



## PATIENT

Ivan Ragalevsky

## SPECIES

Feline

## BREED

DSH

## SEX

Male

## AGE

9 years

## WEIGHT

12 lbs

## INTERPRETED BY

Alicia Angosto  
Guerrero, DMV,  
PgDip, MSc.

## IMAGING PERFORMED BY

Danielle Shemanski,  
DVM, MA

## HOSPITAL NAME

Western New York  
Veterinary Services

## REFERRING VET

Dr. Cheryl Ragalevsky

## INVOICE

10921

## DATE

12/10/2025

## PRESENTING CLINICAL SIGNS

**RDVM REASON FOR REFERRAL:** Ivan is unable to eat small amounts of dry food without vomiting. In addition, he must eat frequent small amounts of canned food or else he vomits. There is no blood work yet. In the past, he has had prominent mesenteric lymph nodes that were a normal gummy worm shape, and a suspected gastric ulcer, which he has taken sucralfate for. No weight loss Owner is planning to start Royal Canin HP  
**CLINICAL SIGNS:** Only eating wet food now and needs to consume in several feedings throughout the day or else he vomits  
**MEDICATIONS:** Sucralfate 1 gm, 1/4 tab bid.

**Abnormal PE/Chem/CBC/UA Results:** Not available, but bloodwork in the past has been unremarkable.

## 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 predominantly anechoic with scant suspended echoes. The proximal urethra and vesicoureteral junction have a normal appearance. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.48x2.52 cm, with a cortical thickness of 0.46 cm in the sagittal plane. The cortex is isoechogenic compared to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. No pyelectasia, nephroliths, or hydronephrosis are observed.

The right kidney is normal in shape and size: 3.79x2.00 cm, with a cortical thickness of 0.39 cm in the sagittal plane. The cortex is isoechogenic compared to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. No pyelectasia, nephroliths, or hydronephrosis are observed.

### Adrenal Glands

The adrenal glands were not clearly visualized.

### Spleen

Splenic thickness is 0.94 cm. The splenic 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 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 dilation of the cystic duct or common bile duct is observed.

### Gastrointestinal



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The stomach is empty, with mural thickness of 1.82 mm and preserved wall layering. The pylorus contains minimal residual ingesta and measures 3.11 mm.

Duodenum: 1.86 mm

Jejunum: 2.04 mm

- Mucosa: 1.10 mm
- Submucosa: 0.84 mm
- Muscularis propria: 0.36 mm

Ileum: 1.75 mm

- Mucosa: 0.37 mm
- Submucosa: 0.60 mm
- Muscularis propria: 0.29 mm

The ileocecal junction measures 3.04 mm (muscularis 0.86 mm).

Normal wall layering is preserved throughout.

No signs of inflammation, ileus, or foreign material are identified.

Colon: mm (measurement not provided), with formed feces in the descending colon.

### *Pancreas*

The right limb and body measure 8.3 mm, and the left limb measures 6.93 mm. Pancreatic parenchyma is slightly hypoechoic relative to adjacent omental fat. The pancreatic duct diameter is 1.10–1.34 mm. No signs of active inflammation of the peripancreatic fat are identified.

### *Free Abdomen*

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

### PRIMARY FINDINGS

- Pancreas: Right limb-body above the upper limit. Slightly hypoechoic.
- No evidence of GI wall thickening, loss of layering, masses, lymphadenopathy, obstruction, or inflammatory changes.

### INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The left pancreatic lobe appears normal. The right lobe is slightly above the upper reference limit, although no significant or clinically relevant pancreatic abnormalities are identified. A mild increase in the diameter of the right lobe and a slight reduction in pancreatic parenchyma are noted; the continuation of the findings is unclear. At the gastric and intestinal level, no visible abnormalities are observed.

However, Ivan's pattern of vomiting - when the stomach is either too empty or too full-, his tolerance of small frequent meals, and his historical response to sucralfate strongly suggest a gastric origin (rather than pancreatic or esophageal disease). Small or early gastric mucosal disease, functional delayed gastric emptying, gastritis, or mild ulceration can all present with normal ultrasonographic findings.

Overall, the imaging findings support a functional or mucosal gastric disorder. However, it would still be prudent to rule out an early pancreatitis as a secondary or concurrent process.



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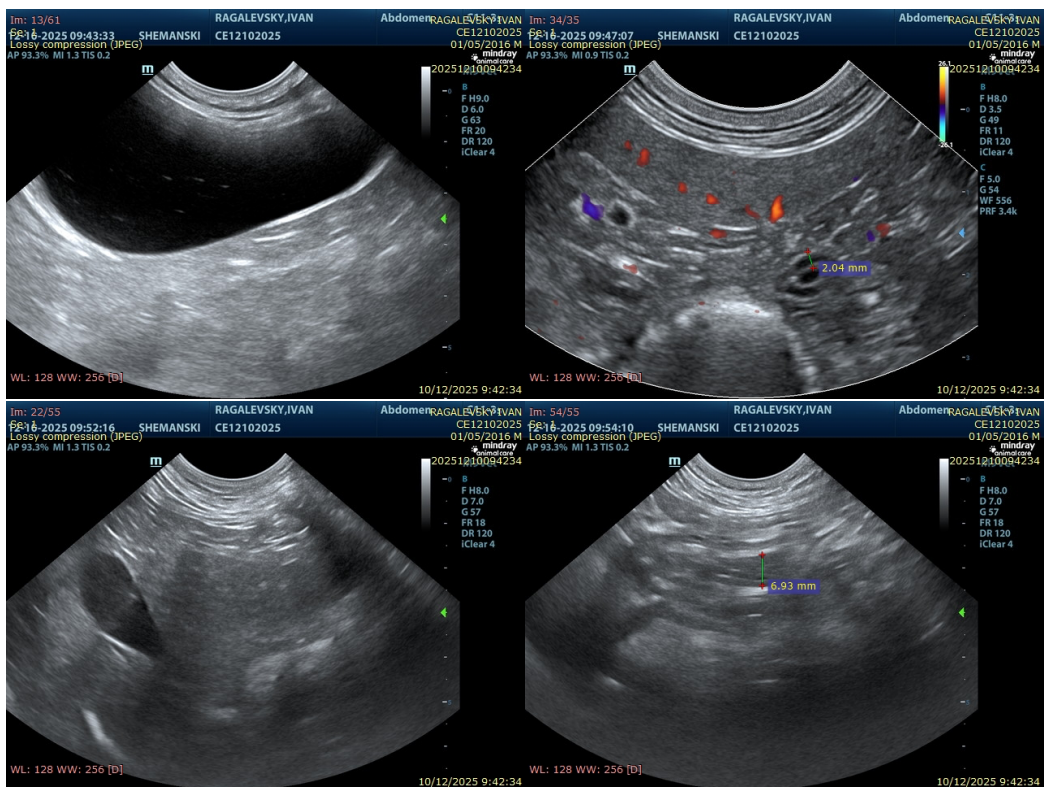
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Veterinary Services

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## Recommendations

- fPLI.
- Consider a therapeutic trial for gastric disease.
- Maintain small, frequent meals; consider transitioning to a highly digestible or hydrolyzed diet.
- Thoracic radiographs may be performed only if regurgitation is suspected or if vomiting occurs immediately after swallowing, to rule out esophageal dilation.
- GI panel (TLI, PLI, cobalamin, folate) may be useful to screen for malabsorption, dysbiosis, or underlying pancreatic insufficiency.
- Endoscopy with gastric and duodenal biopsies should be considered if vomiting persists despite appropriate diet and medical therapy, as mild gastritis, ulceration, early IBD, or functional gastric motility disorders may not be detectable on ultrasound.



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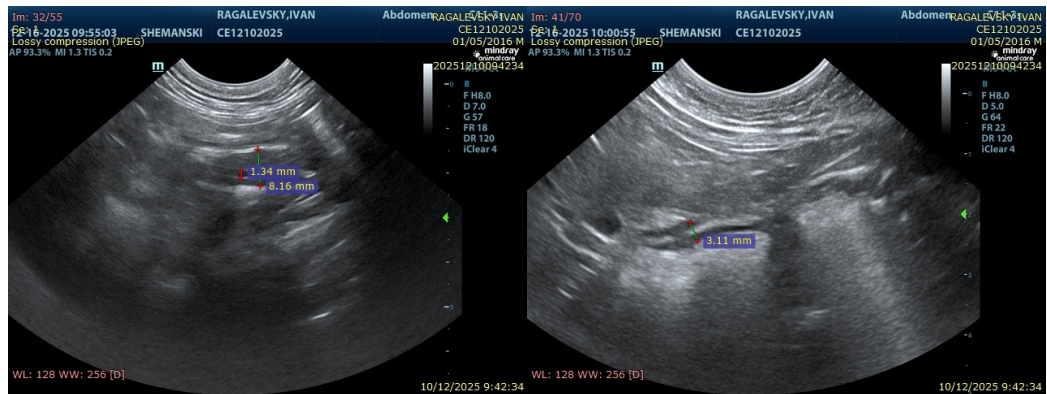
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

[info@SonoPath.com](mailto:info@SonoPath.com)