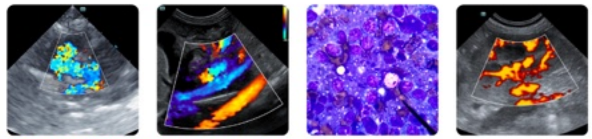


PATIENT
Sarah Lynn Kite

SPECIES
Feline

BREED
Domestic Longhair

SEX
Spayed female

AGE
16 years

WEIGHT
6.69 lbs

INTERPRETED BY
Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY
Ukachi Ugorji, DVM

HOSPITAL NAME
Craig Road AH

REFERRING VET
Dr. Ugorji

INVOICE
68621

DATE
11/12/25

PRESENTING CLINICAL SIGNS

History: Sarah, a 16-year-old feline, presents with a 3-day history of hematemesis after switching to a k/d diet, followed by 3-4 days of inappetence. The owner reports Sarah has not eaten or drunk anything for the last 2 days. The owner notes rapid weight loss and difficulty eating kibble due to dental issues. Previous testing reportedly showed borderline renal disease, mild generalized cardiomegaly, and a grade III systolic heart murmur. Additional history includes nasal discharge and concern for infectious respiratory disease; heartworm and select tick disease screening were reported negative. No information provided regarding urination or defecation patterns.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is slightly turbid, but no sediment is observed. Normal appearance of the proximal urethra and vesicoureteral junction. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney measures slightly small and irregular 2.83x2.14 cm, and the cortical thickness in the sagittal plane is 0.35 cm. The right kidney, measuring 2.74×1.93 cm, with a cortical thickness of 0.36 cm in the sagittal plane.

The renal cortex is isoechoic compared to liver parenchyma, with some cortical hyperechoic striations. The corticomedullary ratio and definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

The left adrenal gland is only partially visualized and measures 0.35 cm. The right adrenal gland measures 0.28 cm at the cranial pole and 0.25 cm at the caudal pole.

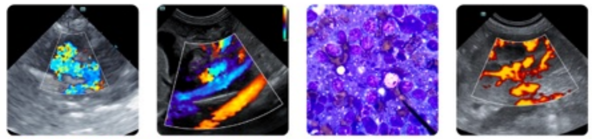
Spleen

Splenic thickness is 0.66 cm. The 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 edges and a regular contour. The parenchyma appears uniform and isoechoic compared to the falciform fat, with normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is thin, and the contents consist of a mild to moderate amount of biliary sludge. No dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach is empty and folded, containing gas, with mural thickness of 1.87 mm and preserved wall layering.
The pylorus measures 4 mm.

Small intestine:

- Duodenum: 1.22 mm
- Jejunum: 1.37–2.20 mm
- Ileum: 1.70 mm (mucosa 0.56 mm, submucosa 0.73 mm, muscularis 0.24 mm)

Wall layering is normal. No signs of obstruction or foreign material are identified. Several segments of small intestine appear corrugated. The ileocecal junction was partially visualized.

Colon: wall thickness 0.97 mm, with formed feces in the descending colon.

Pancreas

The right limb, body, and left limb measure 6.28–8.96 mm and appear normal in shape. The pancreatic parenchyma is hypoechoic relative to the adjacent omental fat. The pancreatic duct is moderately enlarged, measuring 1.98–2.39 mm. No peripancreatic free fluid or fat inflammation is observed.

Peritoneal Cavity

No abdominal effusion or peritonitis is observed. The cranial mesenteric and ileocecal lymph nodes are not visualized, but the surrounding regions appear unremarkable. The iliac trifurcation is normal.

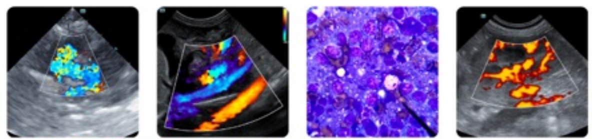
ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Several segments of small intestine with a corrugated pattern.
- Pancreatic parenchyma hypoechoic relative to surrounding fat, with moderate dilation of the pancreatic duct (1.98–2.39 mm).

SECONDARY FINDINGS

- Both kidneys small and irregular in contour; cortical hyperechoic striations present bilaterally.
- Mild to moderate biliary sludge without visible biliary tract dilation.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

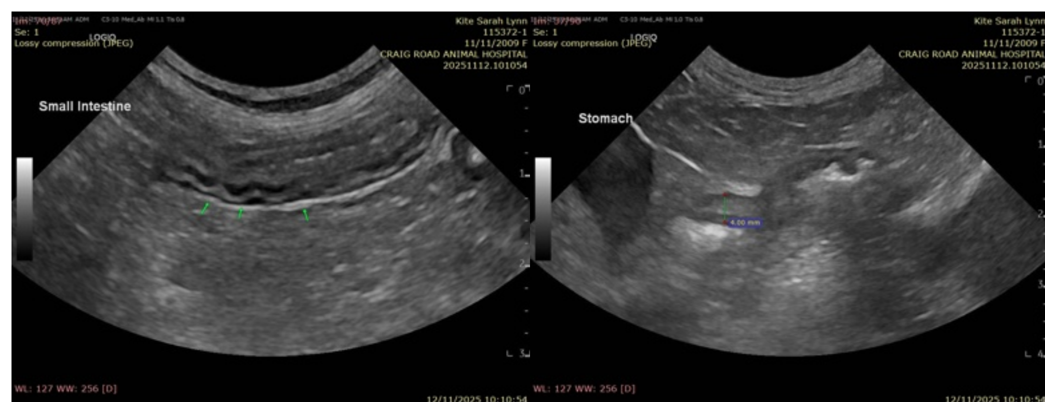
The pancreas is diffusely enlarged and hypoechoic, with marked dilation of the pancreatic duct—a pattern most consistent with chronic pancreatitis in a geriatric cat. Although no peripancreatic fat reaction or free abdominal fluid is present at this time, the clinical presentation and sonographic features carry a high likelihood of an acute exacerbation of an underlying chronic pancreatitis.

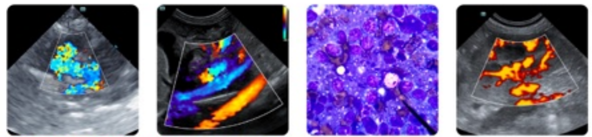
There is also clear evidence of significant gastritis. The stomach shows mural thickening, particularly at the pylorus, and several segments of small intestine exhibit corrugation, a reactive pattern frequently associated with gastric inflammation or pancreatitis. No discrete ulcer crater is visualized; however, given the clinical history of hematemesis, an ulcerative component remains a strong possibility, as gastric ulcers are often missed sonographically.

The kidneys show structural changes consistent with chronic kidney disease, including a small and irregular right kidney and bilateral cortical hyperechogenicity with distinct cortical striations. These findings most likely reflect tubulointerstitial fibrosis or chronic ischemic or inflammatory injury. Although CKD is not the primary driver of the current crisis, these structural changes are clinically relevant and may reduce the cat's physiological reserve during periods of acute illness, dehydration, or anorexia.

Recommendations

- Feline-specific pancreatic lipase (fPLI) to further evaluate pancreatitis.
- Correlate renal findings with full kidney panel (SDMA, UPC, blood pressure) to assess chronic kidney disease severity.
- If gastrointestinal signs persist, consider:
  - B12 (cobalamin) level,
  - GI panel (TLI, folate),
- Supportive care for suspected gastritis/enteritis, including antiemetics, gastroprotectants, and cautious refeeding once vomiting is controlled.





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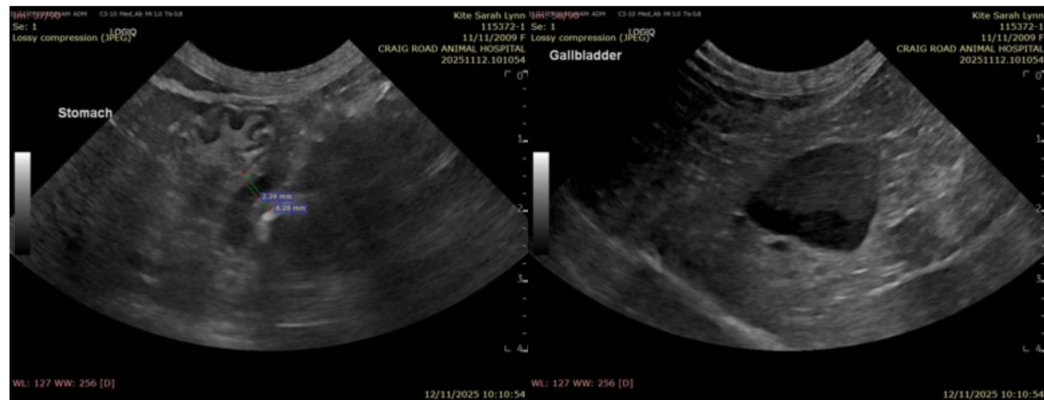

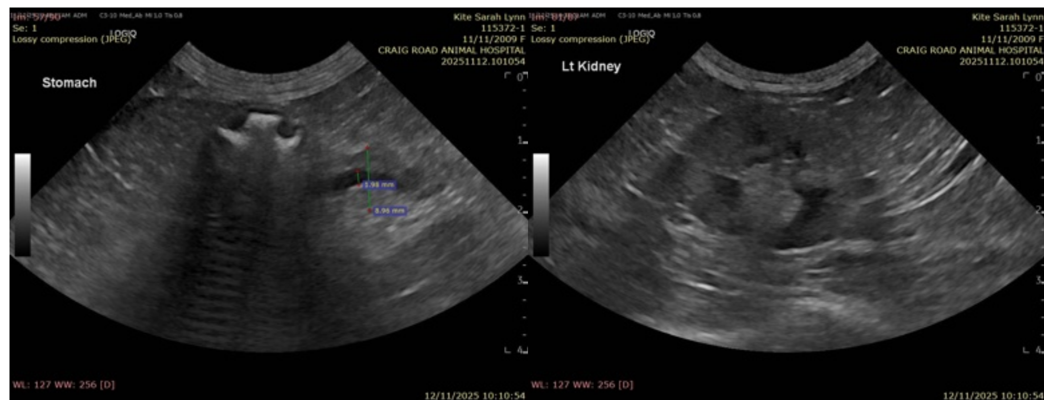

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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