



PATIENT

Mindi Ballou

SPECIES

Feline

BREED

Calico

SEX

Spayed female

AGE

16 years

WEIGHT

6.5 lbs

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Jelena Janjusevic

HOSPITAL NAME

Camden Pet Hospital

REFERRING VET

Dr. Moore

INVOICE

73585

DATE

3/18/26

PRESENTING CLINICAL SIGNS

- Hx weight loss from 8 pounds to 6.5 pounds in past 5 months. Has long term hx of periodic vomiting. Owner says has been eating normally up until a few of days ago. Vomited food 2 days ago. Ate last yesterday AM, but no bm's x 2-3 days. Past 2 days has been hiding more and lethargic and now not eating.
- Exam: dehydration (skin tent, gums tacky), moderate dental disease/tartar, left kidney small, right kidney irregular and larger than right, thin BCS 3/9, normal fecal material palpable Lab: Blood glucose 242 (71-159) BUN and creatinine normal 1.8 mg/dl and 33 mg/dl phosphorus normal 5.0 mg/dl K+ sl low 3.7 mmol/L T4 2.1 ALT elevated at 628 U/L (normal 12-130) Alk Phos low 11 U/L (normal 14-111) all other values normal INH pancreatic lipase normal Urine spgr 1.020 pH 6.5 WBC 30/HPF Bacteria Rods present, cocci suspect presence urine culture pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall appears thin and smooth. The urine is anechoic. The bladder neck and proximal urethra have a normal appearance. There are no calculi and no sonographic evidence of inflammatory or neoplastic changes.

The left kidney measures 3.51×2.14 cm, with a cortical thickness of 0.36 cm. The right kidney measures 3.25×2.16 cm, with a cortical thickness of 0.34 cm. In both kidneys, the cortex is increased in echogenicity, with increased corticomedullary distinction. A medullary rim sign is present. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal glands

The left adrenal gland is not visualized. The right adrenal gland measures 0.35 cm at the cranial pole and 0.36 cm at the caudal pole, with normal shape and echogenicity.

Spleen

Splenic thickness is 1.07 cm, with mildly rounded margins. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture, with several small hyperechoic nodules, the largest measuring 6.00×5.87 mm. The splenic capsule is smooth and regular.

Liver

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



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The gallbladder lumen is normally distended. The wall is thin, and the contents contain a moderate amount of biliary sludge. The cystic duct measures 3.54 mm. The common bile duct measures 2.81–2.60–2.40 mm.

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Gastrointestinal system

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The stomach is empty, containing a moderate amount of fluid, with a wall thickness of 1.95 mm and preserved layering. The pylorus is not visualized.

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Duodenum: 2.07 mm. Jejunum: 2.57 mm, with mucosa 1.65 mm, submucosa 0.56 mm, and muscularis propria 0.31 mm. Ileum: 1.83 mm, with mucosa 0.77 mm, submucosa 0.68 mm, and muscularis propria 0.69 mm. The ileocecal junction measures 3.40 mm, with muscularis propria 1.02 mm. Wall layering is preserved throughout. No signs of ileus, obstruction, or foreign material are identified.

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Colon: 0.91–0.42 mm, with formed feces in the descending segment.

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Pancreas

The evaluated pancreatic regions do not show evidence of overt inflammation or focal lesions.

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Peritoneal cavity

There is no sonographic evidence of abdominal effusion or peritonitis. Cranial mesenteric lymph nodes are mildly enlarged (up to 5.02–5.41 mm) and hypoechoic. Ileocecal lymph nodes are not visualized. The iliac trifurcation appears normal.

IMAGING PERFORMED BY

Jelena Janjusevic

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Marked muscularis thickening (ileum and ileocecal junction).
- Mesenteric lymphadenomegaly.
- Bilateral renal cortical hyperechogenicity with medullary rim sign.

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SECONDARY FINDINGS

- Moderate biliary sludge
- Small splenic hyperechoic nodules

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most significant finding is the disproportionate thickening of the muscularis layer at the level of the ileum and ileocecal junction, with preservation of wall layering. While overall intestinal thickness remains within normal limits, the muscularis-to-mucosa ratio is markedly increased in



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these segments, particularly in the ileum, which is not a normal finding. This pattern raises concern for chronic enteropathy (IBD) and small cell lymphoma. The presence of mildly enlarged, hypoechoic mesenteric lymph nodes support reactive or early infiltrative lymphadenopathy. Importantly, ultrasound cannot definitively differentiate between IBD and small cell lymphoma in cases like this, as there is substantial overlap between the ultrasonographic features of these conditions.

The kidneys show increased cortical echogenicity with a medullary rim sign, which is most consistent with chronic renal changes. This aligns with the suboptimal urine concentrating ability and supports chronic kidney disease.

The liver is unremarkable, which is notable given the marked ALT elevation; this suggests a functional or reactive hepatopathy rather than structural liver disease detectable on ultrasound.

The spleen contains small hyperechoic nodules, which are most consistent with benign age-related changes such as myelolipomas/Bates bodies and are not considered clinically significant.

No ultrasonographic evidence of pancreatitis is identified, although mild or chronic pancreatic disease cannot be excluded in cats.

Recommendations

- A complete gastrointestinal panel is recommended to further evaluate for underlying chronic enteropathy.
- While intestinal biopsy would be required for definitive differentiation between IBD and small cell lymphoma, this should be considered in light of the patient's age and overall clinical status.
- If a more conservative approach is preferred, empirical medical management for chronic enteropathy may be considered, including dietary management and cobalamin supplementation if deficiency is identified.
- Monitor clinical and renal progression closely.
- Address concurrent urinary tract infection based on culture results and continue supportive care as needed.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, based on the complete clinical context.



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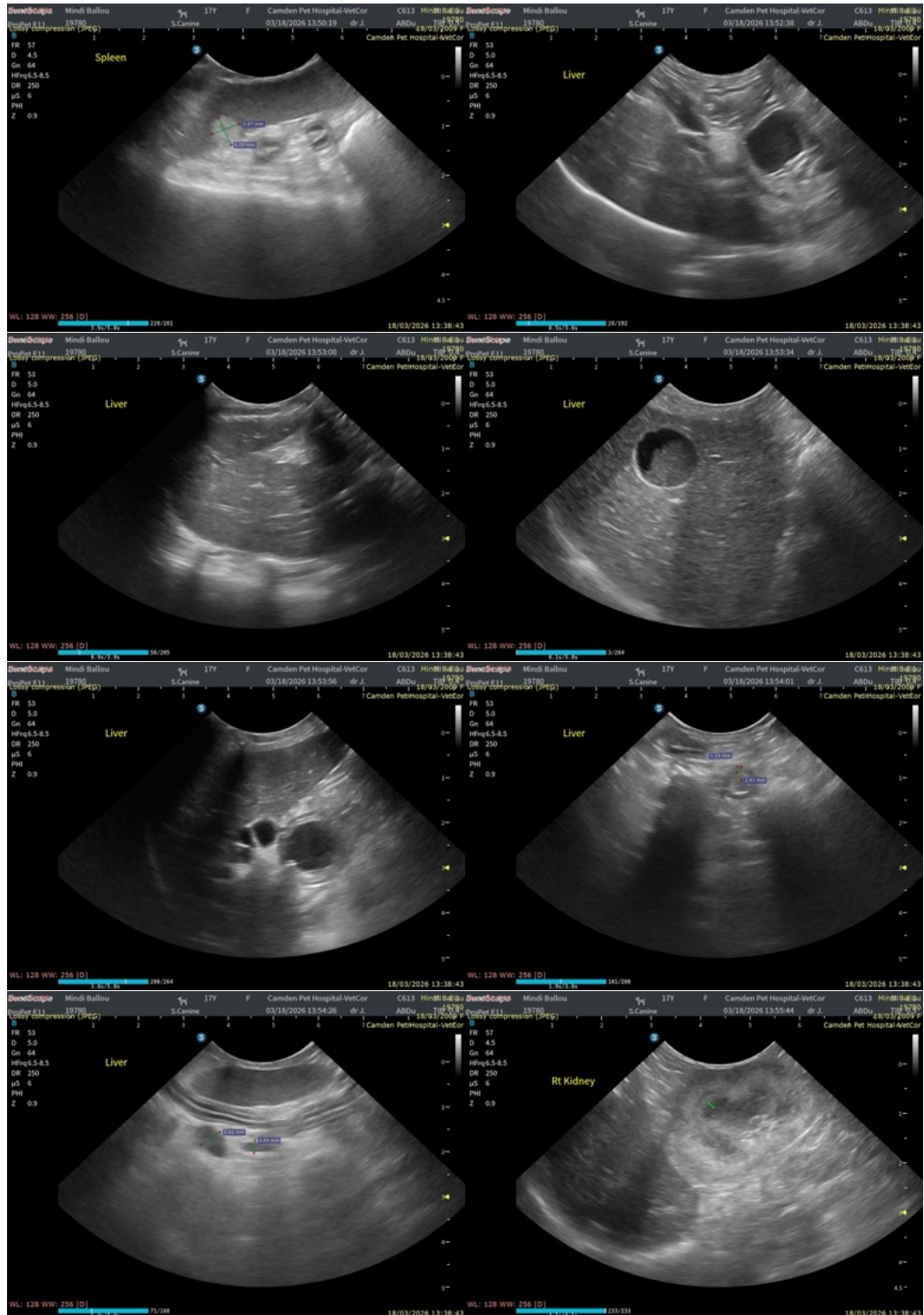
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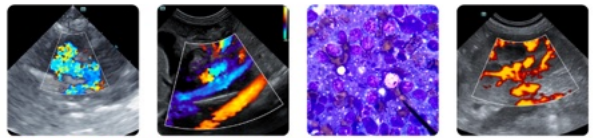
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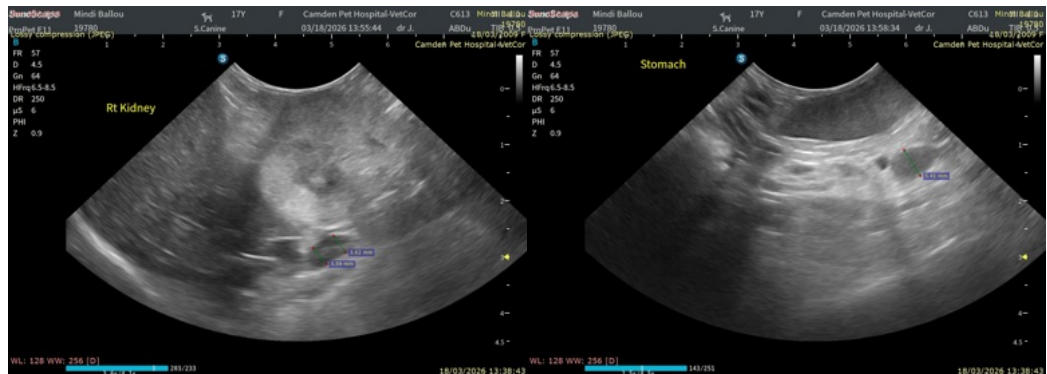
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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