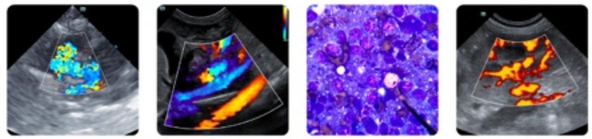


PATIENT

Tuna Roll Cortese

SPECIES

Feline

BREED

Domestic Longhair

SEX

Spayed female

AGE

10 years

WEIGHT

9.04 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Emilia Monachino

HOSPITAL NAME

Finger Lakes AH Vetcor

REFERRING VET

Dr. Kurtz

INVOICE

69879

DATE

1/6/26

PRESENTING CLINICAL SIGNS

History: Chronic vomiting, recently worse, vomiting multiple times daily. Mild weight loss (~0.4 lbs). Owner is reluctant to try prescription diet due to cost.
Abnormal PE/Chem/CBC/UA Results: Labwork performed 12/23/25 - CBC - Eosinophils 1.997 (0.209 - 1.214) K/μL, rest of CBC is WNL; Chemistry/T4 - WNL. UA and Texas GI panel collected today and results are pending. No significant findings on physical exam.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the bladder wall appears 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 sonographic evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 3.73×1.88 cm, with a cortical thickness of 0.32 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 3.09×1.80 cm, with a cortical thickness of 0.29 cm in the sagittal plane.

In both kidneys, the renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. Doppler evaluation demonstrates normal perfusion patterns.

Adrenal Glands

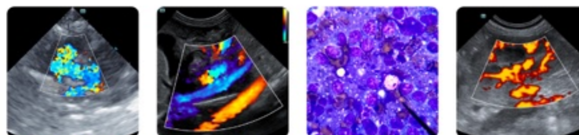
The left adrenal gland measures 0.36 cm at the cranial pole and 0.40 cm at the caudal pole.
The right adrenal gland measures 0.34 cm at the cranial pole and 0.38 cm at the caudal pole.
Both adrenal glands have a mildly globular appearance and appear relatively hypoechoic.

Spleen

Splenic thickness measures 0.61 cm. The splenic parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture without focal 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. The hepatic parenchyma is homogeneous and isoechoic relative to the falciform fat. No hepatic lymphadenopathy is identified.



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The gallbladder is moderately distended. The wall is thin, and the contents are anechoic. The common bile duct measures approximately 2.52–1.47 mm and is within normal limits.

Gastrointestinal

The stomach is empty and folded, with a mural thickness of approximately 2.06 mm and preserved wall layering. The pylorus measures approximately 3.08 mm, with a muscularis thickness of 1.15 mm.

The duodenum measures approximately 1.36 mm.
The jejunum measures approximately 2.02 mm, with preserved wall layering. Measured layers include a mucosa of 0.95 mm, submucosa of 0.51 mm, and muscularis propria of 0.61 mm.
The ileum measures approximately 2.81 mm, with preserved wall layering. Measured layers include a mucosa of 0.74 mm, submucosa of 0.70 mm, and muscularis propria of 1.27 mm. A focal ileal segment measures up to 3.08 mm in total thickness, with muscularis thickening up to 1.36 mm.

The ileocecal junction measures approximately 3.72 mm, with a muscularis thickness of 1.67 mm. No evidence of obstruction, ileus, or foreign material is identified.

The ascending colon measures approximately 1.0 mm and is partially empty. The transverse colon measures approximately 0.64 mm. The descending colon contains formed feces.

Pancreas

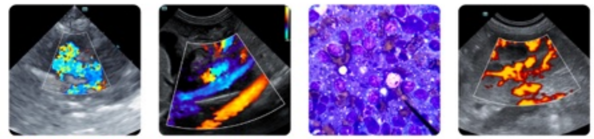
The right pancreatic limb measures approximately 5.82 mm, and the left limb measures approximately 5.60–5.75 mm. Pancreatic parenchyma is isoechoic relative to the adjacent omental fat. The pancreatic duct measures approximately 1.44 mm. No sonographic evidence of active pancreatitis or neoplastic disease is identified.

Peritoneal Cavity

No abdominal effusion or signs of peritonitis are observed. Cranial mesenteric and ileocecal lymph nodes appear within normal limits. The iliac trifurcation is normal

ULTRASONOGRAPHIC FINDINGS

- Muscularis-predominant thickening of the ileum and ileocecal junction, with increased muscularis-to-mucosa ratios.
- Focal segmental ileal wall thickening with preserved layering.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominal ultrasonography reveals small intestinal muscularis-predominant thickening, most pronounced at the ileum and ileocecal junction, with preservation of overall wall layering and without evidence of mechanical obstruction.

The muscularis-to-mucosa ratios are increased, particularly within the ileum (ratio ≈ 1.7) and ileocecal junction (muscularis 1.67 mm within a total thickness of 3.72 mm), a pattern that in cats is most consistent with chronic inflammatory enteropathy. Given the significant eosinophilia, an eosinophilic gastrointestinal disease is strongly suspected: This conditions can produce muscularis-predominant thickening with relatively preserved mucosal architecture on ultrasound.

However, an early low-grade alimentary lymphoma remains a differential diagnosis for muscularis-predominant intestinal thickening in cats; even in the absence of lymphadenopathy, lack of transmural disruption, and preserved wall layering.

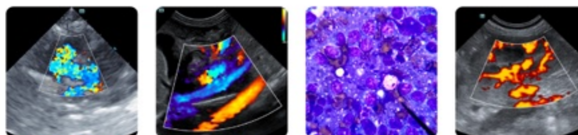
Both adrenal glands are at the upper limits of normal size with a mildly rounded contour and slightly decreased echogenicity, findings that may be consistent with reactive or functional adrenal hyperplasia in the setting of chronic systemic disease.

The pyloric wall thickness and muscularis are within expected limits for a feline patient and may reflect functional or reactive changes in the context of chronic gastrointestinal disease rather than primary pyloric pathology.

The pancreas appears within normal ultrasonographic limits. However, it is important to recognize that chronic or subclinical pancreatitis in cats may not be reliably detected on ultrasonography, and the absence of sonographic abnormalities does not definitively exclude pancreatic disease. As such, concurrent low-grade or chronic pancreatic involvement cannot be ruled out based on imaging alone.

Recommendations

- Await and interpret pending GI panel results, including cobalamin and folate concentrations.
- Dietary modification using a cost-conscious approach, given owner concerns. A strict novel-protein, limited-ingredient over-the-counter diet may be considered if prescription diets are not feasible, emphasizing absolute dietary compliance.
- Empiric medical management for suspected eosinophilic enteropathy, guided by the referring clinician.
- Close clinical monitoring, including body weight, vomiting frequency, stool quality, and repeat CBC to assess eosinophil trends.
- Consider histopathologic sampling if clinical signs persist or worsen despite appropriate dietary and medical management, recognizing that histology is required to definitively differentiate eosinophilic inflammatory disease from low-grade lymphoma.



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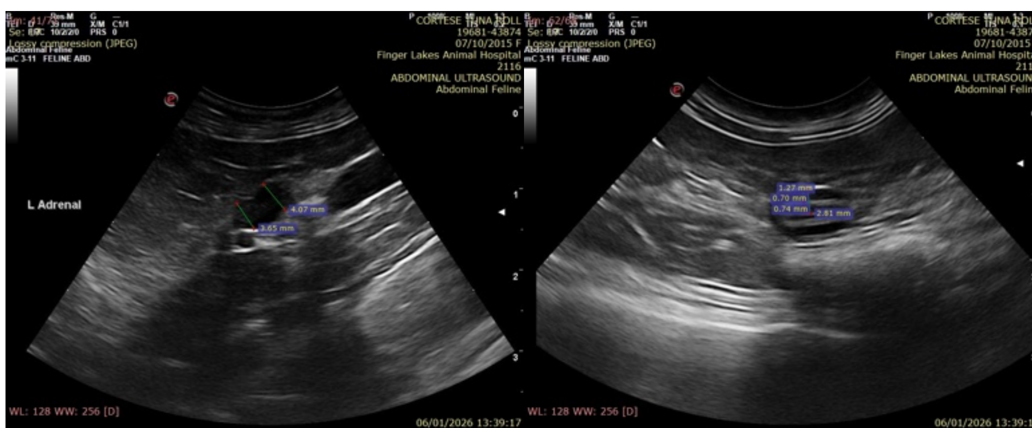

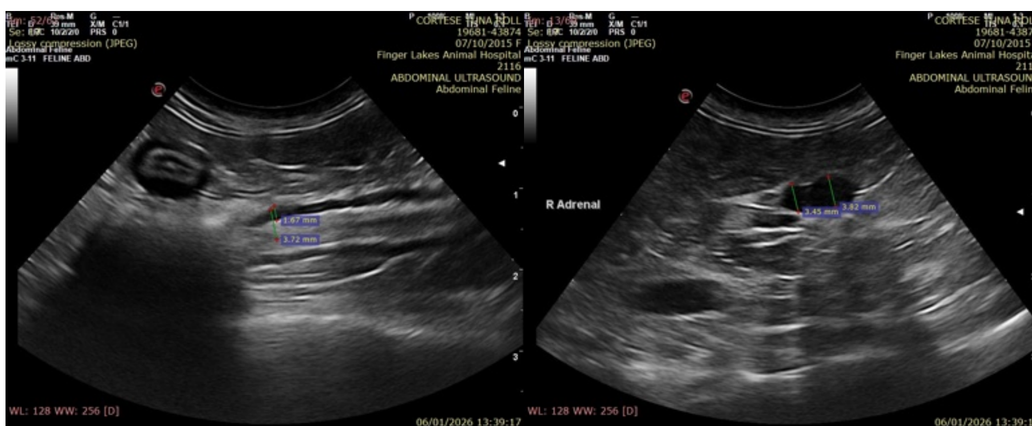

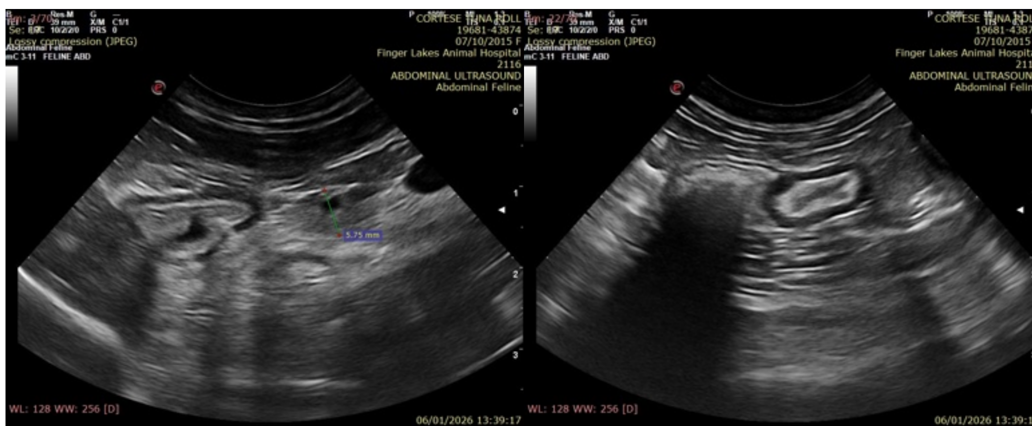

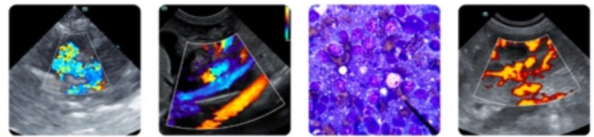

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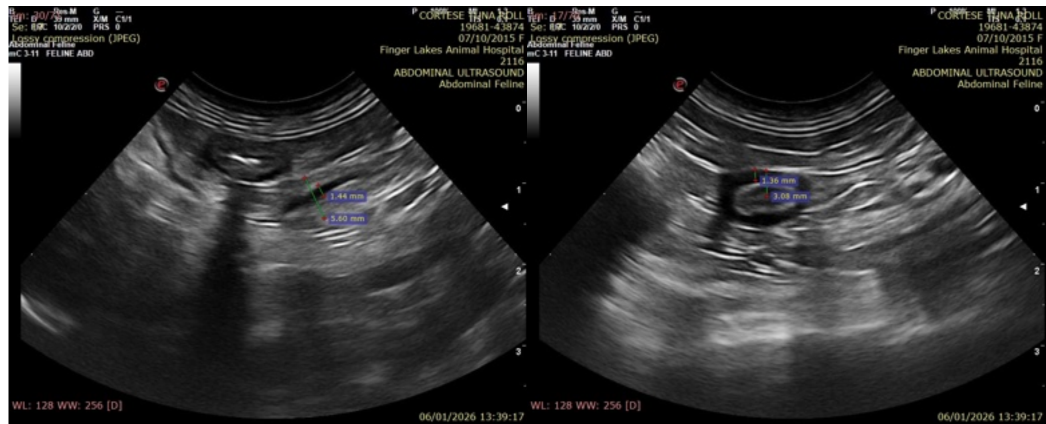

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@SonoPath.com