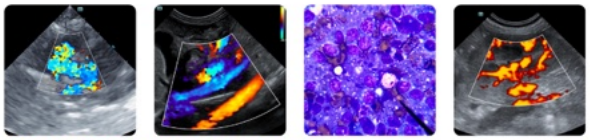



**PATIENT**

Mr Bones Gair

**SPECIES**

Feline

**BREED**

Sphynx

**SEX**

Neutered male

**AGE**

15 years

**WEIGHT**

4.5 lbs

**INTERPRETED BY**

Dr. Alicia Angosto Guerrero

**IMAGING PERFORMED BY**

Dr. Laurentino

**HOSPITAL NAME**

South Saskatchewan AH

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**INVOICE**

69889

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1/6/26

## PRESENTING CLINICAL SIGNS

History: Presented Jan 4, sudden onset of breathing issues, ADR, Inappetant and Fevered. See PE and diagnostic results below. Treated for ""ADR"" in clinic with IVF, Metacam, ampicillin, methadone and Emavert. Chronic meds: amlodipine 1.25 mg PO Q 24 hours, Felimazole 2.5 mg PO Q 12 hours, Solensia SQ Q 30 days. DDx: hypertension/tachycardia- uncontrolled hyperT4 vs cardiac disease (HCM vs other) DDx: Inflammatory leukogram- IBD, neoplasia, other"
"Febrile on presentation Jan 4- resolved. Tachycardia and hypertension on PE- persistent (has improved some with increased amlodipine to 2.5 mg Q 24 hours). Significant lumbar spine pain and spondylosis noted on PE and rads. CBC: mild to moderate leukocytosis characterized by a neutrophilia and monocytosis Chem: mild increase SDMA and BUN with normal Cre, mild hypokalemia (resolved), mild hyperglobulinemia T4: mild hyperthyroidism despite treatment with Felimazole U/A: USG 1.014 with inactive sediment" Bp as per below 276/129 (176) on presentation January 4th (on amlodipine 1.25mg PO SID). Monitored in hospital and average as below: Jan 5th 194/155 (150) Jan 6th dose was increased to 2.5mg PO 169/116 (134) and then later on the day 133/98 (110)

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is normally distended with a thin, smooth wall. The urine is anechoic with scant suspended echoes. The bladder neck and proximal urethra appear normal. No uroliths or ultrasonographic evidence of inflammatory or neoplastic disease are identified.

Left kidney: Normal shape and size (3.47×2.28 cm), cortical thickness 0.38 cm. The cortex is isoechoic to the liver with preserved corticomedullary ratio and definition. A medullary rim sign is present. A small forming nephrolith (~2.83 mm) is identified. No pyelectasia or hydronephrosis. Normal color Doppler perfusion.

Right kidney: Normal shape and size (3.41×2.38 cm), cortical thickness 0.33 cm. Cortex is isoechoic to the liver with preserved corticomedullary ratio and definition. Two nephroliths measuring approximately 4.28–4.34 mm are identified. No pyelectasia or hydronephrosis. Normal color Doppler perfusion.

### *Adrenal Glands*

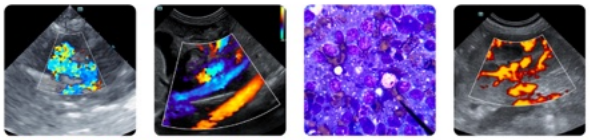
The adrenal glands could not be visualized in the provided cine loops.

### *Spleen*

Normal size (thickness 1.01 cm) with homogeneous echogenicity and smooth margins. No focal lesions.

### *Liver*

Normal size, contour, and echogenicity. No focal hepatic lesions or hepatic lymphadenopathy identified.





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The gallbladder is normally distended with a thin wall and anechoic contents. The common bile duct measures 3.27 mm proximally, tapering to 2.85–2.20 mm distally, and approximately 1.20 mm at the level of the duodenal papilla.

### *Gastrointestinal*

Stomach: Normal wall thickness (2.24 mm) with preserved layering.

Duodenum: Wall thickness increased (up to ~3.38 mm) with preserved layering and a mildly corrugated/spastic appearance.

Jejunum: Wall thickness 2.54 mm, Mucosa: 1.52 mm, Muscularis: 0.46 mm

Ileum: Wall thickness 1.83 mm, Mucosa: 1.00 mm, Muscularis: 0.71 mm

Ileocecal junction: Total thickness 3.71 mm, muscularis 1.74 mm. Several cranial small intestinal segments show hyperechoic mucosal speckling. No mechanical obstruction or foreign material identified.

Colon: Normal wall thickness (0.65 mm) with formed feces.

### *Pancreas*

The pancreas is enlarged (right limb ~6.52 mm; body and left limb ~8.81–8.98 mm) with mildly irregular margins and mild parenchymal hypoechogenicity relative to adjacent fat. A hypoechoic nodule measuring approximately 3.09×4.05 cm is identified near the proximal left pancreatic limb. The pancreatic duct measures approximately 1.23 mm.

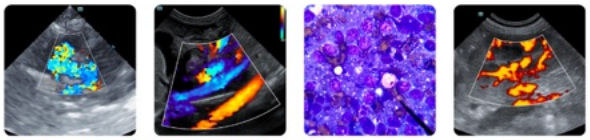
### *Peritoneal Cavity*

A small volume of free abdominal fluid is present within the hepato-diaphragmatic space and between intestinal loops. Reactive changes are confined to the perivascular mesenteric fat surrounding jejunal vessels. Cranial mesenteric lymph nodes measure up to ~0.8 cm, mildly rounded with normal echogenicity. Ileocecal lymph nodes are not visualized.

## ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Duodenal wall thickening with preserved wall layering and mildly corrugated/spastic appearance.
- Jejunal and ileal wall thickening characterized by muscularis hypertrophy, most pronounced at the ileum and ileocecal junction.
- Focal hyperechoic mucosal speckling within cranial small intestinal segments.





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- Diffuse pancreatic enlargement with mildly irregular margins, mild parenchymal hypoechogenicity, and mild pancreatic duct dilation, without peripancreatic fat necrosis or focal effusion.
- Focal mesenteric fat reactivity centered around jejunal vessels.
- Small volume of free abdominal fluid.

SECONDARY FINDINGS

- Mild enlargement and rounding of cranial mesenteric lymph nodes with preserved echogenicity.
- Bilateral nephrolithiasis with medullary rim sign, without obstruction.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Small intestinal abnormalities include duodenal wall thickening with preserved layering and a mildly corrugated appearance, as well as jejunal and ileal wall thickening characterized by disproportionate muscularis hypertrophy. Increased muscularis-to-mucosa ratios are most pronounced at the ileum and ileocecal junction. This pattern is most consistent with chronic inflammatory enteropathy, particularly a lymphoplasmacytic inflammatory process. The presence of hyperechoic mucosal speckling within cranial small intestinal segments further supports a chronic inflammatory etiology. However, early small-cell intestinal lymphoma cannot be entirely excluded based on ultrasonographic findings alone.

The pancreas is diffusely enlarged with mildly irregular margins, mild parenchymal hypoechogenicity, and mild pancreatic duct dilation, without focal mass formation, peripancreatic fat necrosis, or localized effusion. In cats, this constellation of findings is most compatible with pancreatitis, which may represent an acute exacerbation of chronic pancreatic disease.

The reactive changes in the mesenteric fat, centered around the jejunal vessels, along with mild enlargement and rounding of cranial mesenteric lymph nodes with preserved echogenicity, support an active inflammatory response. A small volume of free abdominal fluid is present and is most consistent with reactive or inflammatory effusion.

These imaging findings correlate well with the inflammatory leukogram (neutrophilia and monocytosis) and the patient's acute systemic signs (fever, anorexia, lethargy), supporting a diagnosis of active inflammatory disease involving the pancreas and proximal small intestine.

Renal findings, including bilateral nephrolithiasis and a medullary rim sign without obstruction, are most consistent with chronic or incidental changes and are unlikely to be contributing to the current acute clinical presentation. These findings may be influenced by systemic factors such as hypertension and early renal dysfunction.

The imaging features, in conjunction with clinical and laboratory data, favor inflammatory disease with possible chronic components and acute decompensation.

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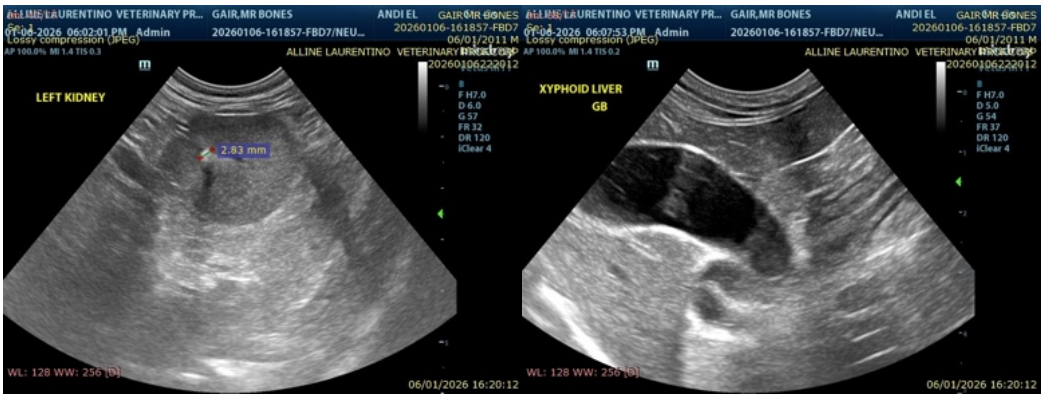
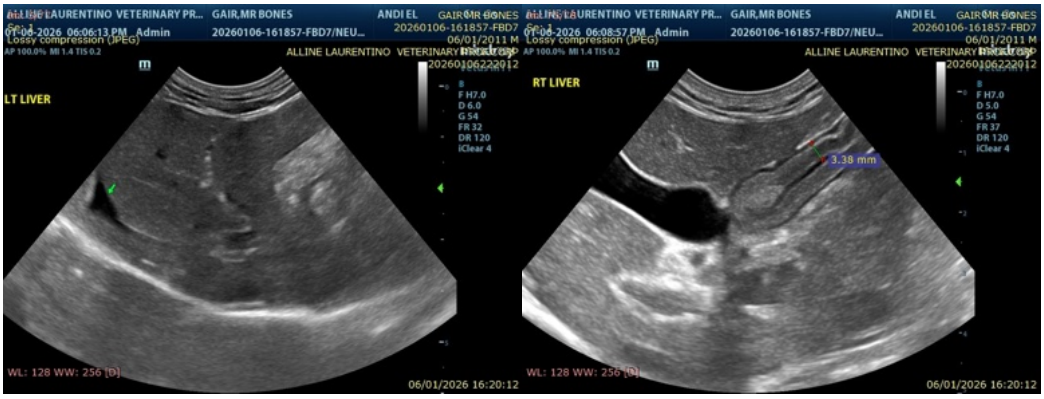
Recommendations

- Supportive care targeting pancreatitis and inflammatory gastrointestinal disease is appropriate, with close monitoring of appetite, hydration status, abdominal comfort, and systemic signs.
- If not already performed, Spec fPL testing is recommended.
- Dietary management and anti-inflammatory strategies may be considered at the discretion of the attending clinician. Further diagnostics, as gastrointestinal panel results (if pending), should be integrated once available.
- Repeat abdominal ultrasonography to assess evolution of pancreatic, intestinal, and mesenteric changes and to monitor for potential complications.
- Periodic monitoring of renal parameters (creatinine, SDMA, urinalysis) and blood pressure is advised, given the presence of nephroliths and the patient's history of hypertension, although these findings are not currently considered the primary driver of clinical signs.



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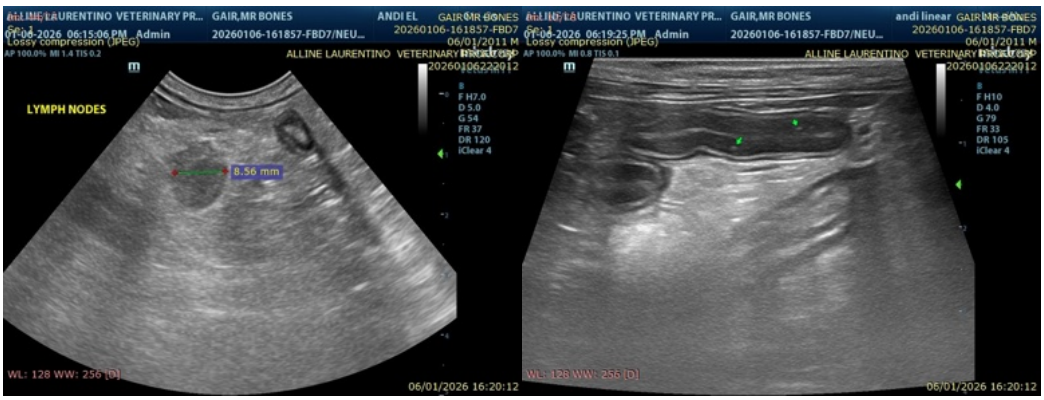


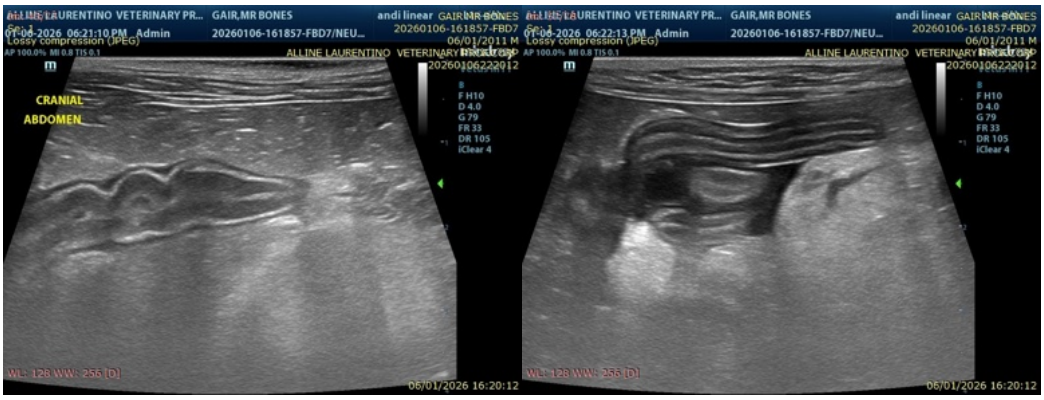


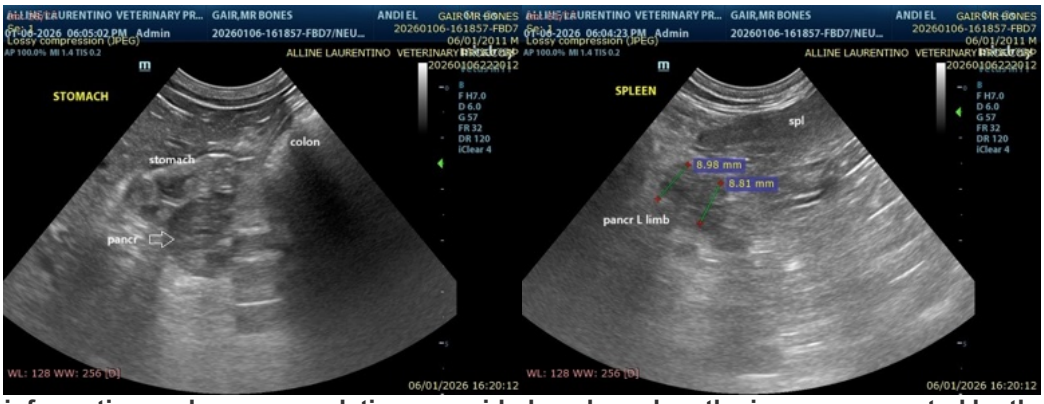


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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