



## PATIENT

Ruby Evans

## SPECIES

Feline

## BREED

Domestic Medium Hair

## SEX

Spayed female

## AGE

9 years

## WEIGHT

13.54

## INTERPRETED BY

Dr. Alicia Angosto  
Guerrero

## IMAGING PERFORMED BY

Ruth Loomis

## HOSPITAL NAME

Brookwood AC

## REFERRING VET

Dr. Loomis

## INVOICE

69440

## DATE

12/18/25

## PRESENTING CLINICAL SIGNS

History: Chronic vomiting - up ticked in the last few months. Vomiting both food and bile. Hx of dry hard stool. No wt loss/ normal appetite O has tried numerous different food Teeth grinding at home - normal dental radiographs

Abnormal PE/Chem/CBC/UA Results: Mildly elevated BUN - all else WnL

## 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 appear normal. No uroliths or ultrasonographic evidence of inflammatory or neoplastic disease are identified.

The left kidney is normal in shape and size, measuring 3.34 × 2.08 cm, with a cortical thickness of 0.32 cm in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

The right kidney is normal in shape and size: 3.48 x 2.47 cm, and the thickness of the cortex is 0.35b cm, in the sagittal plane. The cortical is isoechoic compared to liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths or hydronephrosis.

### *Adrenal Glands*

The left adrenal gland is not visualized. The right adrenal gland measures approximately 0.41 cm at the cranial pole and 0.34 cm at the caudal pole.

### *Spleen*

Splenic thickness measures approximately 0.72 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 margins and a regular contour. The hepatic parenchyma is uniform and isoechoic relative to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The gallbladder wall is thin. 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 empty, folded, and predominantly fluid-filled. Mural thickness is variable, ranging from approximately 2.03 to 4.49 mm, with preserved wall layering. Visualization of the pyloric region was suboptimal and could not be fully assessed.

The duodenum measures approximately 2.03 mm. The jejunum measures approximately 1.80 mm, with the following wall layer measurements: mucosa ~1.00 mm, submucosa ~0.35 mm, and muscularis propria ~0.18 mm. The ileum measures approximately 1.59 mm, with preserved wall layering (mucosa ~0.46 mm, submucosa ~0.77 mm, muscularis propria ~0.21 mm). The ileocecal junction measures approximately 2.52 mm, with a muscularis thickness of approximately 1.19 mm. No evidence of gastrointestinal obstruction, ileus, or intraluminal foreign material is identified.

The colon measures approximately 0.59–0.68 mm and contains formed fecal material within the descending segment.

## *Pancreas*

The pancreas appears subjectively hypoechoic with increased image contrast; however, no definitive ultrasonographic features of pancreatitis are identified.

## *Peritoneal Cavity*

No abdominal effusion or signs of peritonitis are observed.

Cranial mesenteric lymph nodes measure approximately 2.67–3.04 mm and demonstrate normal shape and echogenicity.

Ileocecal lymph nodes measure approximately 2.75–3.39 mm.

Gastric and pancreaticoduodenal lymph nodes measure approximately 3.26–3.27 mm and appear within normal limits.

The iliac trifurcation is unremarkable.

## ULTRASONOGRAPHIC FINDINGS

- Predominantly fluid-filled stomach, with variability in mural thickness (up to 4.49 mm).
- Mild prominence of the ileocecal junction muscularis.
- Mild, symmetric enlargement of cranial mesenteric, gastric, and pancreaticoduodenal lymph nodes (within upper normal limits)



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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach is predominantly fluid-filled, with mild variability in mural thickness but preserved wall layering. This appearance, together with the presence of bruxism and bile vomiting, is highly suggestive of chronic gastritis, delayed gastric emptying, and chronic nausea. Suboptimal visualization of the pyloric region limits full assessment, but no definitive pyloric mass or obstructive lesion is identified.

The small intestine demonstrates normal wall layering and thickness, with a relatively thin muscularis propria and preserved mucosal architecture, findings that do not support alimentary lymphoma at this time. Mild prominence of the ileocecal junction muscularis may reflect chronic low-grade inflammatory change or altered motility, a common finding in cats with long-standing gastrointestinal disease.

Mild, symmetric enlargement of cranial mesenteric, gastric, and pancreaticoduodenal lymph nodes, with preserved shape and echogenicity, is most consistent with reactive lymphoid hyperplasia, likely secondary to chronic gastrointestinal inflammation rather than neoplastic infiltration.

Overall, the ultrasonographic findings, combined with the clinic, favor a diagnosis of inflammatory bowel disease (IBD spectrum), with chronic inflammatory gastropathy, and possible gastrointestinal dysmotility. However, early or low-grade lymphoma cannot be definitively characterized by ultrasonography alone.

### Recommendations

- Consider a stepwise, conservative medical approach, including:
  - A strict dietary trial (novel protein or hydrolyzed diet).
  - Antiemetic and anti-nausea therapy (maropitant, ondansetron) given the presence of bruxism.
  - Gastric acid modulation or mucosal support as clinically indicated.
- Further evaluation with a feline gastrointestinal panel, including cobalamin and folate, is recommended.
- Management of constipation with dietary fiber modulation, hydration optimization, or prokinetic support should be considered, as chronic constipation may exacerbate nausea and vomiting.
- Follow-up abdominal ultrasonography may be useful if clinical signs progress, weight loss develops, or response to therapy is suboptimal, to reassess gastrointestinal wall thickness and lymph node changes.
- Invasive diagnostics (gastrointestinal biopsy) are not currently prioritized; however, they should be considered if the patient fails to respond to therapy or if clinical signs or ultrasonographic findings worsen.



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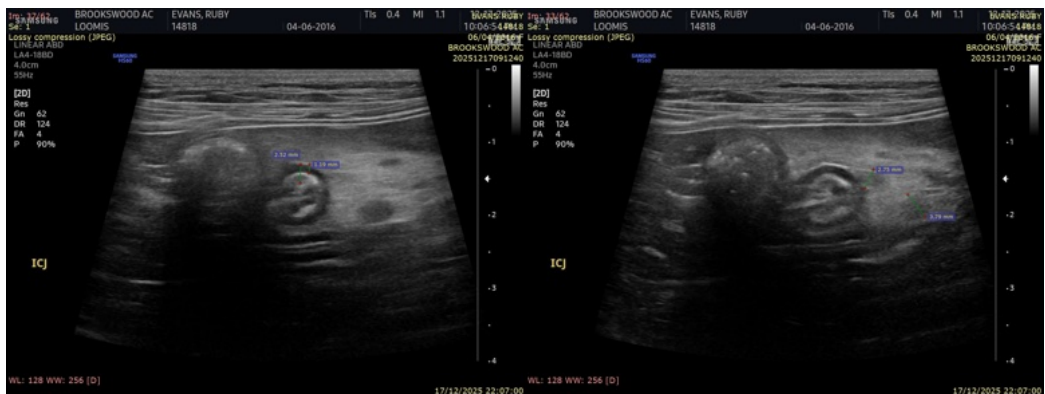
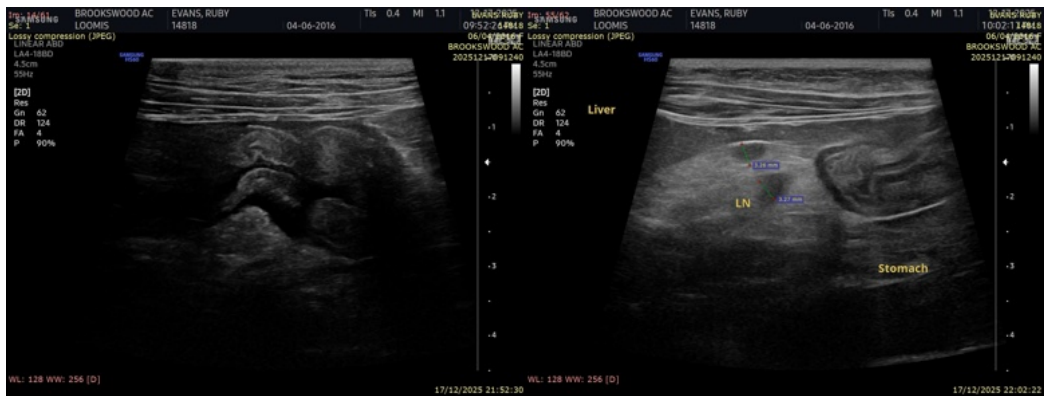
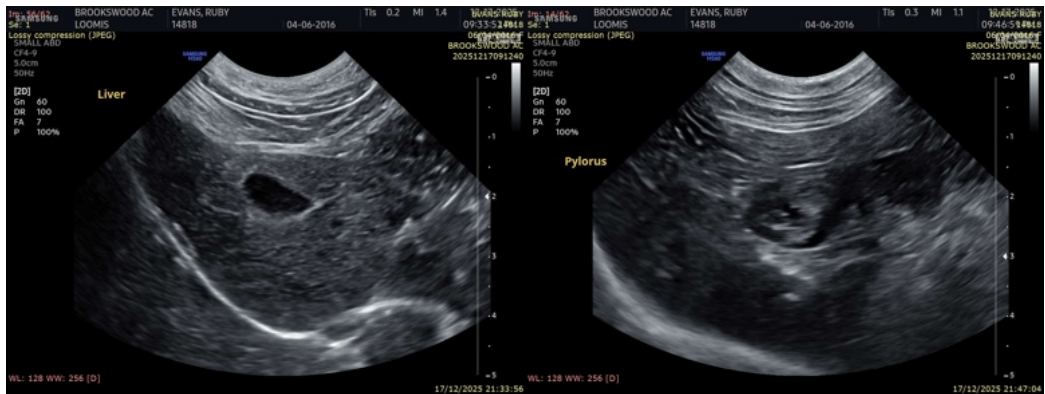
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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