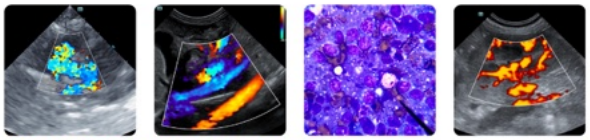


PATIENT

Tess Homa

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

12 years

WEIGHT

7.1 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Jenna Smith, CVT

HOSPITAL NAME

Annville Cleona VA

REFERRING VET

Dr. Bardsley

INVOICE

69329

DATE

12/16/25

PRESENTING CLINICAL SIGNS

History: Appointment 12/2/25: • Weight loss noticed over the past 2 months • Vomiting episodes in the last 3 weeks, approx 1x/week • Vomit mostly contains bile, sometimes with a little food and tiny hairball • Normal to increased appetite Vomiting became more frequent and diarrhea developed after the appointment. Hypoallergenic diet trial started (Blue Buffalo HF); vomiting and diarrhea improved, but appetite decreased. Lethargy now noted.
CBC/Chem/T4 all normal Total weight loss: 2.4 lb (9.5 lb to 7.1 lb)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the bladder wall appears thin and smooth. The urine is anechoic. The bladder neck and proximal urethra 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, measuring 3.46 × 2.33 cm, with a cortical thickness of 0.38 cm in the sagittal plane. The renal cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler demonstrates a normal perfusion pattern.

The right kidney is normal in shape and size, measuring 3.37 × 2.11 cm, with a cortical thickness of 0.35 cm in the sagittal plane. The renal cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler demonstrates a normal perfusion pattern.

Adrenal Glands

The left adrenal gland is not clearly visualized for accurate evaluation. The right adrenal gland measures 0.21 cm at the cranial pole and 0.23 cm at the caudal pole.

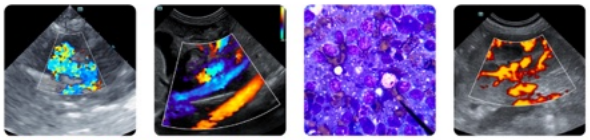
Spleen

Splenic thickness is 0.52 cm. The 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 hepatic 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 dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach is distended with liquid retained ingesta, with a mural thickness of 1.45 mm and preserved wall layering. Subjectively, gastric peristalsis appears increased; however, motility appears somewhat ineffective, with a to-and-fro movement noted. The pylorus measures approximately 2.83 mm.

The duodenum measures 2.69 mm and appears mildly corrugated, with a spastic appearance. The jejunum measures 2.33 mm, with the following wall layer measurements: mucosa 1.30 mm, submucosa 0.49 mm, and muscularis propria 0.48 mm. The ileum measures 2.88 mm, with mucosa 0.73 mm, submucosa 0.81 mm, and muscularis propria 0.99 mm. Wall layering is preserved. The ileocecal junction is not clearly visualized. A mucosal intestinal pattern is noted. No signs of obstruction, ileus, or foreign material are identified.

The colon wall thickness measures 0.83 mm, with formed feces present in the descending segment.

Pancreas

The left pancreatic limb measures 5.04 mm. The pancreatic parenchyma is hypoechoic relative to the adjacent omental fat. The pancreatic duct measures approximately 1.20 mm in diameter. No evidence of active inflammation of the peripancreatic fat is observed.

Peritoneal Cavity

No abdominal effusion or evidence of peritonitis is observed. Cranial mesenteric lymph nodes measure approximately 5.38 mm in thickness, and ileocecal lymph nodes measure approximately 4.2–4.5 mm; both demonstrate normal shape and echogenicity. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

- Mild gastric distension with retained ingesta and subjectively increased but ineffective gastric motility.
- Mild duodenal corrugation with a spastic appearance.
- Jejunum: Muscularis-to-mucosa ratio ≈ 0.37. Ileum: Muscularis-to-mucosa ratio ≈ 1.36
- Hypoechoic pancreatic parenchyma with mild pancreatic duct dilation.
- Mild enlargement of cranial mesenteric and ileocecal lymph nodes with normal echogenicity

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastrointestinal tract demonstrates preserved wall layering throughout; however, there is mild diffuse thickening of the muscularis layer, particularly within the ileum, along with duodenal corrugation and altered gastric motility. This pattern is most consistent with a chronic inflammatory enteropathy, and in a cat of this age with marked weight loss, raises concern for chronic enteropathy with a possible

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infiltrative component, including inflammatory bowel disease or low-grade alimentary lymphoma. The absence of loss of layering or focal mass lesions makes high-grade lymphoma very unlikely based on ultrasonography alone.

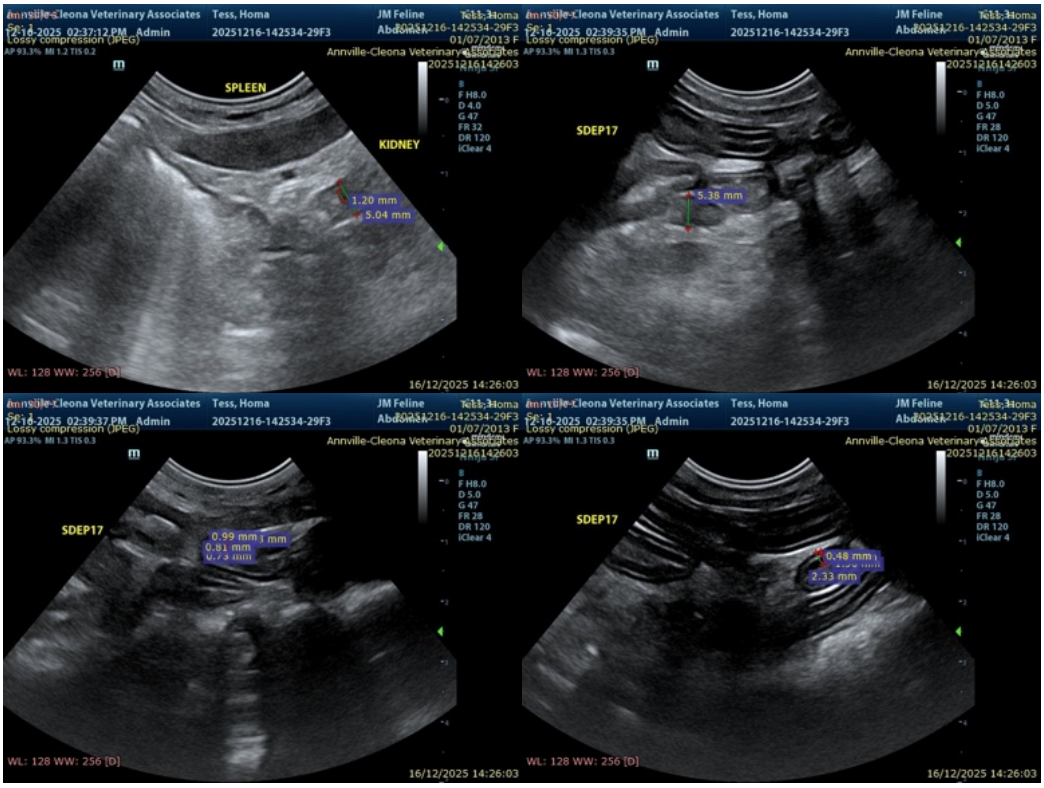
The gastric distension with retained ingesta and subjectively increased but ineffective motility is nonspecific, but may reflect functional gastric dysmotility, often seen secondary to chronic gastrointestinal disease.

The pancreas appears hypoechoic relative to the surrounding fat, with mild dilation of the pancreatic duct, but without peripancreatic fat inflammation. These findings are nonspecific but may be compatible with chronic or low-grade pancreatitis, which may coexist with chronic enteropathy in cats (triaditis).

The mild enlargement of mesenteric and ileocecal lymph nodes, with preserved shape and echogenicity, is most consistent with reactive lymphadenopathy rather than overt nodal infiltration.

Recommendations

- Further evaluation with a comprehensive gastrointestinal panel (including cobalamin, folate, and feline pancreatic lipase) is recommended to better characterize gastrointestinal and pancreatic involvement.
- Given the clinical progression and imaging findings, endoscopic or full-thickness intestinal biopsies should be considered if clinical signs persist or worsen, to differentiate between inflammatory bowel disease and low-grade lymphoma.
- Continued dietary management and close clinical monitoring are advised.



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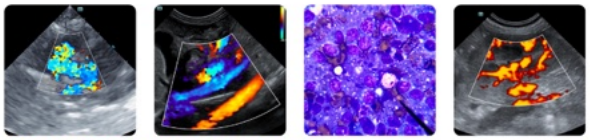

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@SonoPath.com