



PATIENT

Abigial Animals in
Distress

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

9 years

WEIGHT

8.11 lbs

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Dr. Pamela Bay

HOSPITAL NAME

For Cats Only VC

REFERRING VET

Dr. Bay

INVOICE

69364

DATE

12/4/25

PRESENTING CLINICAL SIGNS

History: Not eating, hiding

Abnormal PE/Chem/CBC/UA Results: CBC: HCT 38.6%, neut 11.41 (H) Chem/lytes: BUN 15 (L), TP 10.8 (H), chol 58 (L), glob 7.4 (H) T4: 2.1 UA: USG > 1.050, protein 100 (H), UBG 1, bili 1

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 turbid with abundant floating sediment. The proximal urethra and vesicoureteral junction appear normal. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.98x2.02 cm, with a cortical thickness of 0.34 cm in the sagittal plane. The right kidney is normal in shape and size: 3.70x2.26 cm, with a cortical thickness of 0.35 cm in the sagittal plane. The renal cortex is slightly increased in echogenicity, resulting in increased corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler shows a normal perfusion pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Left adrenal: 0.31 cm (cranial pole), 0.35 cm (caudal pole). Right adrenal: 0.37 cm (cranial pole), 0.31 cm (caudal pole).

Spleen

Splenic thickness is 0.61 cm. The parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture without focal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp margins and a regular contour. The parenchyma appears uniform and isoechoic to the falciform fat, with normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is normal, and the contents consist of biliary sludge. The common bile duct measures 2.92–1.63 mm from proximal to distal. No dilation is identified.

Gastrointestinal

The stomach is semi-distended with ingesta; mural thickness is 1.49 mm, with preserved wall layering.

Duodenum: 1.87 mm. Jejunum: 2.06 mm (Mucosa 0.75 mm, Submucosa 0.64 mm, Muscularis propria 0.52 mm). Ileum: 2.47–2.52 mm (Mucosa 0.84 mm, Submucosa 0.50 mm, Muscularis propria 0.50 mm).



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All segments show preserved layering. The ileocecal junction measures 3.02 mm with a muscular layer of 0.89 mm. There is considerable gas and some fluid within the bowel, but loops are not dilated, and peristalsis is increased.

Colon (transverse) wall thickness: 0.95 mm, with formed feces in the descending colon.

Pancreas

Pancreatic thickness is 5.49 mm. Pancreatic parenchyma is slightly hypoechoic relative to adjacent omental fat. The pancreatic duct diameter is 0.86 mm. No signs of active inflammation or neoplastic disease are observed.

Peritoneal Cavity

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

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Ileocecal junction mildly thickened (3.02 mm; muscularis 0.89 mm).
- Pancreatic parenchyma not enlarged, but slightly hypoechoic relative to fat.
- Increased bowel gas; increased peristalsis.

SECONDARY FINDINGS

- Turbid urine with abundant floating echogenic debris.
- Slightly increased renal cortical echogenicity.
- Gallbladder sludge.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastrointestinal tract shows normal mural thickness and preserved layering throughout, with no evidence of infiltrative disease. Jejunal and ileal muscularis:mucosa ratios (0.69:1 and 0.60:1 respectively) remain within physiologic limits, and total wall-to-muscularis ratios are appropriate for normal wall layering. However, the bowel contains increased gas, and peristalsis is heightened, consistent with functional ileus, gastroenteritis, stress, or hypermotility secondary to pain or systemic inflammation. The ileocecal junction is mildly thickened (total wall thickness of 3.02 mm) with a muscularis layer measuring 0.89 mm. Total wall-to-muscularis ratio of approximately 3.39:1, which remains within acceptable physiologic limits for this region. No evidence of infiltrative disease or mass lesions.

Mild bilateral renal cortical hyperechogenicity with preserved architecture. These findings are nonspecific and may be associated with early chronic kidney disease, systemic inflammatory disease, or proteinuric nephropathy.



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Gallbladder sludge and mild gallbladder wall thickening without biliary duct dilation. Changes are most consistent with cholestasis secondary to systemic illness, anorexia, or dehydration rather than primary biliary disease.

Given the markedly elevated globulins, low cholesterol, anorexia, and behavioral changes, the leading differential diagnosis is systemic inflammatory or infectious disease. The patient's biochemical pattern is highly suggestive of feline infectious peritonitis (dry form), even in the absence of overt ultrasonographic abnormalities.

Other differentials include chronic inflammatory disease, immune-mediated processes, or infectious causes (*Bartonella*, *Mycoplasma*), though these are less likely based on current imaging.

Recommendations

- AGP (Alpha-1 acid glycoprotein). If not feasible: Serum coronavirus antibody titer.
- CBC/chemistry review for trends.
- GI panel: folate, cobalamin, TLI and fPLI.
- FeLV/FIV if not recently updated.
- UPC ratio to characterize proteinuria.
- If clinical signs persist and a definitive diagnosis has not been reached, consider serum protein electrophoresis to further characterize the hyperglobulinemia, as well as secondary-tier infectious disease testing, including *Bartonella* PCR/serology and *Mycoplasma haemofelis* PCR.

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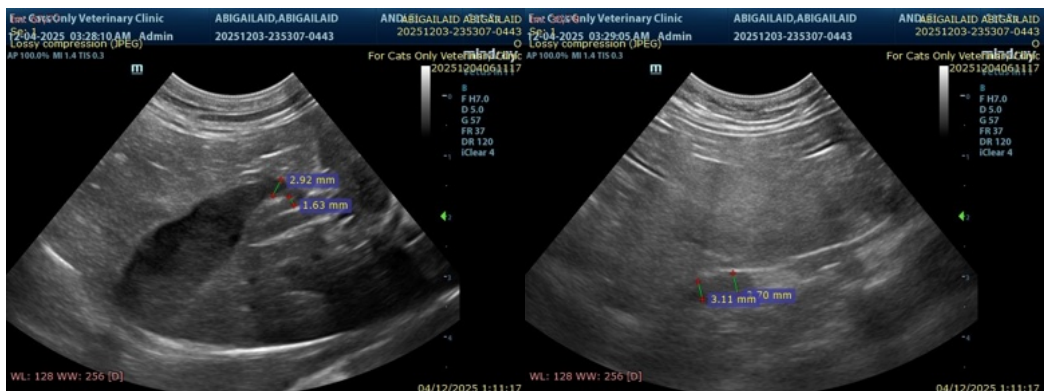
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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