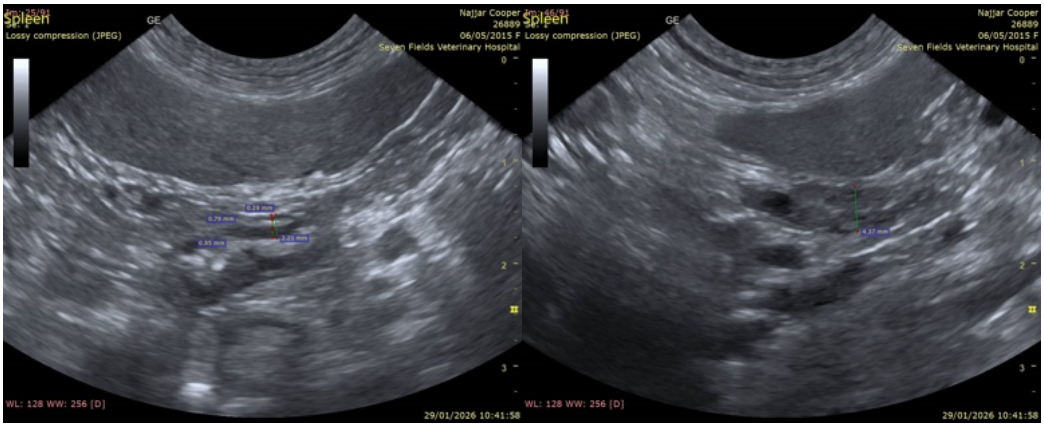

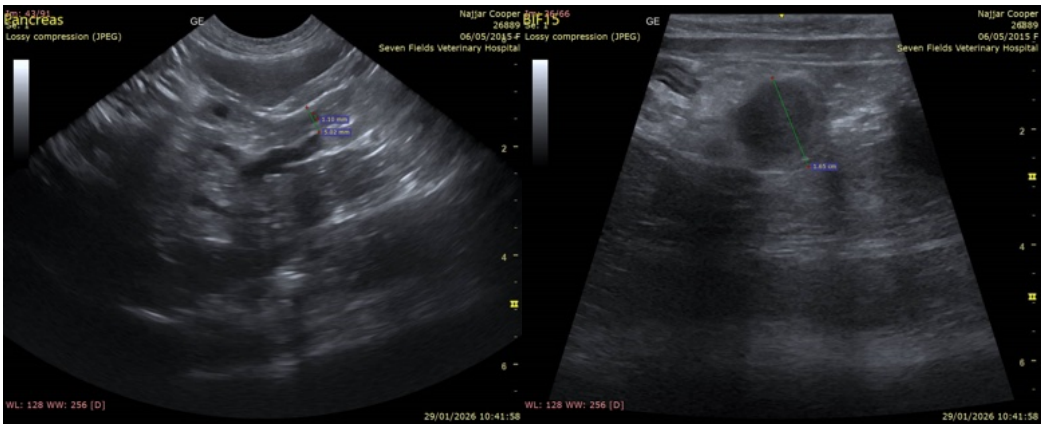

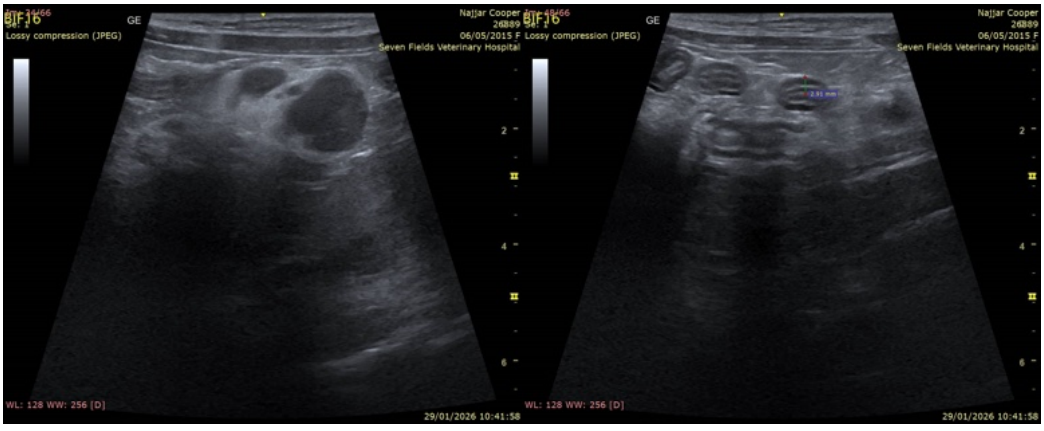

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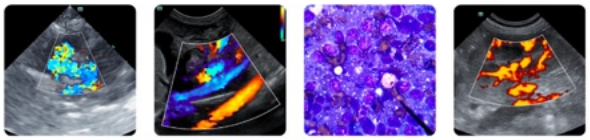

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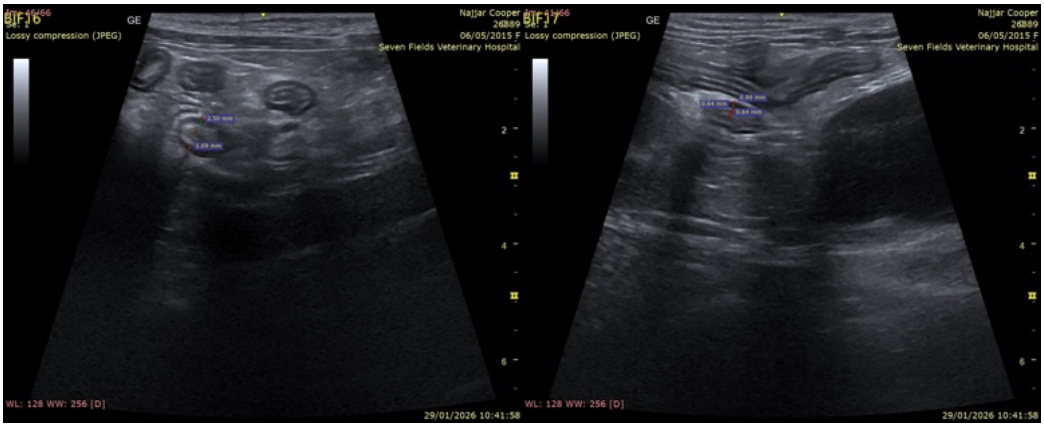

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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