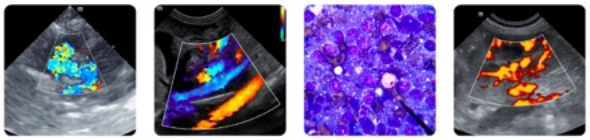


PATIENT

Connie Lucia

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

14 years

WEIGHT

7.5 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Brandi Kurzowski

HOSPITAL NAME

Corfu VC

REFERRING VET

Dr. Kelver

INVOICE

68777

DATE

11/18/25

PRESENTING CLINICAL SIGNS

P presented Sept 2025 for marked weight loss, was 19 lb in July 2025, now 6.6 lb. P was vomiting frequently (food and/ or liquid) and has been sleeping a lot. Acting fine otherwise, is eating normally and drinking more than normal. Bloodwork ran in September was abnormal, prescribed veraflox and BW is improved. Weight loss has slowed down and p gained a pound from September. Pursuing ultrasound prior to starting steroid trial.
7/22/25 Chem- NSF T4- 2.2 (normal) 9/4/25 CBC- WBC: 46.3 (3.9-19), Neuts 38.938 (2.62-15.17), Mono 1.204 (0.042-0.467), Platelets 478 (100-44), rest WNL Chem- BUN 41 (16-37), Creat 1.4 (0.9-2.3), ALT 23 (27-158), rest WNL Idexx SDMA 17 (0-14), T4 1.6 (0.8-4.7) 11/6/25 WBC 19.4 K/uL (3.9-19.0), EOS 2.444 K/uL (0.209 - 1.214), BASO 0.446 K/uL (0-0.1), Rest of the CBC is WNL Chemistry is WNL, SDMA 11 (0-14), T4 2.3 (0.8-4.7)

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 anechoic. Normal appearance of the proximal urethra and vesicoureteral junction. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.09x2.18 cm, and the thickness of the cortex is 0.30 cm, in the sagittal plane. The cortical is isoechogenic compared to liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths or hydronephrosis.

The right kidney is normal in shape and size: 3.48x2.34 cm, and the thickness of the cortex is cm, 0.29 cm in the sagittal plane. Details of cortical echogenicity cannot be reliably assessed due to suboptimal machine settings affecting echogenicity estimation; however, it is assumed to be similar to the contralateral kidney. No pyelectasia, nephroliths, or hydronephrosis are observed.

Adrenal Glands

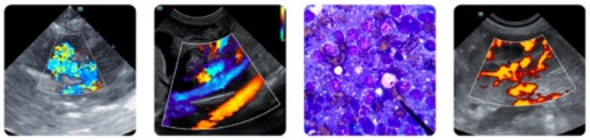
Both adrenal glands show normal shape and echogenicity. The left adrenal gland measures 0.40 cm at the cranial pole and 0.48 cm at the caudal pole. The right adrenal gland measures 0.43 cm at the cranial pole and 0.39 cm at the caudal pole.

Spleen

Splenic thickness is 0.9 cm. The parenchyma demonstrates normal echogenicity and 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 liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.



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The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is partially distended with digested food material and fluid, with mural thickness ranging from 1.83–2.28 mm and preserved wall layering. The pylorus was not visualized.

Both the stomach and intestinal tract contain residual food material and abundant mucous content, together with increased peristaltic activity, suggesting that the patient was not adequately fasted prior to the examination.

Duodenum: 1.75 mm. Jejunum: 2.76 mm (mucosa 1.63 mm, submucosa 0.76 mm, muscularis propria 0.18 mm). Ileum: wall layering is normal; measurements obtained include mucosa 0.56 mm, submucosa 0.80 mm, muscularis propria 0.24 mm. The ileocecal junction 2.60 mm, muscularis 1.59 mm.

Colon: transverse colon measures 0.75 mm with soft material present; descending colon measures 0.85 mm with formed feces.

Pancreas

The pancreatic parenchyma is mildly hypoechoic relative to the adjacent omental fat. The pancreatic duct is not dilated. No ultrasonographic evidence of active inflammation or neoplastic disease is identified. The pancreatic thickness at the region examined are 5.55 and 5.70 mm.

Peritoneal Cavity

No abdominal effusion or peritonitis is observed. Cranial mesenteric lymph nodes are not visualized, but the surrounding regions appeared unremarkable. Ileocecal lymph nodes 1.27x0.5 cm the largest, oval and hypoechoic. The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Jejunal wall thickening (2.76 mm).
- Ileal muscularis borderline increased relative to mucosa. ileocecal junction mildly thickened with mild muscularis hyperplasia.
- Pancreatic parenchyma slightly hypoechoic relative to surrounding fat.

SECONDARY FINDINGS

- Residual gastric and intestinal ingesta with increased peristalsis, consistent with incomplete fasting or delayed gastric emptying (correlation with the actual fasting duration prior to the examination is recommended).

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

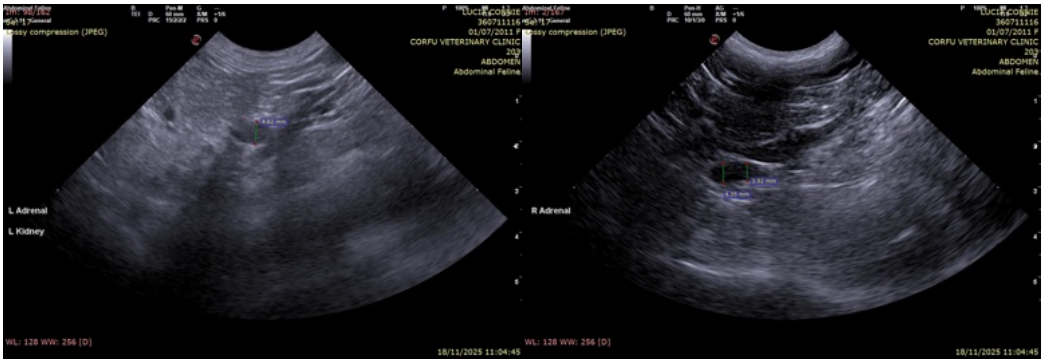
On ultrasound, no focal mass lesions, loss of wall layering, or obstructive patterns are identified in the gastrointestinal tract. However, the presence of residual ingesta and mucous content throughout the stomach and intestines, together with increased peristalsis, indicates insufficient fasting or possible delayed gastric emptying, and this limits full assessment of gastric and proximal intestinal motility. The jejunum shows mild mural thickening, and the ileum (especially the ileocecal junction) displays a mild increased muscularis layer.

Overall, the combination of persistent mild anemia, eosinophilia/basophilia, mild segmental intestinal wall changes, and incomplete fasting limiting gastric assessment is most consistent with chronic inflammatory enteropathy, with differentials including eosinophilic enteritis, food-responsive enteropathy, or early low-grade lymphoma, although the preserved wall layering makes high-grade neoplasia unlikely.

The pancreas appears mildly hypoechoic relative to fat, a nonspecific finding that can occur with age, prior inflammation, or body condition. No abdominal effusion or peritonitis is identified.

Recommendations

- Correlate findings with fasting duration to rule out delayed gastric emptying vs. incomplete fasting.
- Perform a GI panel (cobalamin, folate, TLI) and fPLI.
- Consider fecal testing (float/PCR) given eosinophilia.
- Begin a dietary trial (novel or hydrolyzed protein).
- If fecal testing is negative and the patient continues to exhibit signs of chronic gastrointestinal inflammation, intestinal biopsy is recommended to obtain a definitive diagnosis.



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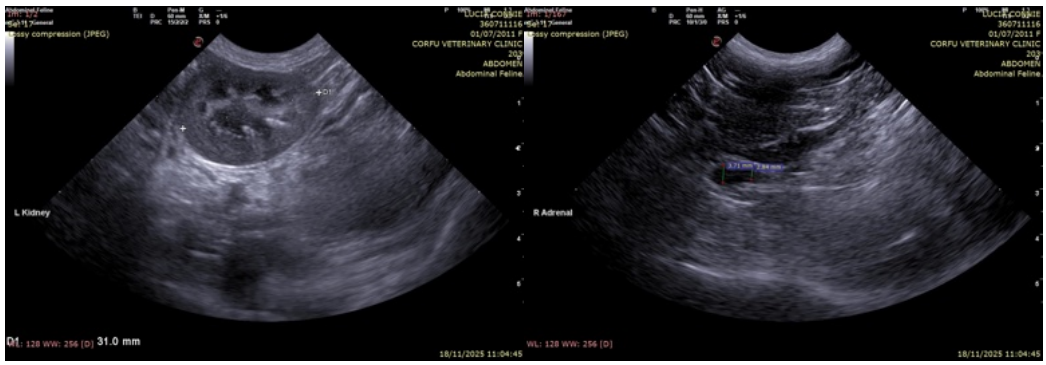

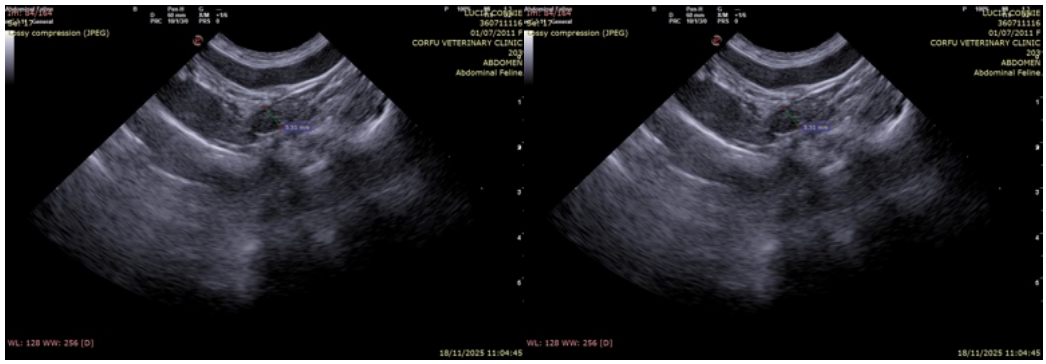

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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