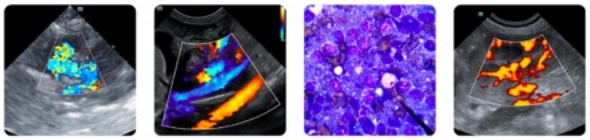


PATIENT

Tommy Standley

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

13 years

WEIGHT

9.6 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Sativa

HOSPITAL NAME

Petroglyph AH

REFERRING VET

Dr. Sanchez

INVOICE

71543

DATE

2/12/26

PRESENTING CLINICAL SIGNS

- On going vomiting for the last 2-3 months, approx. 1-2 times per week
- Noted PU/PD during this time
- Clinical signs improved on Prednisolone and Cerenia

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The wall appears thin and smooth. The urine is predominantly anechoic with scant suspended echoes. The bladder neck and proximal urethra appear normal. No calculi or mural abnormalities are identified.

The left kidney measures 5.08×2.56 cm in the sagittal plane, with a cortical thickness of 0.48 cm. The right kidney measures 4.80×2.79 cm in the sagittal plane, with a cortical thickness of 0.42 cm.

In both kidneys, the renal cortex is markedly increased in echogenicity relative to the liver. Corticomedullary differentiation is preserved. A mild medullary rim sign is present. No pyelectasia, nephrolithiasis, or hydronephrosis is identified.

Adrenal Glands

Both adrenal glands demonstrate normal contour and echogenicity. The left adrenal gland measures 0.34 cm at the cranial pole and 0.39 cm at the caudal pole. The right adrenal gland measures 0.32 cm at the cranial pole and 0.28 cm at the caudal pole. These measurements fall within normal feline reference ranges (generally ≤0.45 cm dorsoventral thickness).

Spleen

No video clips of the spleen were available for evaluation.

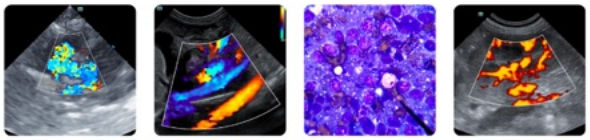
Liver

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

The gallbladder is normally distended. The wall is thin. A small amount of biliary sludge is present. No dilation of the cystic duct or common bile duct is identified.

Gastrointestinal

The stomach is empty and folded. Gastric wall thickness measures 2.01 mm with preserved layering. The pylorus measures 4.83 mm. The duodenum measures 1.88 mm.



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The jejunum measures 2.57 mm with the following layering:

- Mucosa: 1.26 mm, Submucosa: 0.81 mm, Muscularis propria: 0.48 mm

The ileum measures 2.69 mm with the following layering:

- Mucosa: 0.88 mm, Submucosa: 0.75 mm, Muscularis propria: 1.08 mm

Wall layering is preserved throughout evaluated segments.

The muscularis-to-mucosa ratio in the jejunum is approximately 0.38 (0.48/1.26), which is within normal limits. In the ileum, the muscularis-to-mucosa ratio is approximately 1.23 (1.08/0.88), indicating muscularis predominance.

Caudal to the left kidney, a transiently visualized structure measuring approximately 3.3 mm in thickness was noted. Wall layering could not be confidently assessed due to limited visualization, and definitive characterization is not possible based on available imaging.

The colon measures 0.84 mm with few formed feces present.

Pancreas

The pancreas measures 6.93 mm in thickness. The parenchyma is mildly hypoechoic relative to the adjacent omental fat. The pancreatic duct measures 1.58 mm in diameter. No peripancreatic fat hyperechogenicity or focal mass is identified.

Peritoneal Cavity

No abdominal effusion or peritonitis is observed. Cranial mesenteric and ileocecal lymph nodes are not visualized.

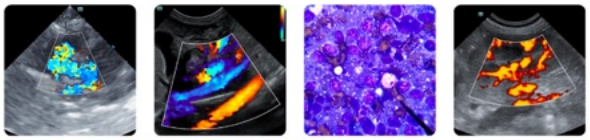
A caudal mesenteric lymph node measures 1.03×0.50 cm and normal shape and echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Ileal muscularis-predominant thickening (muscularis-to-mucosa ratio .>1).
- Mild pancreatic enlargement with mild ductal dilation.
- Marked bilateral renal cortical hyperechogenicity and mild medullary rim sign.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Marked bilateral renal cortical hyperechogenicity with preserved corticomedullary definition and mild medullary rim sign is most consistent with chronic renal parenchymal change. This finding may correlate with PU/PD and possible chronic kidney disease.



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The ileum demonstrates a muscularis-to-mucosa ratio greater than 1, indicating disproportionate muscularis thickening. In cats, this pattern is most commonly associated with chronic enteropathy and may be seen with inflammatory bowel disease (IBD) or small cell lymphoma. Ultrasonographic overlap between IBD and low-grade lymphoma is well recognized, and definitive differentiation cannot be made based on imaging alone.

The transiently observed segment measuring 3.3 mm cannot be definitively characterized; given the limited visualization, it should not be overinterpreted but warrants follow-up imaging.

The pancreas is mildly enlarged (6.93 mm; normal feline pancreatic thickness typically ≤6–7 mm depending on body size), with a mildly dilated pancreatic duct (1.58 mm; normal usually ≤1–1.5 mm in older cats). In geriatric cats, mild ductal dilation may be age-related; however, in the context of chronic vomiting, chronic low-grade pancreatitis remains a consideration.

Recommendations

- Renal parameters (creatinine, SDMA, urine specific gravity) should be evaluated to correlate with ultrasonographic renal changes.
- Serum cobalamin measurement is recommended given ileal involvement.
- Consider a full gastrointestinal panel (including cobalamin, folate, and fPLI), especially If clinical signs persist or worsen.
- At this stage, invasive diagnostics are not immediately indicated given the mild ultrasonographic changes and positive clinical response to prednisolone. If advanced diagnostics are considered in the future, corticosteroid therapy should ideally be tapered prior to repeat imaging or biopsy, as it may mask ultrasonographic or histologic findings.
- Follow-up abdominal ultrasound to monitor:

➢ Ileal wall thickness and muscularis-to-mucosa ratio.

➢ The region caudal to the left kidney where transient mural thickening was suspected.

➢ Visualization of the ileocecal junction, as this is a key site of pathology in feline chronic enteropathies.

➢ Renal cortical echogenicity and progression of chronic renal changes.

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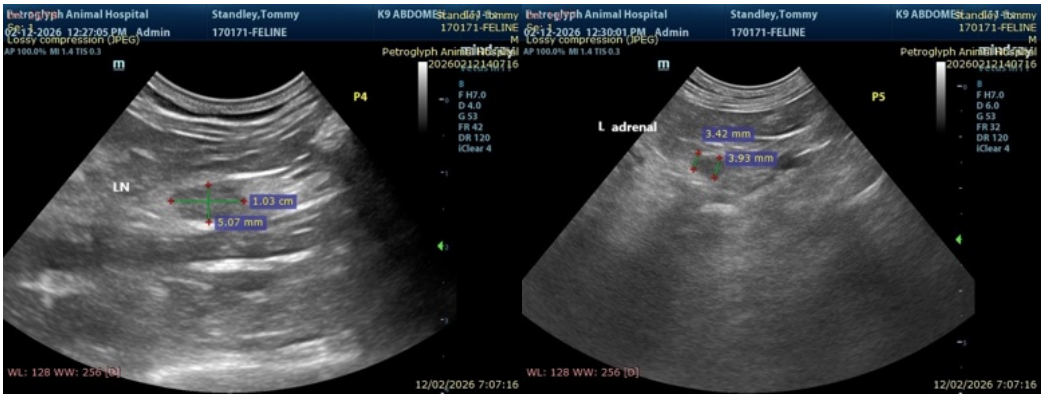

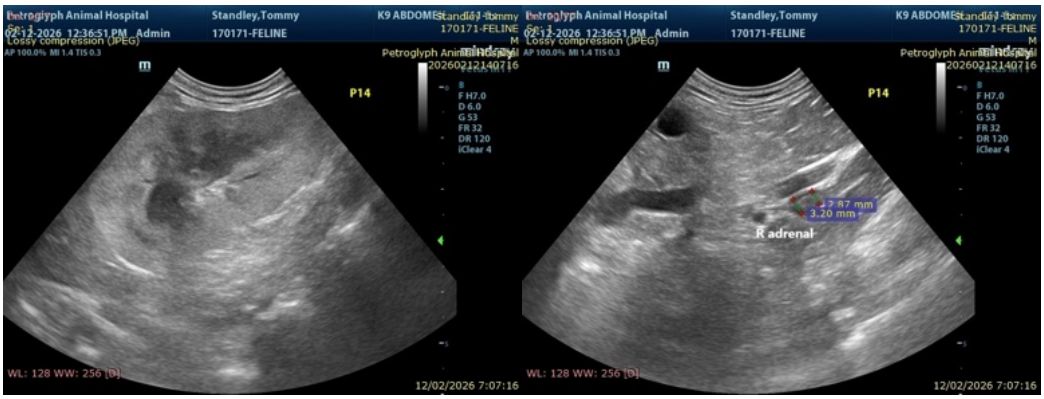

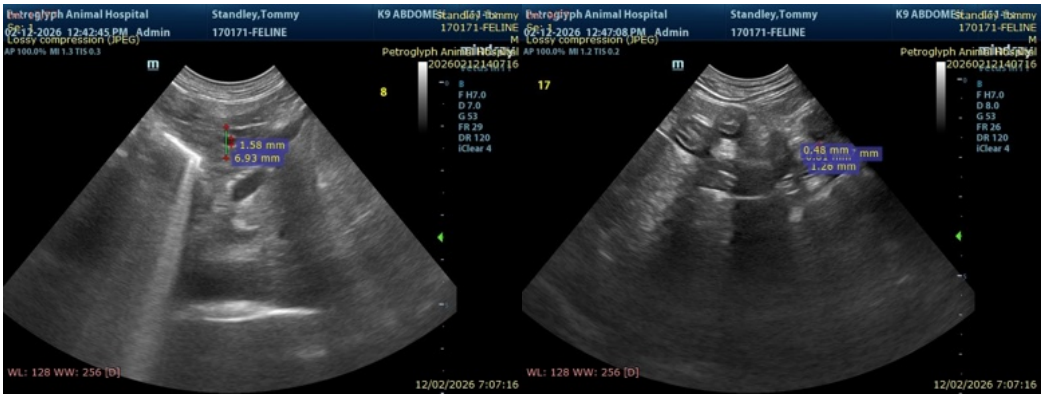

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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