



PATIENT

Scamper Bake

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

10 years

WEIGHT

10 lbs

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Justin Eckenrode, DVM

HOSPITAL NAME

Carlisle Small Animal
VC

REFERRING VET

Dr. Shamitko

INVOICE

69040

DATE

11/25/25

PRESENTING CLINICAL SIGNS

History: Weight loss, possible vomiting (O has multiple cats and has not seen who is actually vomiting)
Patient History : P seen in Sept for yearly exam and had lost 2# since last appt in 2023. P on z/d diet and recently started b12 injections. P has gained a little over 1# since starting b-12 injections in Sept (weekly for 4 weeks then monthly). O has not seen P vomiting, but is finding vomit piles in the house. Urination and defecation presumed normal at this time. P has been dewormed with topical preventions and oral dewormer. Primary concern or rule out: GI neoplasia vs inflammatory vs other
Abnormal PE/Chem/CBC/UA Results: CBC/Chem/UA 9/15/25: Monocytes 0.475 (0.467H) TP 9.3 (8.8H), ALB 2.5 (2.6L), GLOB 6.8 (5.9H), ALT 20 (27L), ALP 5 (12L), CK 59 (64L), TT4 2.4 WNL USG 1.060, UPCR 0.1 BAR on exam

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 slightly turbid with some floating echoes. 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: 3.79 x 2.33 cm, and the thickness of the cortex is 0.33 cm, in the sagittal plane.

The right kidney is normal in shape and size: 4.34 x 2.43 cm, and the thickness of the cortex is 0.38 cm, in the sagittal plane.

The renal cortex is slightly increased in echogenicity, resulting in increased corticomedullary distinction. A mild medullary rim sign is present. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler shows a normal pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. The left adrenal gland measures 0.27 cm at the cranial pole and 0.26 cm at the caudal pole. The right adrenal gland measures 0.24 cm at the cranial pole and 0.25 cm at the caudal pole.

Spleen

Splenic thickness is 0.43 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 distended, showing a liquid pattern. Mural thickness of 2.06 mm, with preserved wall layering.

The pylorus measures 2.99 mm. Duodenum: 1.98 mm. Jejunum: 2.23–2.37 mm. Mucosa: 0.93 mm. Submucosa: 0.82 mm. Muscularis propria: 0.26 mm. Ileum: 2.04–2.29 mm. Mucosa: 0.86 mm. Submucosa: 0.61 mm. Muscularis propria: 0.99 mm. Normal wall layering. The ileocecal junction was not visualized.

Colon: transverse segment 2.31 mm with preserved layers and soft content. Descending segment 2.06 mm, with minimal fecal material.

Pancreas

Pancreatic thickness is 6.23 mm. The right limb, body, and left limb appear normal. Pancreatic parenchyma is isoechoic to the adjacent omental fat. The diameter of the pancreatic duct is 1.20 mm. No signs of active inflammation or neoplastic disease are evident.

Peritoneal Cavity

No abdominal effusion or peritonitis is observed. Cranial mesenteric lymph nodes and ileocecal lymph nodes are not visualized. The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Fluid-distended stomach with normal mural architecture.
- Ileal muscularis hypertrophy (muscularis/mucosa ratio ~1.15).
- Colonic thickening with preserved layering.
- Mild renal cortical hyperechogenicity with subtle medullary rim sign.

SECONDARY FINDINGS

- Slightly turbid urine with floating echoes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both kidneys are within normal size ranges and maintain normal corticomedullary definition; however, the renal cortices are mildly hyperechoic with a subtle medullary rim sign, which may indicate early chronic renal change, metabolic stress, or age-related alteration. The bladder contains slightly turbid



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urine with floating hyperechoic echoes, compatible with benign sediment. No cystitis or lower urinary tract disease is identified.

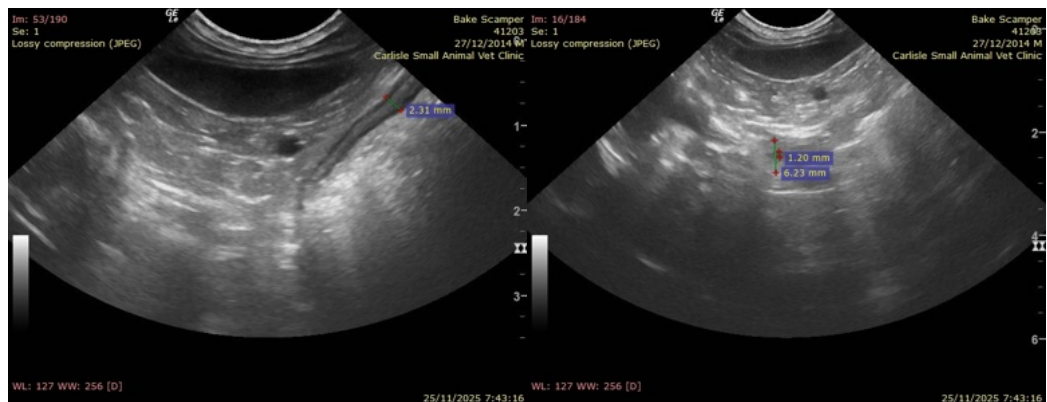
The stomach is distended with fluid and exhibits preserved mural layering and normal wall thickness: This can represent a delayed gastric emptying (functional or inflammatory), particularly in a patient with suspected vomiting and weight loss. The duodenum and jejunum show normal wall thickness and preserved layering. However, the ileum exhibits a disproportionately thickened muscularis layer (muscularis hypertrophy) rather than technical variation. Total ileal thickness remains within the upper normal range, but the pattern of layer distribution is abnormal. This finding is most consistent with chronic enteropathy, particularly an inflammatory small intestinal disease with muscularis-predominant remodeling, as described in feline IBD. Neoplastic infiltration is considered less likely given the preserved wall layering and absence of focal masses or lymphadenopathy.

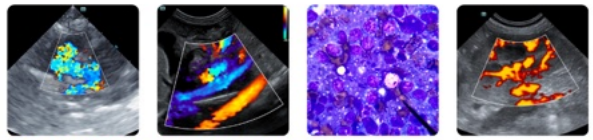
The colon presents additional abnormalities. The transverse colon is thickened and the descending colon is at the high end of normal. Layering remains preserved, and the lumen contains soft, formed material. These findings support colonic inflammation but do not suggest neoplasia. The ileocecal junction is not visualized, which limits full assessment of the distal bowel.

No abdominal lymphadenopathy, effusion, or peritoneal inflammation is observed.

Recommendations

- Correlate ileal and colonic abnormalities with clinical signs; findings support chronic enteropathy (inflammatory bowel disease).
- Consider a GI panel (TLI, folate, cobalamin) to evaluate for small intestinal dysfunction and dysbiosis.
- If symptoms persist or worsen, consider endoscopic or surgical biopsies to differentiate IBD from early small-cell lymphoma.
- Monitor renal values (creatinine, SDMA, USG, UPC) to assess progression of mild cortical changes.





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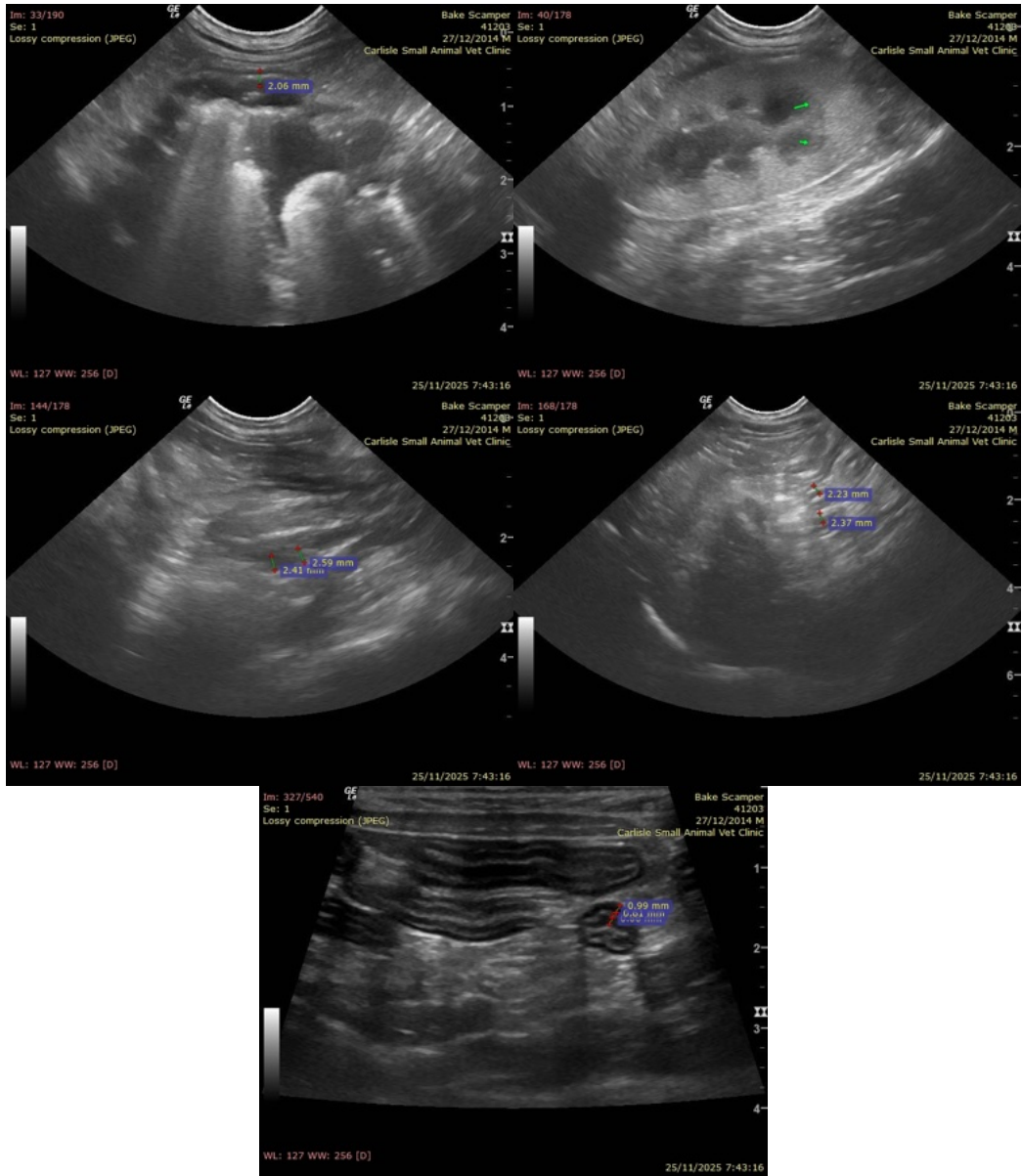
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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