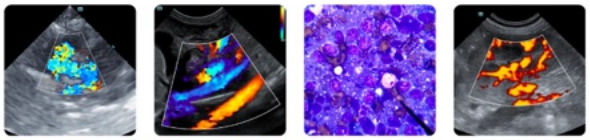


PATIENT

Ethan Rutherford

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

10 years

WEIGHT

12.1 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Brandi Kurzowski

HOSPITAL NAME

Corfu VC

REFERRING VET

Dr. Beatty

INVOICE

69041

DATE

11/25/25

PRESENTING CLINICAL SIGNS

History: P presented 11/20/25 for vomiting bile and clear liquids for several days. P is on a prescription fiber response diet and has been doing well. O elected outpatient treatment of cerenia and ondansetron. P improved initially, but now p is still not acting right and eating less overall, opted to pursue ultrasound. Vomiting - Open - gastritis vs other Hyperglycemia/glucosuria - secondary to stress vs true DM (less likely)
Abnormal PE/Chem/CBC/UA Results: UA- Glucose 300mg/dL, USG >1.050, pH 7 Cbc- Retic 67.5 k/uL, neut 12.95 k/uL Chem- Glu 374mg/dL, BUN 13mg/dL Panc lipase- WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the urinary bladder wall appears thin and smooth. The urine is turbid with abundant floating debris. 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: 2.74 x 2.25 cm, and the thickness of the cortex is 0.45 cm, in the sagittal plane. The right kidney is normal in shape and size: 3.11 x 2.18 cm, and the thickness of the cortex is 0.40 cm, in the sagittal plane. The renal cortex is slightly increased in echogenicity, resulting in increased corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler shows a normal pattern.

Adrenal Glands

The left adrenal gland measures 0.29 cm at the cranial pole and 0.28 cm at the caudal pole. The right adrenal gland is not observed.

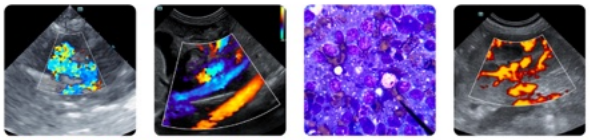
Spleen

Splenic thickness is 0.49 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 appears uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

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.



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Gastrointestinal

The stomach is empty, with a liquid pattern, mural thickness of 2.63 mm, and preserved wall layering. The pylorus measures 2.78 mm and contains a small amount of ingesta/hair producing some acoustic shadowing; this is likely agglomerated ingesta rather than foreign material, based on history.
The duodenum was not observed. Jejunum: 2.19 mm. Mucosa: 0.98 mm. Submucosa: 0.81 mm. Muscularis propria: 0.49 mm. Ileum: 1.87 mm. Mucosa: 0.34 mm. Submucosa: 0.59 cm. Muscularis propria: 0.67 mm. Normal wall layering. The ileocecal junction was not visualized. No signs of obstruction, ileus, or foreign material are identified.

Colon: 1.09 mm, with formed feces in the descending segment.

Pancreas

The pancreas was not clearly visualized, although the regions examined did not show signs of inflammation.

Peritoneal Cavity

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

ULTRASONOGRAPHIC FINDINGS

- Ileal muscularis hypertrophy (muscularis/mucosa ratio ≈ 1.97).
- Fluid-filled stomach; correlate with fasting to rule out delayed gastric emptying.
- Markedly turbid urine with abundant debris (sediment).
- Mild renal cortical hyperechogenicity with increased corticomedullary distinction.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach is fluid-filled with normal mural architecture and contains a small amount of agglomerated hair/food material at the pylorus producing mild acoustic shadowing. No structural pyloric abnormality or gastric mass is identified. The presence of fluid should be correlated with fasting interval, as delayed gastric emptying cannot be excluded in a patient with persistent vomiting.

Overall, the most significant abnormality is the ileal muscularis hypertrophy, which strongly suggests chronic inflammatory enteropathy. The fluid-filled stomach may reflect delayed gastric emptying associated with gastrointestinal inflammation or vomiting. The ileocecal valve, a region of relevance in feline lymphoma, was not visualized on today's examination. Likewise, the ileocecal and cranial mesenteric lymph nodes were not identified, although the surrounding mesentery did not demonstrate

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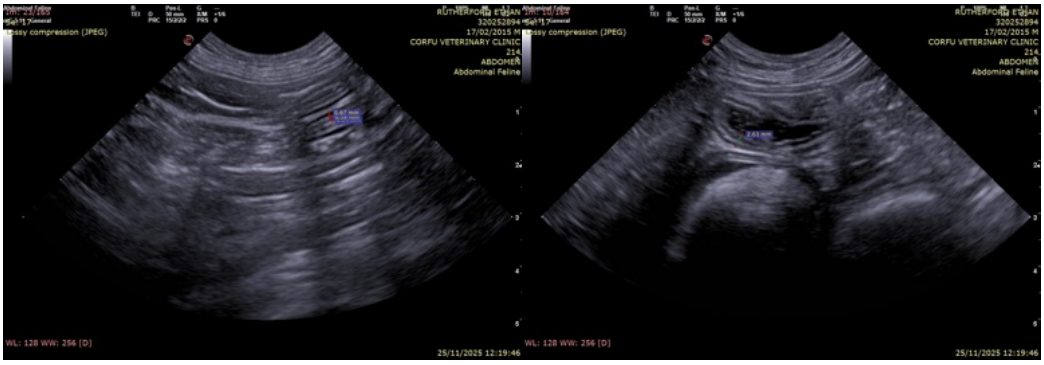
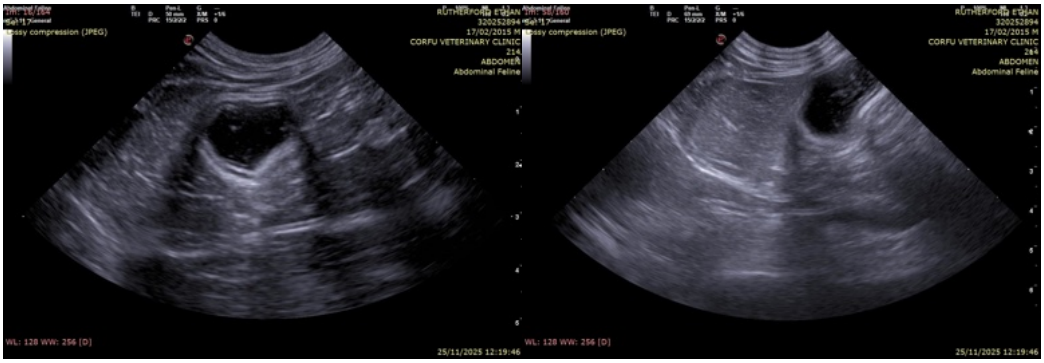
abnormalities. As these structures could not be evaluated directly, an early low-grade lymphoma cannot be completely excluded despite the absence of sonographically suspicious features.

The kidneys are normal in size and shape with preserved architecture; however, there is mild cortical hyperechogenicity with increased corticomedullary distinction. This may reflect early chronic renal change, metabolic stress, or age-related alteration. No evidence of obstruction or nephrolithiasis is present. The bladder contains markedly turbid urine with abundant floating debris, consistent with significant cellular or crystalline sediment; however, the bladder wall remains normal, and there is no ultrasonographic evidence of cystitis or lower urinary tract obstruction.

Recommendations

- Correlate ileal findings with GI signs; consider gastrointestinal panel (TLI, folate, cobalamin).
- If diabetes mellitus is suspected, or if there is renewed suspicion of pancreatitis or other pancreatic disease, further evaluation with Spec fPL or repeat ultrasound using a high-frequency linear transducer is recommended. The sensitivity of abdominal ultrasound for detecting feline pancreatitis—particularly when performed with lower-frequency probes—is known to be limited.
- If vomiting persists, consider GI-specific therapy or endoscopy with ileal biopsy for a definitive diagnosis.
- Perform complete urinalysis (sediment exam, crystals, protein, culture if indicated).
- Monitor renal values (creat, SDMA, UPC) due to mild cortical changes.





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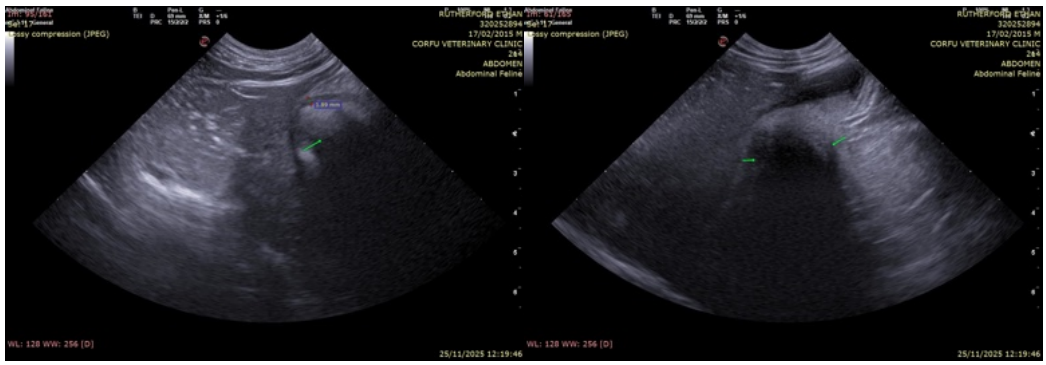

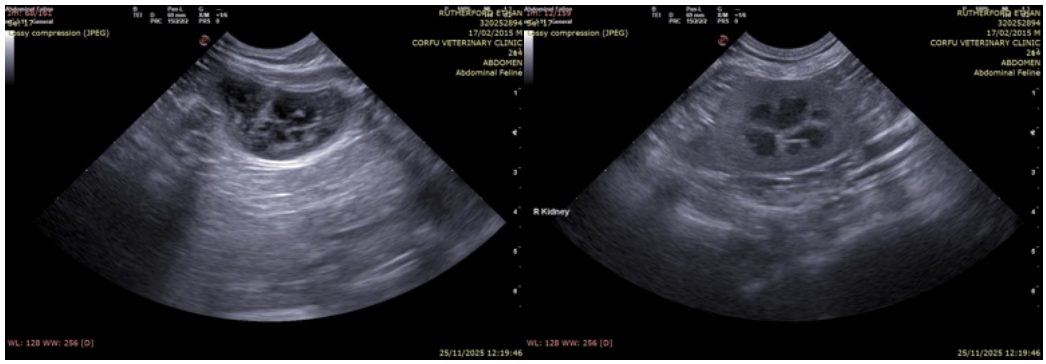

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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