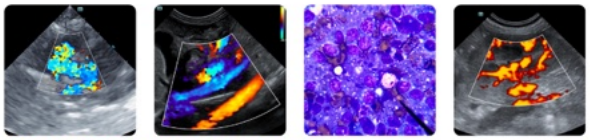


PATIENT

Ceelo Makinen

SPECIES

Feline

BREED

Domestic Medium Hair

SEX

Neutered male

AGE

12 years

WEIGHT

8.7 kg

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Caroline Tan

HOSPITAL NAME

Healing Traditions VC

REFERRING VET

Dr. Vocheroth

INVOICE

69747

DATE

12/31/25

PRESENTING CLINICAL SIGNS

History: Attending reports acute on chronic hyporexia. No V. Still passing normal BM. O noted coughing and fainting recently. hx of asthma. No reported cardiac murmur or cardiomeg on rads. BP well Sedated w dexdom. On cerenia
Labs unremarkable Thoracic rads consistent with mild bronch pattern. Abd rads unremarkable

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is thin and smooth. The urine is turbid, with multiple suspended echogenic particles. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic disease.

The left kidney is normal in shape and size, measuring 4.13×2.43 cm, with a cortical thickness of 0.38 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.94×2.30 cm, with a cortical thickness of 0.37 cm in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

The left adrenal gland measures 0.30 cm at the cranial pole and 0.32 cm at the caudal pole. The right adrenal gland is not clearly visualized; differentiation from an adjacent lymph node is uncertain based on location and appearance.

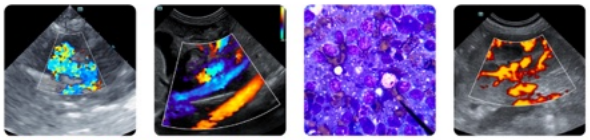
Spleen

Splenic thickness measures 0.73 cm. The splenic parenchyma appears mildly hypoechoic and mildly heterogeneous, with a slightly coarse echotexture. No discrete splenic masses or focal parenchymal abnormalities are identified. 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, 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 contains a small amount of ingesta. Gastric wall thickness measures 1.69 mm, with preserved wall layering. The pyloric wall measurement is not provided.

The duodenum measures 1.79 mm. The jejunum measures 3.02 mm, with the following wall layer measurements: mucosa 1.45 mm, submucosa 0.51 mm, and muscularis propria 1.11 mm.
The ileum measures 2.31 mm, with mucosa 0.73 mm, submucosa 0.45 mm, and muscularis propria 0.96 mm; wall layering is preserved. The ileocecal junction measures 2.95 mm, with a muscularis thickness of 1.08 mm. No evidence of gastrointestinal obstruction, ileus, or foreign material is identified.

The colonic wall measures approximately 0.81–1.09 mm, with formed fecal material present in the descending colon.

Pancreas

The pancreas measures approximately 5.62 mm in maximal thickness. The pancreatic parenchyma is hypoechoic relative to the adjacent omental fat. The pancreatic duct is not dilated.

Peritoneal Cavity

No abdominal effusion or evidence of peritonitis is observed. The ileocecal lymph nodes measure approximately 2.72–3.55 mm in thickness and have normal shape and echogenicity. Cranial mesenteric lymph nodes are not visualized, but surrounding regions appear unremarkable. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Diffuse small intestinal muscularis thickening with preserved wall layering (jejunal and ileal predominance).
- Increased muscularis-to-mucosa ratios in the jejunum and ileum.
- Mild, diffuse splenic parenchymal heterogeneity without focal mass.

SECONDARY FINDINGS

- Turbid urinary bladder contents consistent with benign sediment.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominal ultrasonography demonstrates diffuse small intestinal muscularis thickening with preserved wall layering, most notable in the jejunum and ileum. The muscularis-to-mucosa ratios are increased, particularly at the level of the ileum (jejunal muscularis-to-mucosa ratio approximately 0.8:1; ileal muscularis-to-mucosa ratio approximately 1.3:1), with preserved wall layering. At the ileocecal junction,

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the muscularis propria measures approximately 1.08 mm within a total wall thickness of 2.95 mm, representing approximately 37% of the total wall thickness, with preserved wall layering. The ultrasonographic pattern is most consistent with chronic inflammatory enteropathy, most likely lymphoplasmacytic in nature, with low-grade alimentary lymphoma remaining a key differential diagnosis given the known overlap between these entities in cats.

Importantly, there is no loss of intestinal wall layering, no focal intestinal masses, and no evidence of obstruction, making aggressive or high-grade neoplastic disease less likely at this time.

The ileocecal lymph nodes are normal in size and appearance, and cranial mesenteric lymph nodes are not enlarged or conspicuous, which further supports a chronic, low-grade process rather than advanced intestinal lymphoma.

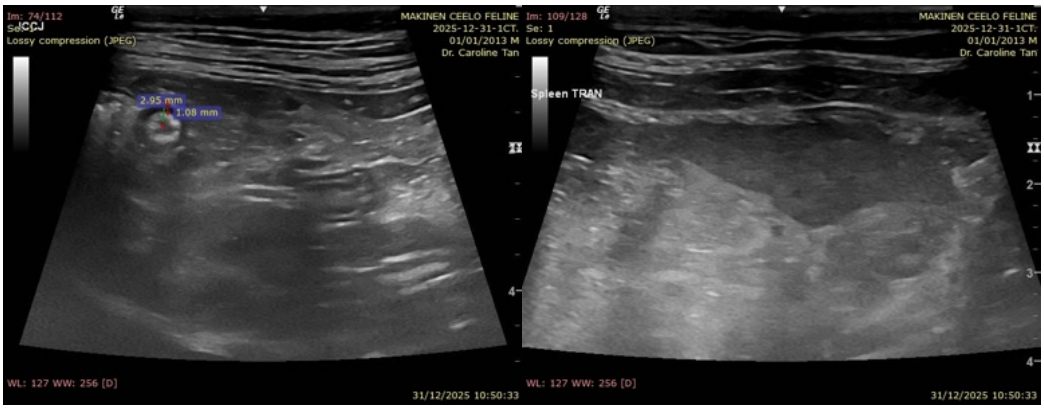
The spleen demonstrates mild diffuse parenchymal heterogeneity without a discrete focal mass or architectural distortion. This appearance is most consistent with reactive or benign splenic change rather than focal splenic pathology.

The pancreas is mildly hypoechoic but normal in size, with no peripancreatic fat reaction or ductal dilation. In the absence of supportive clinical or laboratory findings, this appearance is most consistent with age-related or chronic subclinical change, and there is no ultrasonographic evidence of active pancreatitis.

Turbid urine with suspended echoes and a smooth bladder wall is most consistent with benign urinary sediment (mucus, cellular debris, microscopic crystals), in the absence of bladder wall abnormalities.

Recommendations

- Complete gastrointestinal panel testing including cobalamin, folate, TLI, and pancreatic lipase.
- Strict dietary and supportive management (strict novel protein or hydrolyzed diet, and supplement cobalamin if deficient). Add adjunctive GI support as clinically indicated.
- Clinical and imaging follow-up based on response:
  - Monitor appetite, body weight, and clinical signs.
  - Repeat abdominal ultrasound only if clinical signs persist or worsen, weight loss develops, or laboratory abnormalities arise.
- Consider intestinal biopsies, recognizing that full-thickness biopsies provide higher diagnostic yield for muscularis-predominant disease.



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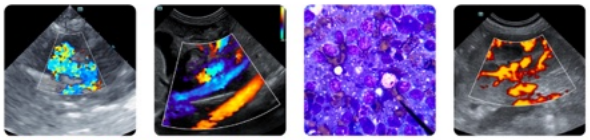

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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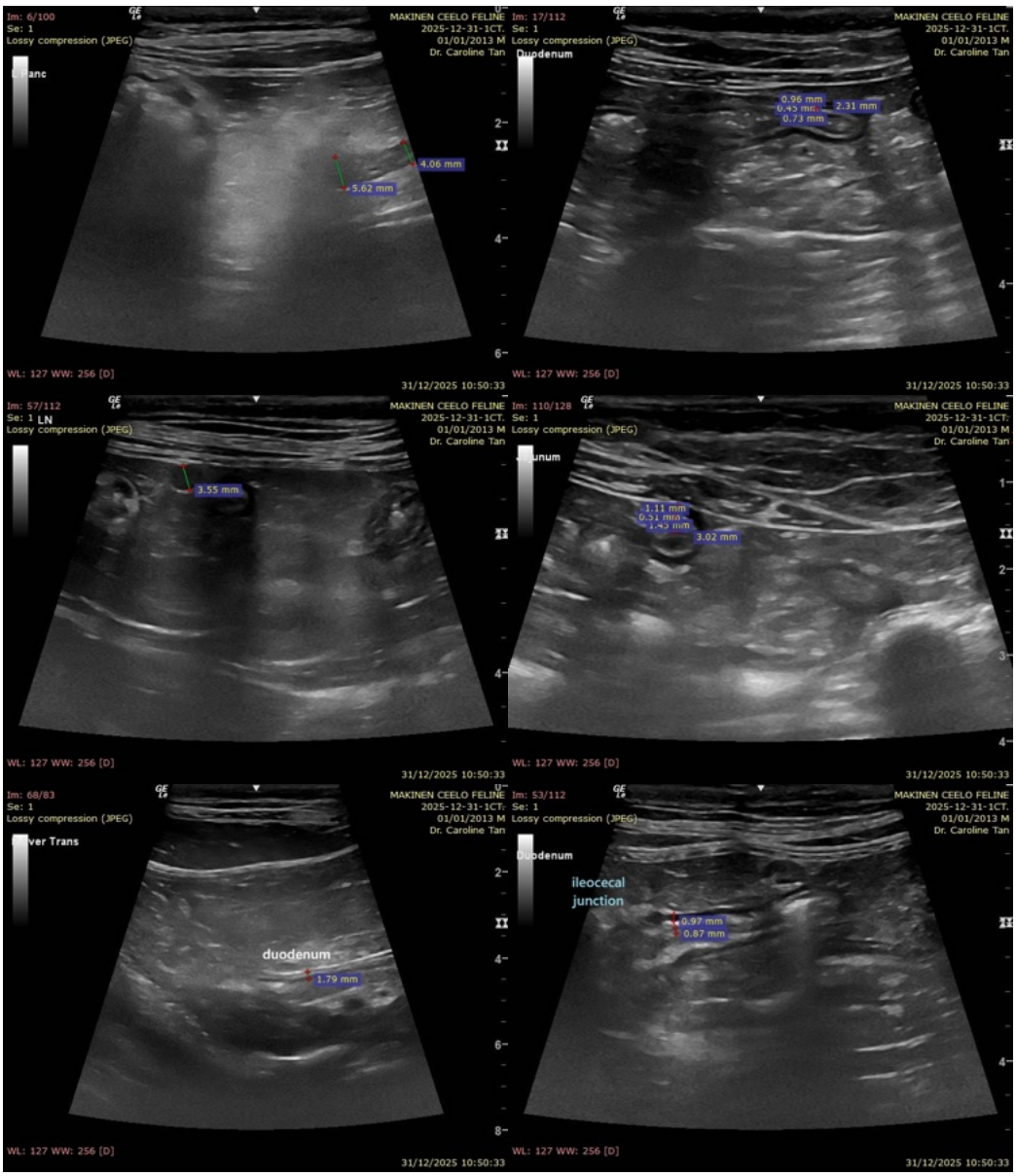

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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