



PATIENT

Josie Acadia VC

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

17 years

WEIGHT

3 kg

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Danielle Jaspar RVT

HOSPITAL NAME

Orchard VC

REFERRING VET

Dr. Gudelot

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PRESENTING CLINICAL SIGNS

History: About 1 week of decreased appetite, painful in abdomen, lethargic/withdrawn. Patient responds to Buprenorphine for pain, but is painful once it wears off. BW was unremarkable * patient is fasted for 12 hours for AUS - despite stomach not being empty.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall appears thin and smooth. The urine appears slightly turbid, though no mineral sediment is observed and this may be artefactual. Normal appearance of the proximal urethra and vesicoureteral junction. No calculi or evidence of inflammatory or neoplastic changes.

The left kidney measures 3.28×1.89 cm, cortical thickness 0.33 cm. The cortex is isoechoic to the liver, corticomedullary definition is preserved. Mild pyelectasia (3.49 mm) is present. No nephrolithiasis or hydronephrosis.

The right kidney measures 3.34×1.86 cm, cortical thickness 0.33 cm. The cortex is isoechoic to liver, corticomedullary definition preserved. Mild pyelectasia (2.17 mm) is present. No nephrolithiasis or hydronephrosis.

Adrenal Glands

Left adrenal gland: 0.41 cm (cranial pole), 0.42 cm (caudal pole). Right adrenal gland: 0.41 cm (cranial pole), 0.43 cm (caudal pole).

Spleen

Splenic thickness 1.12 cm. Homogeneous parenchyma with normal echotexture. Smooth capsule. Normal vasculature.

Liver

Subjectively normal in size with regular contour and sharp margins. Parenchyma is uniform and isoechoic compared with falciform fat. No hepatic lymphadenopathy.

Normally distended; thin wall; anechoic contents. No dilation of the cystic or common bile ducts.

Gastrointestinal

The stomach is distended with food and gas. Wall thickness 1.23 mm with preserved layering. Pylorus 2.49 mm. Duodenum: 1.94 mm (proximal), 1.77 mm (distal).



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Jejunum: 1.95 mm (mucosa 0.97 mm, submucosa 0.76 mm, muscularis 0.50 mm). Ileum: 1.89 mm (mucosa 0.84 mm, submucosa 0.64 mm, muscularis 0.28 mm). Ileocecal junction: 2.84 mm, muscularis 0.83 mm. Normal wall layering; no obstruction or foreign material identified.

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Ascending colon 1.04 mm with semi-liquid material; descending colon 0.63 mm with more formed feces.

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Pancreas

Right limb 4.93 mm, and left limb 5.15 mm (within normal limits). Parenchyma is isoechoic to omental fat. Pancreatic duct 0.62 mm. No peripancreatic inflammation or masses are observed.

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Peritoneal Cavity

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No effusion or peritonitis.

Cranial mesenteric and ileocecal lymph nodes not visualized; surrounding regions unremarkable. Iliac trifurcation normal.

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ULTRASONOGRAPHIC FINDINGS

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Guerrero

PRIMARY FINDINGS

- Stomach markedly distended with food despite 12-hour fast → delayed gastric emptying suspected.
- Increased fluid content in ascending and transverse colon.
- Muscularis / total wall thickness 29% (normal ranges from 25–35%).

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SECONDARY FINDINGS

- Mild bilateral pyelectasia.
- Adrenal glands mildly prominent but still within normal limits (≤ 0.45 cm).

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach is significantly distended with food and gas despite a 12-hour fast, strongly suggesting delayed gastric emptying. In an older cat with systemic illness and abdominal discomfort, this may reflect:

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- Early gastric dysmotility secondary to systemic disease.

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- Gastritis.
- Pain-induced ileus.

Intestinal segments show normal thickness and layering overall, though the ileocecal muscularis is mildly prominent, which is a nonspecific finding and may occur with low-grade inflammation, early IBD,



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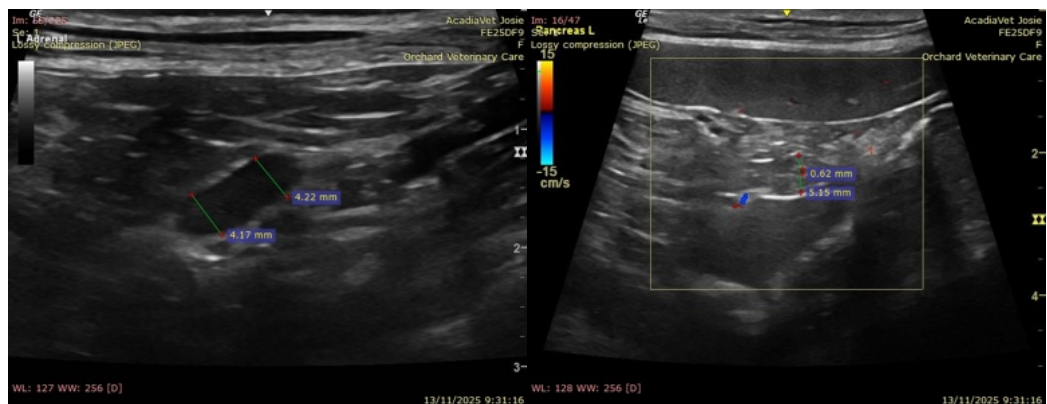
or transient reactive change. The ascending colon contains semi-liquid content, compatible with mild colitis that may help explain recent gastrointestinal signs.

The pancreas appears within normal limits, and no peripancreatic inflammation is identified. Although pancreatitis cannot be fully excluded—especially in cats—there are no supportive sonographic changes at this time.

The mild, bilateral pyelectasia observed in this patient is very likely a physiologic finding rather than a sign of obstruction or primary renal disease. Cats receiving intravenous fluids—especially when the bladder is moderately to markedly full at the time of the scan—may show transient renal pelvic dilation due to increased urine production and passive distension.

Recommendations

- Supportive care for gastrointestinal signs (analgesia, antiemetics, gastroprotectants, and hydration as clinically indicated).
- If clinical signs persist despite supportive care, a feline gastrointestinal panel (TLI, fPLI, folate, and cobalamin) is recommended to further evaluate chronic enteropathy, early pancreatitis, or concurrent malabsorption disorders. Assessment of serum cobalamin is particularly valuable in geriatric cats with weight loss and chronic gastrointestinal signs.
- Dietary management.
- Monitor renal values and urine output, given the mild bilateral pyelectasia.





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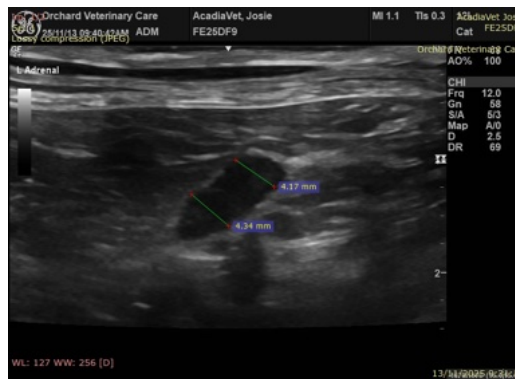
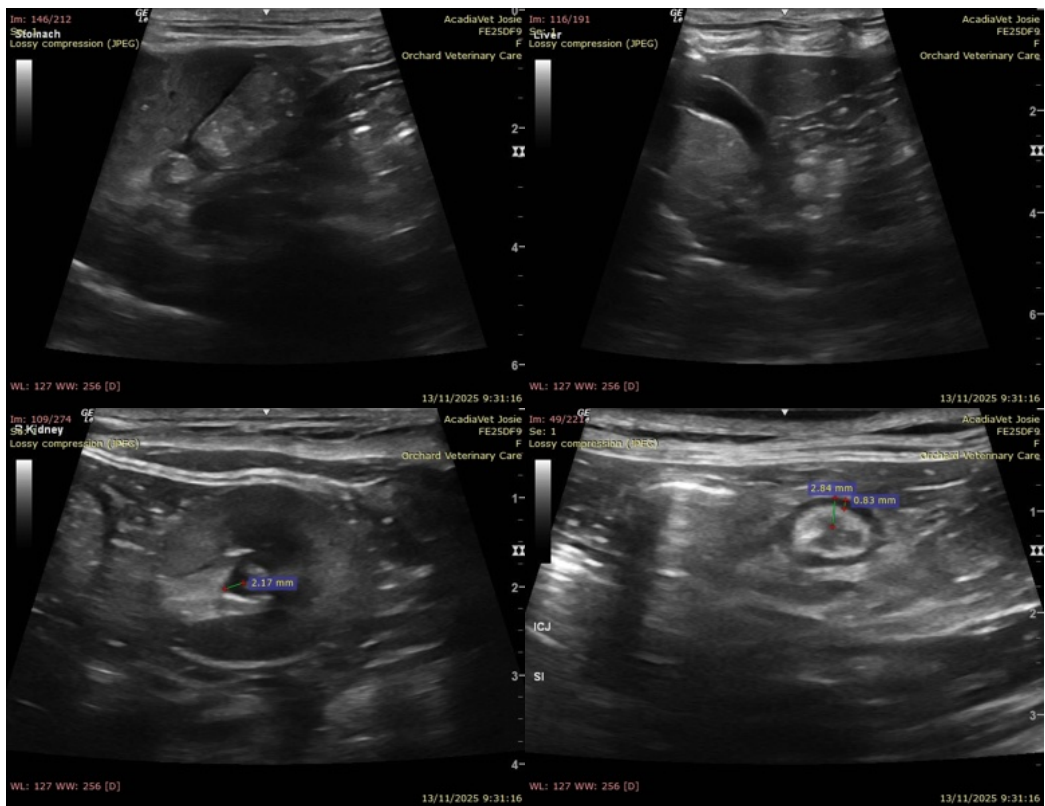
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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