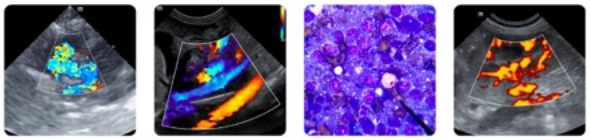


PATIENT

Bee Fan

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

13 years

WEIGHT

11.4 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Cecelia Dean

HOSPITAL NAME

Wellesley AH

REFERRING VET

Dr. Dean

INVOICE

73602

DATE

3/19/26

PRESENTING CLINICAL SIGNS

- 3/6 presents for ADR, occasional clear liquid vomit.
- CBC/Chem/T4/fecal wnl UA pending, collected today

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall appears thin and smooth. The urine is predominantly anechoic with scant suspended echoes. 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 2.46×1.39 cm, with a cortical thickness of 0.21 cm in the sagittal plane. The cortex is isoechoic relative to the hepatic parenchyma. A few small hyperechoic foci are present within the cortex, consistent with mineralization. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

The right kidney measures 4.87×2.27 cm, with a cortical thickness of 0.41 cm in the sagittal plane. The cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler shows a normal vascular pattern.

Adrenal glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.22 cm at the cranial pole and 0.24 cm at the caudal pole. The right adrenal gland measures 0.21 cm at the cranial pole and 0.24 cm at the caudal pole.

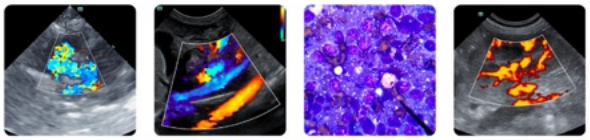
Spleen

Splenic thickness is 0.64 cm. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture without focal abnormalities. The splenic capsule is smooth and regular. Splenic vasculature appears normal.

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.

The gallbladder lumen is normally distended. The wall is thin, and the contents are anechoic. The common bile duct measures 3.86–3.04–2.05 mm.



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Gastrointestinal system

The stomach is distended with ingesta, with a wall thickness of 1.04 mm and preserved layering. The pylorus measures 3.40 mm.

Duodenum: 1.38 mm. Jejunum: 1.97 mm, with mucosa 1.26 mm, submucosa 0.36 mm, and muscularis propria 0.22 mm. Ileum: 2.24 mm, with mucosa 0.68 mm, submucosa 0.83 mm, and muscularis propria 0.58 mm. The ileocecal junction measures 2.19 mm, with mucosa 0.99 mm and muscularis propria 0.64 mm. Wall layering is preserved throughout.

Colon: 0.48 mm, with formed feces in the descending segment.

Pancreas

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

Peritoneal cavity

There is no abdominal effusion or peritonitis. Cranial mesenteric lymph nodes are not visualized, and the surrounding regions appear unremarkable. Ileocecal lymph nodes measure 3.11–3.57 mm, with normal shape and hypoechoic echogenicity, and mild increased echogenicity of the surrounding fat. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

- Marked renal asymmetry.
- Mild muscularis thickening (ileum and ileocecal junction).
- Mild perinodal fat echogenicity (ileocecal region).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The kidneys are markedly asymmetric, with a small left kidney and enlarged right kidney, while both maintain normal architecture. In cats, normal renal length is typically ~3.0–4.5 cm. The left kidney (2.46 cm) is below expected size, consistent with chronic change (chronic kidney disease or prior insult). The presence of small cortical mineralization further supports chronic renal change in the left kidney.

The right kidney (4.87 cm) is enlarged, most consistent with compensatory hypertrophy. The preservation of corticomedullary definition and normal echogenicity suggests that the contralateral kidney is functionally adapting rather than affected by primary disease. This pattern is common in unilateral chronic renal disease and is clinically relevant, although current biochemical values are within normal limits.

Within the gastrointestinal tract, there is mild disproportionate thickening of the muscularis layer at the level of the ileum and ileocecal junction, with preserved layering. The muscularis-to-mucosa ratio is mildly increased in these segments, which is not a normal finding but remains subtle. This pattern is

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compatible with early or mild chronic enteropathy, including IBD or, less likely, early small cell lymphoma.

The ileocecal lymph nodes are within normal size limits and maintain normal morphology, although there is mild hyperechogenicity of the surrounding fat, which may reflect a low-grade or reactive inflammatory process. These findings support mild, likely early enteropathy rather than a clearly infiltrative disease.

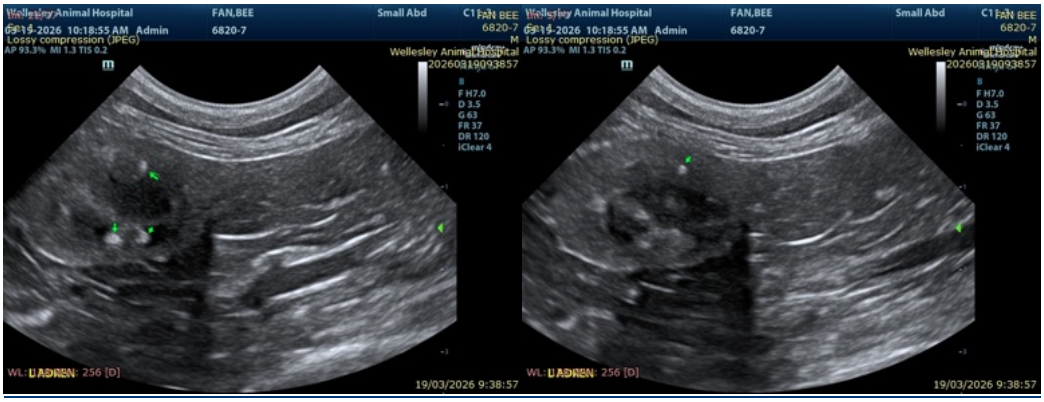
Overall, this is a subtle study, with findings most consistent with:

- Unilateral chronic renal change with compensatory hypertrophy.
- Mild distal small intestinal disease (early chronic enteropathy).

Recommendations

- Given the history of intermittent vomiting and current clinical signs, further evaluation for early chronic enteropathy may be considered (complete gastrointestinal panel or cobalamin assessment).
- Empirical medical management (dietary modification ± cobalamin supplementation if indicated) may be considered based on clinical response.
- If clinical signs persist or progress, intestinal biopsy would be required for definitive differentiation between inflammatory and infiltrative disease, although a conservative approach may be reasonable initially.
- Renal monitoring.

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



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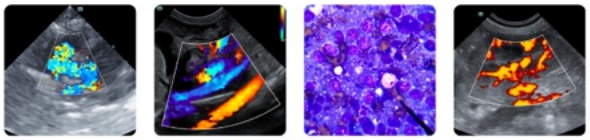

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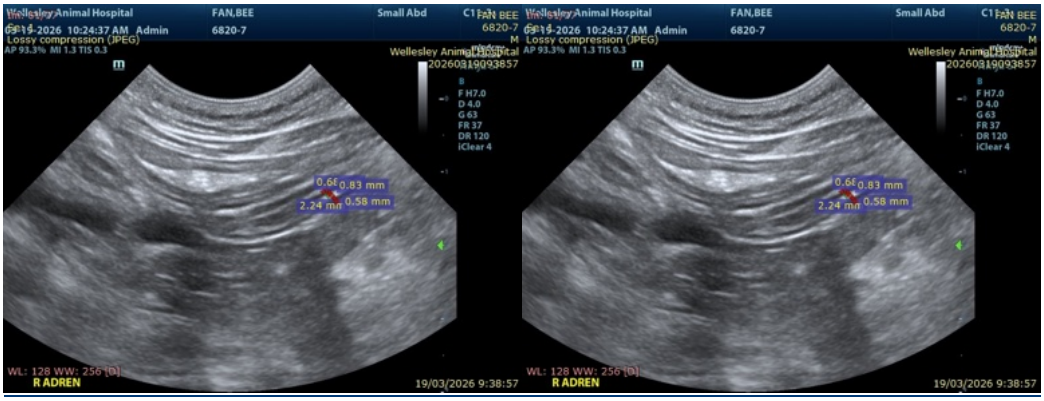

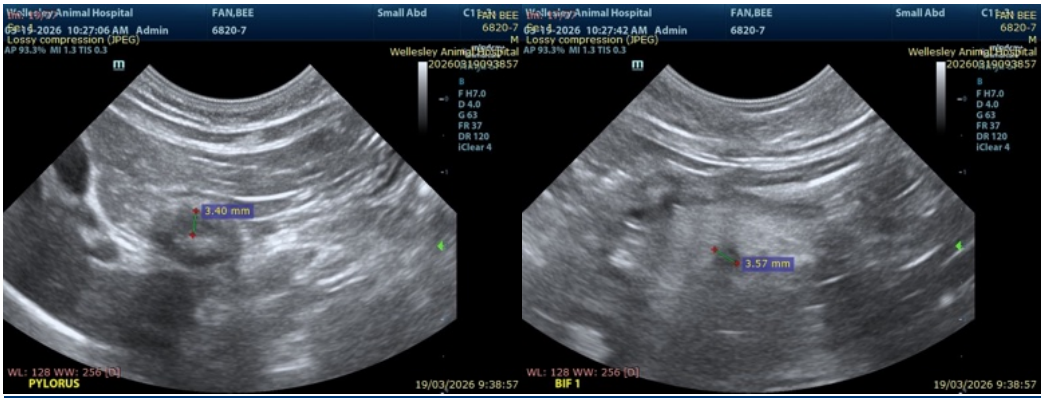

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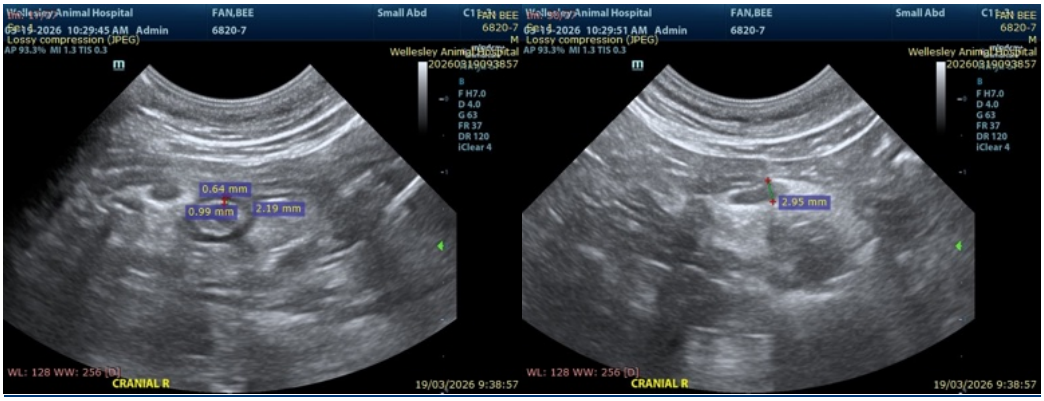

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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