



PATIENT

Mittz Ramos

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

13 years

WEIGHT

12.2 lbs

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Dr. Andrew Beachy

HOSPITAL NAME

Linn VH

REFERRING VET

Dr. Megan Beachy

INVOICE

71204

DATE

2/3/26

PRESENTING CLINICAL SIGNS

- Chronic weight loss - 7/30/2025 14.7 lbs, 1/19/2026 11.6 lbs, 2/2/2026 12.2 bs. Pt has been doing better in the last couple of weeks and did regain some weight. Occasional vomiting. History of pancreatitis (3 months ago). Normal energy.
- Concern for possible mass in caudal abdomen based on palpation. Idexx Renal Panel - Monocytosis, nucleated RBC's; no other significant findings (high normal Creatinine, SDMA).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is thin and smooth. Urine is predominantly anechoic with scant suspended echoes. 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 4.35×2.54 cm, with a cortical thickness of 0.34 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.77×2.24 cm, with a cortical thickness of 0.30 cm in the sagittal plane. In both kidneys, the renal cortex is isoechogenic compared to liver parenchyma. The corticomedullary ratio and corticomedullary definition are otherwise preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is observed. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

The adrenal glands were not visualized.

Spleen

The spleen 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 homogeneous and isoechoic relative to the falciform fat, with normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder is markedly distended. The wall is thin. The lumen contains a small amount of biliary sludge. The common bile duct measures 5.53 mm proximally, tapering to 3.45 mm and 3.11 mm distally.

Gastrointestinal

The stomach is empty and folded, with a wall thickness of 1.37 mm and preserved wall layering. The pyloric wall measures 2.90 mm.



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The duodenum measures 1.82 mm.

The jejunum measures 2.17 mm overall; however, one jejunal segment is focally thickened up to 3.66 mm, and an adjacent segment measures up to 4.92 mm with focal loss of normal wall layering at that site.

The ileum measures 1.92–1.93 mm with preserved wall layering. The ileocecal junction is not visualized.

The colon wall measures 0.82 mm and contains formed fecal material within the descending colon.

Pancreas

The pancreas measures 7.90–8.78 mm in thickness. The pancreatic parenchyma is hypoechoic relative to the adjacent omental fat. The pancreatic duct measures up to 1.74 mm in diameter.

Peritoneal Cavity

Ill-defined hypoechoic areas are present within the retroperitoneal region, adjacent to the abnormal intestinal loops, compatible with edema and inflammation of peripancreatic and retroperitoneal adipose and connective tissues.

Cranial mesenteric lymph nodes are identified, measuring 1.07 cm and 1.36 cm, and appear hypoechoic. Ileocecal lymph nodes are not visualized. The iliac trifurcation appears normal.

Thoracic Evaluation

Immediately cranial to the origin of the great vessels in the cranial mediastinal region, a rounded lymph node measuring approximately 1.45 cm in thickness is identified.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Pancreatic enlargement and hypoechogenicity with mild pancreatic duct dilation.
- Ill-defined hypoechoic retroperitoneal changes consistent with inflammatory edema.
- Focal jejunal wall thickening with localized loss of wall layering.
- Cranial mesenteric lymphadenopathy and enlarged mediastinal lymph node.

SECONDARY FINDINGS

- Marked gallbladder distension with mild biliary sludge and common bile duct dilation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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Pancreatic findings are compatible with recurrent or ongoing pancreatitis. Adjacent to the pancreas, ill-defined hypoechoic changes within the right retroperitoneal region are present. In the context of pancreatitis, this appearance is most consistent with extension of inflammatory edema into the surrounding retroperitoneal adipose and connective tissues. This pattern reflects the anatomic continuity of peripancreatic and retroperitoneal tissue planes and does not, by itself, imply a separate retroperitoneal pathology.

Within the jejunum, focal segmental wall thickening with localized loss of normal layering is identified. These changes exceed expected reactive measurements and, when considered alongside cranial mesenteric lymphadenopathy, raise concern for a clinically significant intestinal process. Differential considerations include intestinal neoplasia (particularly lymphoma), and severe focal inflammatory enteritis. Ultrasonographic overlap between these entities is well recognized, and definitive differentiation cannot be achieved on imaging alone. Jejunal changes are accompanied by marked hyperechogenicity of the adjacent mesenteric and retroperitoneal fat, consistent with active inflammatory involvement of the surrounding adipose and connective tissues.

The markedly distended gallbladder with mild biliary sludge and a common bile duct diameter at the upper limits of expected values may reflect functional biliary stasis, which can be associated with pancreatitis or systemic illness, without definitive evidence of extrahepatic biliary obstruction.

A mildly enlarged cranial mediastinal lymph node is identified. In the context of pancreatitis with associated retroperitoneal inflammatory changes, this finding is most consistent with reactive lymphadenopathy related to systemic or regional inflammatory drainage, particularly in the absence of primary pulmonary or cardiac abnormalities. While early multicentric lymphoma cannot be completely excluded based on imaging alone, this appearance is not typical of that disease process.

Recommendations

- Continue medical management of pancreatitis, prioritizing stabilization and clinical improvement before pursuing additional invasive diagnostic procedures. Given the degree of peripancreatic and mesenteric inflammation, manipulation or sampling of the pancreas is not recommended at this time.
- In the context of cranial mesenteric lymphadenopathy, ultrasound-guided cytologic sampling of the cranial mesenteric lymph node may be considered as a minimally invasive option to further characterize the process, if clinically appropriate and if the patient's condition allows. This recommendation is made from an imaging standpoint, recognizing the limitations of cytology and that clinical judgment should guide decision-making.
- Definitive intestinal biopsy, may be considered at a later stage once the patient is clinically improved and inflammatory changes have stabilized.
- All diagnostic and therapeutic decisions should ultimately be guided by the primary clinician, integrating imaging findings with clinical status, laboratory results, and response to treatment.



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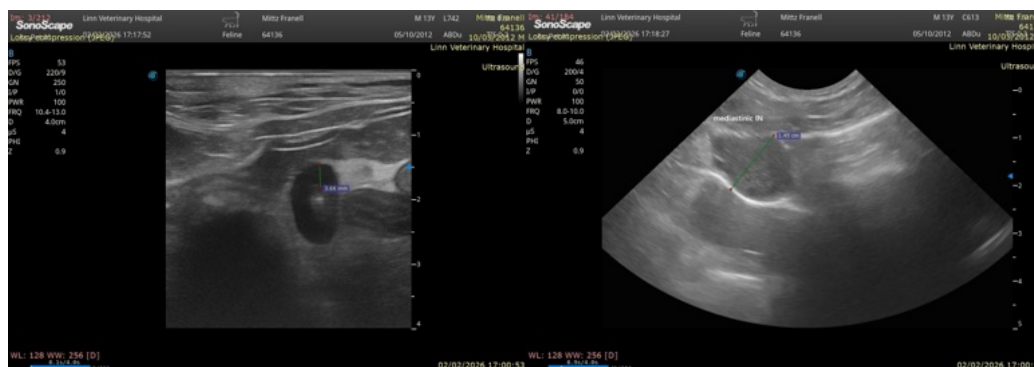
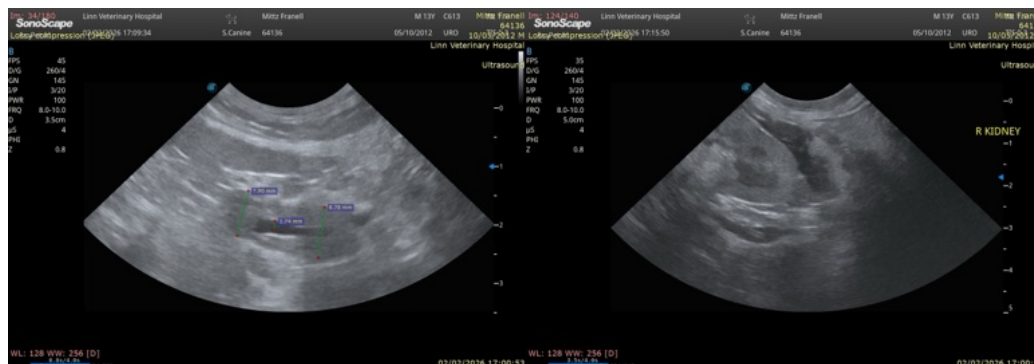
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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