



PATIENT

Rosey Lundy

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

11 years

WEIGHT

2 kg

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Sophie Lee DVM

HOSPITAL NAME

Northshore VH

REFERRING VET

Michaela Edgers, DVM

INVOICE

73715

DATE

3/23/26

PRESENTING CLINICAL SIGNS

- History of chronic enteropathy treated with hypoallergenic/novel protein diets and previous prednisolone.
- January 2025-January 2026 pt lost 0.5 lb
- Pt has lost 0.7 lb in the last 6 weeks.
- O stopped prednisolone 2 weeks ago because it causes pt to chew on her forelegs and act agitated. This resolved after discontinuation.
- Hypercalcemia workup
- 11/2024 abdominal ultrasound indicated chronic pancreatitis, mild chronic renal change, intact segmental small intestinal borders, mild colitis. At that time she was being worked up for diarrhea and hematochezia, which are now resolved. 3/16/26: new hypercalcemia with total calcium at 13 (8.2 - 11.2 mg/dL). SDMA 17 (0 - 14 µg/dL) with creatinine 1.2 (0.9 - 2.3 mg/dL). Mild monocytosis. PCV 38%. Total T4 normal at 1.6 (0.8 - 4.7 µg/dL) 3/23/26: ionized calcium normal at 1.38 (1.04 - 1.44 mmol/L) and mild hypokalemia .2 (3.4 - 4.9 mEq/L) BCS 2/9, MCS 2/4, moderately dehydrated at 7-8%.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is predominantly anechoic with scant suspended echoes. Normal appearance of the bladder neck and proximal urethra. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.57×1.99 cm, and the thickness of the cortex is 0.34 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Doppler color shows a normal vascular pattern.

The right kidney is normal in shape and size: 3.67×1.85 cm, and the thickness of the cortex is 0.30 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Doppler color shows a normal vascular pattern.

Adrenal Glands

Dorsoventral diameters measured in the sagittal plane: the left adrenal gland was not clearly visualized. The right adrenal gland measures 0.25 cm at the cranial pole and 0.24 cm at the caudal pole.

Spleen

Splenic thickness is 0.94 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.



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Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma is uniform and isoechoic compared 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 primarily anechoic with a small amount of biliary sludge. The common bile duct measures 1.69–1.95 mm from proximal to distal.

Gastrointestinal

The stomach is empty and folded, with mural thickness (1.57 mm) and preserved wall layering. The pylorus measures 2.87 mm.

Duodenum: 3.18 mm. Jejunum: 2.48–2.72 mm (mucosa: 1.47 mm; submucosa: 0.47 mm; muscularis propria: 0.29 mm). Ileum: 2.52–2.84 mm (mucosa: 0.83 mm; submucosa: 0.89 mm; muscularis propria: 0.72 mm), with preserved wall layering. The ileocecal junction measures 3.32 mm (mucosa: 0.71 mm; muscularis: 1.30 mm). All intestinal segments subjectively appear thickened, with a small amount of luminal fluid present.

Colon: ascending colon 1.09 cm with normal layering and luminal content including partially undigested material; descending colon 1.65 cm, with normal layering and minimal luminal content.

Pancreas

Right limb measures 4.54–5.54 mm; left limb measures 5.3 mm in thickness. The pancreatic parenchyma is mildly hypoechoic to isoechoic relative to the adjacent omental fat. The pancreatic duct is not dilated. No peripancreatic fat inflammation is identified.

Free Abdomen

A very small volume of abdominal effusion is present. Ileocecal lymph nodes measure 2.60–3.11 mm. Cranial mesenteric lymph nodes measure up to 4.23 mm in thickness, with normal shape and mildly hypoechoic echogenicity. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Increased intestinal muscularis thickness (notably ileum and ileocecal junction; muscularis/mucosa ratio ≥ 1).
- Mild mesenteric lymph node enlargement/alteration.
- Small amount of abdominal effusion.

SECONDARY FINDINGS

- Subtle pancreatic parenchymal changes.
- Mild biliary sludge.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

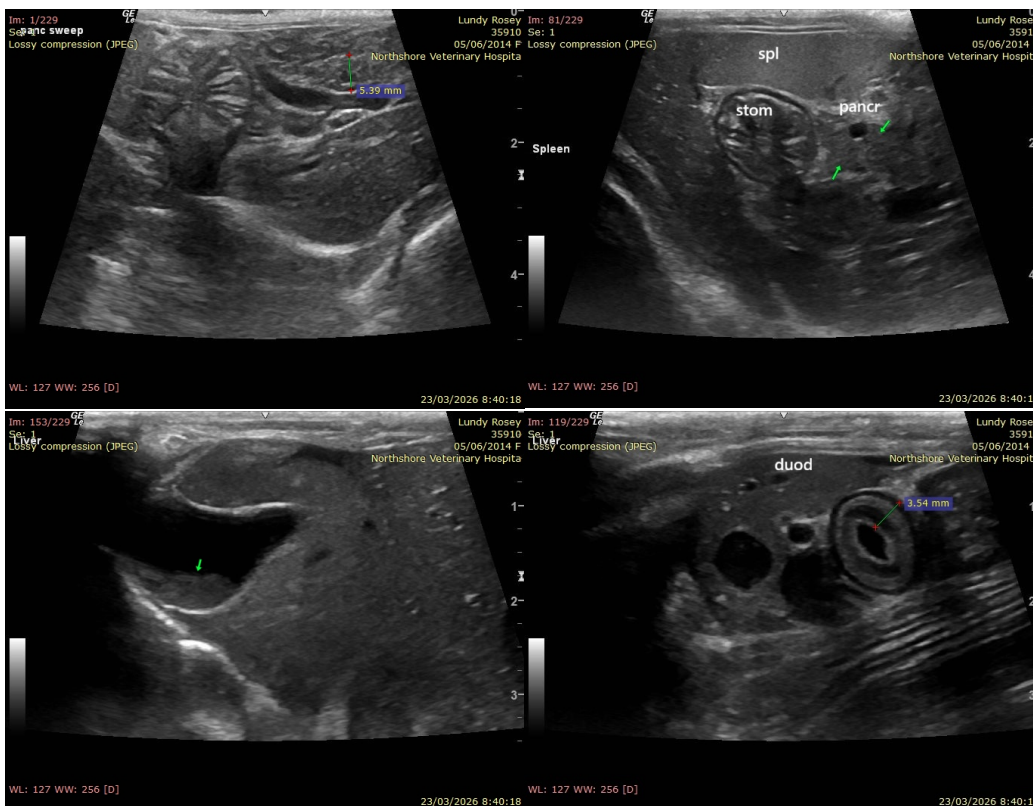
The intestinal tract shows diffuse changes characterized by increased muscularis thickness relative to the mucosa, particularly in the ileum and ileocecal junction (muscularis-to-mucosa ratio approaching or exceeding 1), with preserved wall layering. This pattern supports a chronic enteropathy, with primary differentials including inflammatory bowel disease and small cell lymphoma. These entities cannot be reliably distinguished based on ultrasonographic findings alone, particularly in the context of weight loss and prior steroid therapy.

Mild mesenteric lymph node changes and a very small volume of abdominal effusion are present, which may be reactive but, in this clinical context, support a chronic inflammatory or infiltrative process. The pancreas shows mild, nonspecific changes, which may be age-related; however, chronic pancreatitis cannot be excluded.

Recommendations

- Complete gastrointestinal panel if not already performed.
- If immunosuppressive therapy is being reintroduced, intestinal biopsies are recommended prior to initiation, as corticosteroid treatment may affect histopathologic interpretation.
- Supportive care.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status and ongoing response to treatment.





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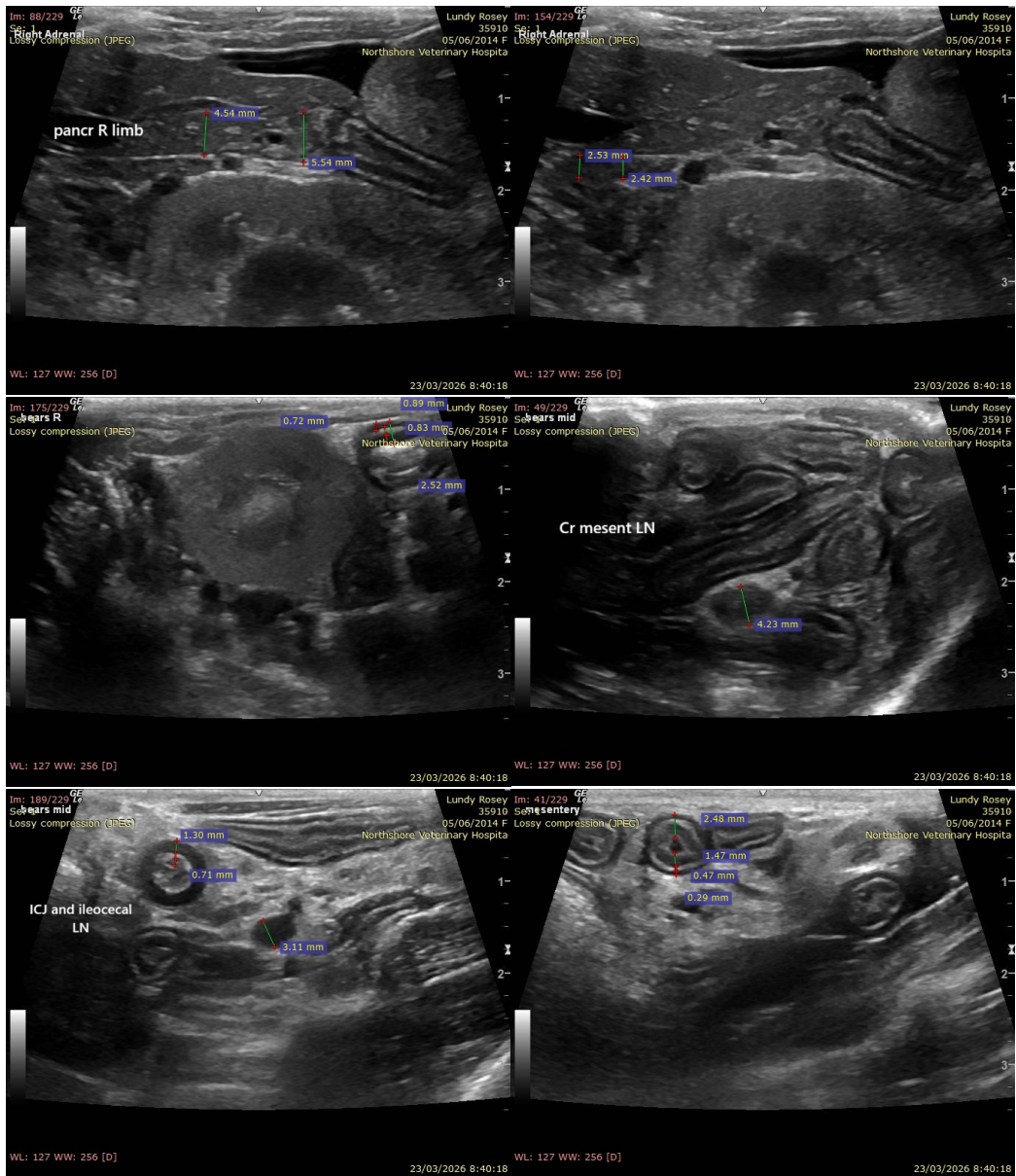
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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