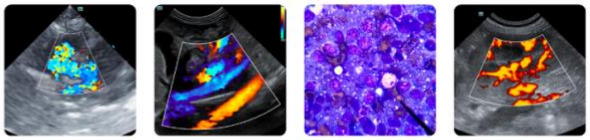




**PATIENT**

Noah Van Wie

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

16 Years

**WEIGHT**

7 pounds

**INTERPRETED BY**

Alicia Angosto Guerrero, DMV, PgDip, MSc.

**IMAGING PERFORMED BY**

Julia Bakker DVM

**HOSPITAL NAME**

Orange Blossom Veterinary Imaging

**REFERRING VET**

Dr. Christina Whitcomb DVM

**INVOICE**

12599

**DATE**

12/05/25

## PRESENTING CLINICAL SIGNS

Consistent weight loss of about 1 lb over the last few months. - Minor kidney value elevations observed in the cat's blood work.- Currently on the high end of stage one kidney insufficiency but unlikely to explain weight loss.- Ultrasound scheduled for further assessment of internal organs.- Lymphoma not ruled out; ultrasound to assess lymph nodes and other structures.- Emphasis on encouraging food intake with any palatable food.

Abnormal PE/Chem/CBC/UA Results: Labs attached

## 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 anechoic. The proximal urethra and vesicoureteral junction have a normal appearance. No calculi or evidence of inflammatory or neoplastic changes are identified.

The left kidney is normal in shape and size (3.70×2.21 cm), with a cortical thickness of 0.50 cm in the sagittal plane. The renal cortex is hyperechoic with decreased corticomedullary distinction. Mild pyelectasia (3.59 mm) is present. No nephroliths or hydronephrosis are observed. Color Doppler shows a normal vascular pattern.

The right kidney is normal in shape and size (3.78×2.23 cm), with a cortical thickness of 0.36 cm in the sagittal plane. The renal cortex is hyperechoic with decreased corticomedullary definition. No pyelectasia, nephroliths, or hydronephrosis are identified. Color Doppler shows a normal vascular pattern.

### *Adrenal Glands*

Both adrenal glands display normal shape and echogenicity.
Left adrenal gland: 0.36 cm (cranial pole)×0.32 cm (caudal pole).
Right adrenal gland: 0.34 cm (cranial pole)×0.37 cm (caudal pole).

### *Spleen*

The spleen was not visualized in any of the videos provided, therefore splenic evaluation could not be performed.

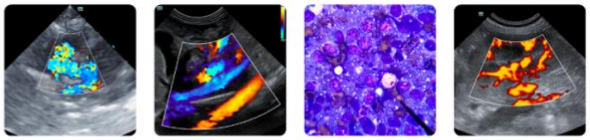
### *Liver*

The liver is subjectively normal in size, with sharp edges and a regular contour. The hepatic parenchyma appears hyperechoic compared with falciform fat, with a few small hypoechoic foci (0.71×0.99 cm). No hepatic lymphadenopathy is observed.

The gallbladder lumen is moderately distended. The wall is thin, and the contents are primarily anechoic. No dilation of the cystic duct or common bile duct is identified.

### *Gastrointestinal*

The stomach is empty and folded, with preserved wall layering.
Duodenum: 2.87 mm.
Jejunum: 3.65 mm (Mucosa 1.61 mm, Submucosa 0.68 mm, Muscularis propria 0.88 mm).





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Ileum: 2.77 mm (Mucosa 0.98 mm, Submucosa 0.61 mm, Muscularis propria 1.10 mm).
Wall layering is normal.

Transverse colon: wall thickness 0.90 mm, diameter 1.39 cm, containing abundant liquid and gas.
Descending segment: wall thickness 0.87 mm, markedly dilated (2.45 cm diameter), filled with liquid and a 1.25-cm segment of undigested material.

### *Pancreas*

The right limb, body, and left limb of the pancreas appear normal.
Parenchymal thickness: 7.39–7.43 mm, with irregular borders and slightly hypoechoic parenchyma.
The pancreatic duct measures 1.37 mm.
No signs of active inflammation of the peripancreatic fat are evident.

### *Free Abdomen*

No abdominal effusion or peritonitis is observed.
Cranial mesenteric lymph node: 6.25 mm thick, slightly hypoechoic.
Ileocecal lymph nodes: 4.10 mm and 5.25 mm.
The surrounding regions appear unremarkable.
The iliac trifurcation is normal.

## PRIMARY FINDINGS

- Renal cortical hyperechogenicity bilaterally with decreased corticomedullary definition. Mild left pyelectasia.
- Diffuse hepatic hyperechogenicity with small hypoechoic hepatic foci.
- Prominence of the intestinal muscularis layer, most evident in the jejunum.
- Marked colonic fluid and gas accumulation, with focal segment containing undigested material.
- Mild enlargement of cranial mesenteric and ileocecal lymph nodes.
- Pancreas slightly thickened with mildly hypoechoic parenchyma and irregular margins, pancreatic duct mildly enlarged.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both kidneys are normal in size yet demonstrate cortical hyperechogenicity with reduced corticomedullary definition, consistent with chronic kidney disease. The mild left pyelectasia is nonspecific and may reflect age-related pelvic dilation, dehydration, increased urine flow, or diuresis rather than obstruction.

The liver is diffusely hyperechoic with a few small hypoechoic foci, a pattern most consistent with lipidosis or chronic hepatopathy. The hypoechoic hepatic foci are nonspecific; small regenerative nodules, vacuolar hepatopathy, or early nodular remodeling are most likely.

The pancreas is slightly thickened with irregular, mildly hypoechoic parenchyma, although there is no peripancreatic fat inflammation. This may represent chronic subclinical pancreatitis, which is common in geriatric cats and may contribute to inappetence or malabsorption. The pancreatic duct diameter is within the expected range for older cats.

Intestinal wall layering is preserved throughout, and no focal masses or areas of layer effacement are identified. However, subjectively, the muscularis layer appears more prominent than expected.

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Quantitatively, jejunal layering shows a mucosa of 1.61 mm and a muscularis of 0.88 mm (mucosa:muscularis ratio ≈ 1.8, higher than the typical feline range of 1.0–1.5), supporting the visual impression of relative muscularis prominence. In the ileum, the mucosa and muscularis (0.98 mm and 1.10 mm, ratio ≈ 0.9) fall within normal limits, yet the overall appearance still suggests mild, early muscularis hypertrophy.

This pattern is most compatible with chronic enteropathy, including lymphoplasmacytic inflammatory bowel disease, or early small-cell lymphoma. The colon is fluid- and gas-filled, consistent with functional stasis, but shows no structural abnormalities.

Mesenteric lymph nodes display mild enlargement with preserved architecture, consistent with reactive hyperplasia, though lymphoid activation is a common concurrent finding in both IBD and small-cell lymphoma and does not exclude either condition.

Recommendations

- Complete GI panel, including spec fPL.
- If a definitive diagnosis is desired, intestinal biopsy (endoscopic or full-thickness) is recommended, as it is the only way to differentiate chronic enteropathy from small-cell lymphoma with certainty. Because the patient has been on long-term corticosteroids, it is essential to discontinue steroids for at least *2–3 weeks* prior to biopsy (when clinically safe), as glucocorticoids can obscure lymphoid infiltrates and significantly reduce diagnostic accuracy on histopathology and PARR testing.
- Although biopsy is the only method to confirm the diagnosis, initiating chlorambucil empirically is a widely accepted therapeutic trial in geriatric cats with chronic enteropathy vs small-cell lymphoma.
- Renal monitoring.
- Follow-up abdominal ultrasound.

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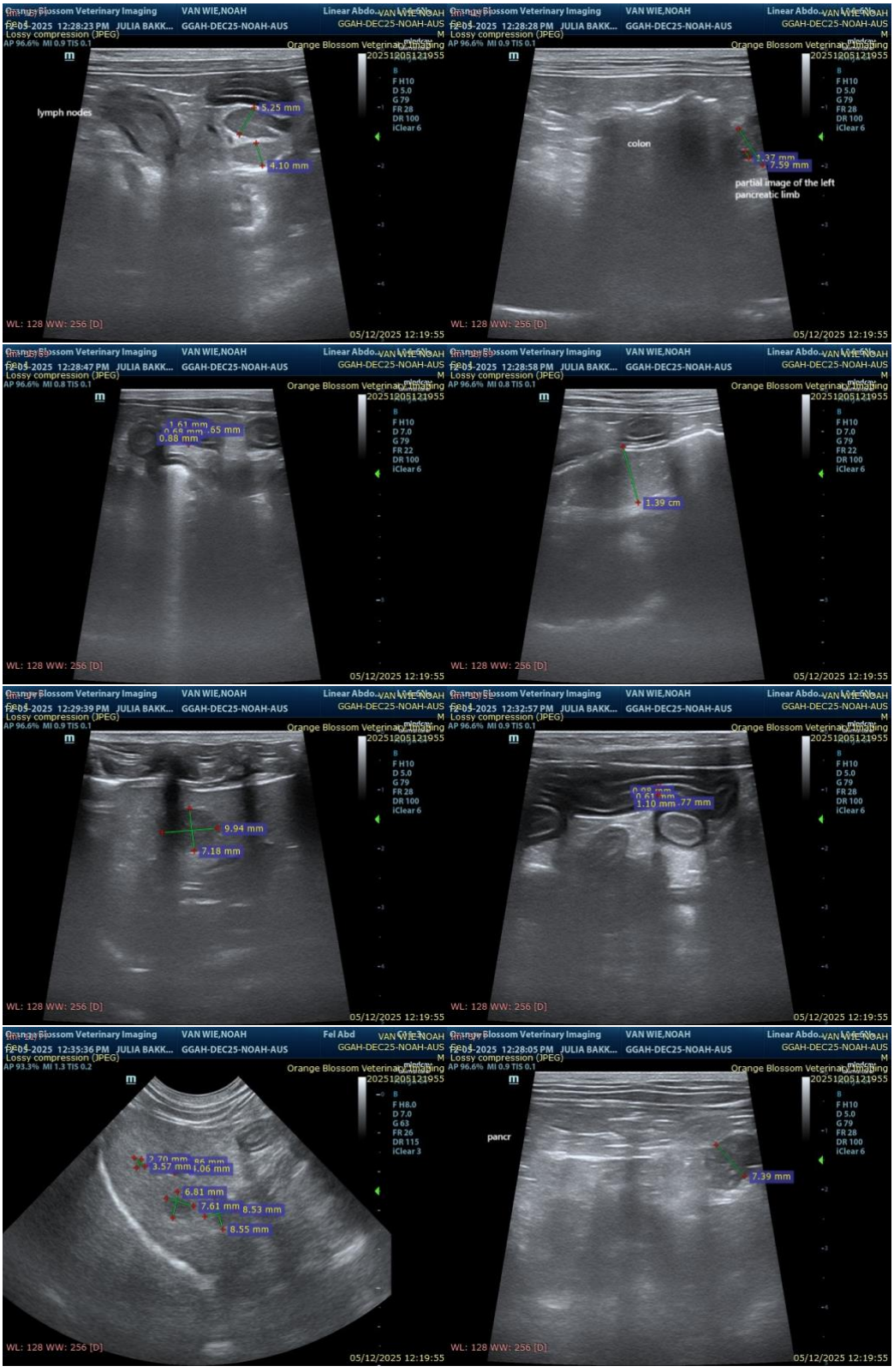

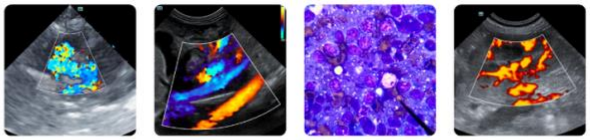



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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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