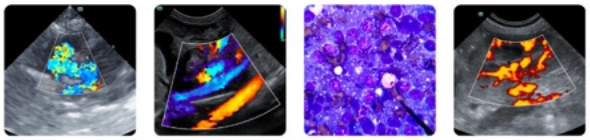


PATIENT

Dory Stewart

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

14 years

WEIGHT

5.26 kg

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Tara Hayes

HOSPITAL NAME

Valley VC

REFERRING VET

Dr. Tara Hayes

INVOICE

73834

DATE

3/25/26

PRESENTING CLINICAL SIGNS

- Chronic vomiting - recently increased in frequency. Happens in episodes of vomiting 5 or more times in a day. These episodes have been happening every 1-2 weeks lately.
- History of IBD - still on B12 monthly, previously on prednisolone (not on this recently). Two previous ultrasounds showed jejunal thickening.
- Rx include: methimazole 1.875 mg BID (transdermal) and Restoralax every 3 days in the morning (1/4 tsp)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended, with a thin and smooth wall. The urine is predominantly anechoic with scant suspended echoes. The bladder neck and proximal urethra appear normal. No calculi or sonographic evidence of inflammatory or neoplastic changes are identified.

The left kidney is normal in shape and size, measuring 3.50×2.30 cm, with a cortical thickness of 0.43 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio and definition are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler shows a normal vascular pattern.

The right kidney is normal in shape and size, measuring 3.62×2.19 cm, with a cortical thickness of 0.37 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio and definition are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler shows a normal vascular pattern.

Adrenal Glands

Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.27cm at the cranial pole and 0.29 cm at the caudal pole. The right adrenal gland measures 0.45 cm at the cranial pole and 0.48 cm at the caudal pole.

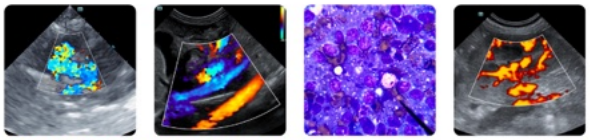
Spleen

Splenic thickness is 0.57 cm. The parenchyma is homogeneous with normal echogenicity, with a few small hyperechoic nodules consistent with myelolipomas, the largest measuring 2.12×3.19 mm. The splenic capsule is smooth and regular. Splenic vasculature appears normal.

Liver

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

The gallbladder is normally distended. The wall measures 1.14 mm and appears within normal limits. The contents are anechoic. The common bile duct measures 2.99 mm proximally, 2.28 mm mid-portion, and 0.99 mm distally.



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Gastrointestinal

The stomach is empty and folded, with a wall thickness of 1.33 mm and preserved layering. The pylorus measures 2.73 mm.

The duodenum measures 2.13 mm.
The jejunum measures 2.76 mm, with preserved wall layering. The mucosa measures 1.65 mm, the submucosa 0.47 mm, and the muscularis propria 0.56 mm.

The ileum measures 2.51 mm, with preserved wall layering. The mucosa measures 0.84 mm, the submucosa 0.43 mm, and the muscularis propria 1.02 mm. In another segment, the muscularis measures up to 1.73 mm.

The ileocecal junction measures 3.93 mm, with muscularis thickness of 1.49 mm.

Wall layering is preserved throughout. No evidence of obstruction, ileus, or intraluminal foreign material is identified.

The colon measures 0.59 mm and contains formed feces.

Pancreas

The evaluated pancreatic regions show no evidence of overt inflammation or focal lesions.

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation appears normal.

PRIMARY FINDINGS

- Mild-to-moderate muscularis thickening, most pronounced in the ileum and ileocecal region.
- Borderline common bile duct dilation (proximal up to ~3 mm).

SECONDARY FINDINGS

- Incidental splenic myelolipomas.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most relevant finding is segmental muscularis thickening, particularly involving the ileum and ileocecal junction, with preservation of wall layering.
The muscularis-to-mucosa ratio is:

- Jejunum: ~0.34 → within normal limits.
- Ileum: ~1.21–2.0 → clearly increased.

This pattern supports a chronic enteropathy, with muscularis hypertrophy most pronounced in the distal small intestine. In cats, this finding is commonly associated with both inflammatory bowel disease and small-cell lymphoma, and there is significant ultrasonographic overlap between these entities.

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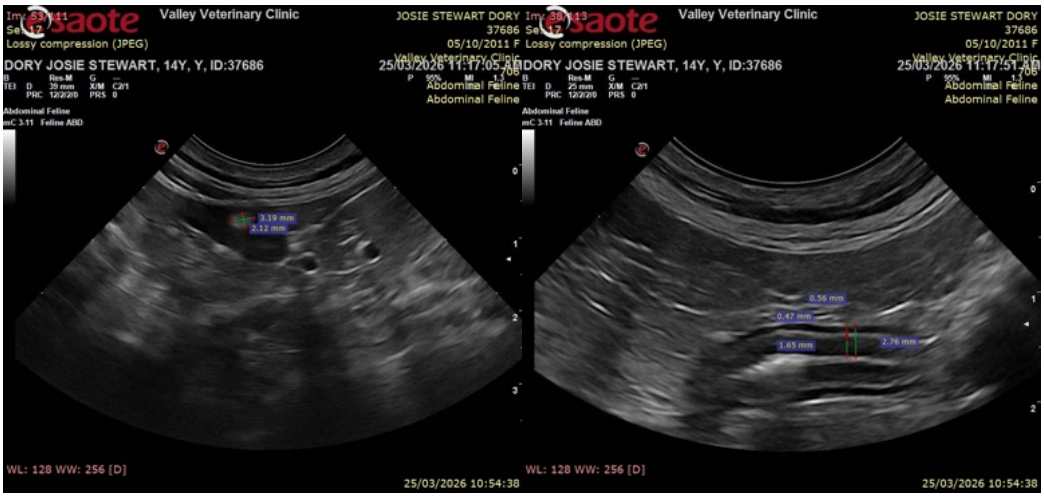
Given the clinical history (chronic vomiting, prior diagnosis of IBD, and discontinuation of prednisolone), these findings are most consistent with exacerbation or progression of chronic inflammatory enteropathy. However, early or evolving small-cell lymphoma cannot be excluded based on ultrasound alone.

The common bile duct is mildly prominent proximally (up to ~3 mm). In the absence of gallbladder wall thickening or intrahepatic biliary dilation, this is of uncertain clinical significance, although early or mild biliary involvement cannot be entirely excluded.

The pancreas appears unremarkable; however, as in many feline cases, pancreatitis cannot be excluded ultrasonographically.
Recommendations

- Reassessment of medical management is recommended, particularly considering reintroduction or adjustment of anti-inflammatory therapy, depending on clinical response and clinician preference.
- Continued cobalamin supplementation is appropriate. Evaluation of cobalamin/folate levels may be considered if not recently assessed.
- Dietary management should be reviewed, and a strict dietary trial (novel or hydrolyzed protein) may be beneficial if not already optimized.
- If clinical signs persist, worsen, or become refractory to medical management, further diagnostic investigation (intestinal biopsy) should be considered to differentiate inflammatory disease from small-cell lymphoma.
- Additional testing (fPLI) may be considered if pancreatic involvement is suspected clinically.



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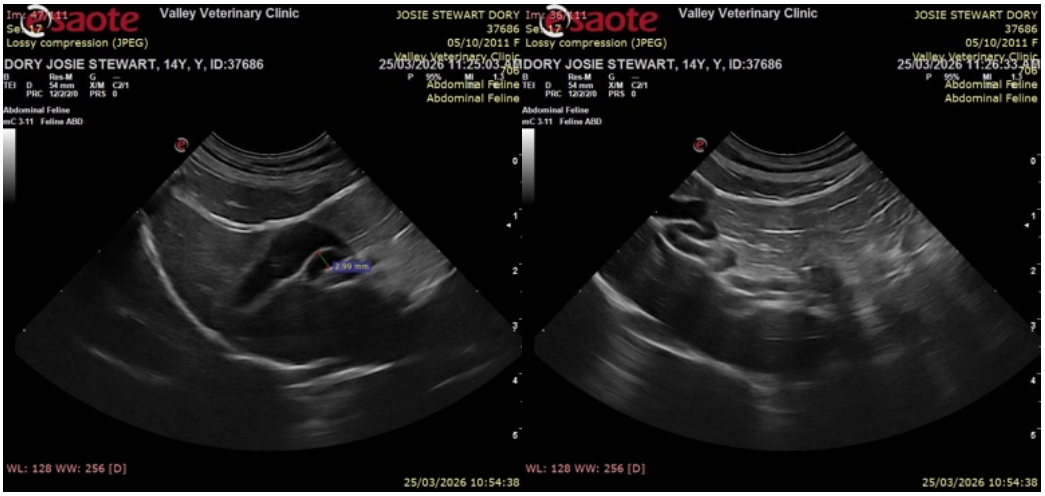

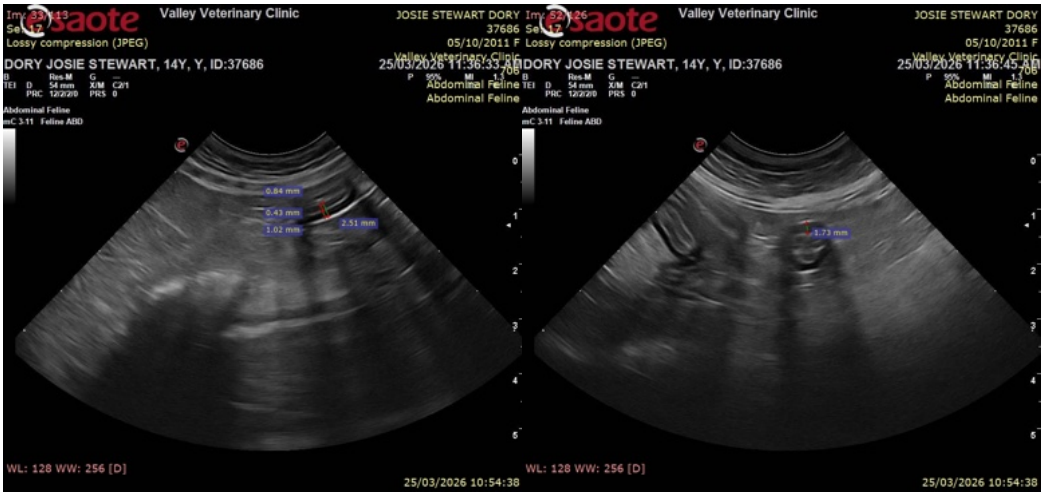

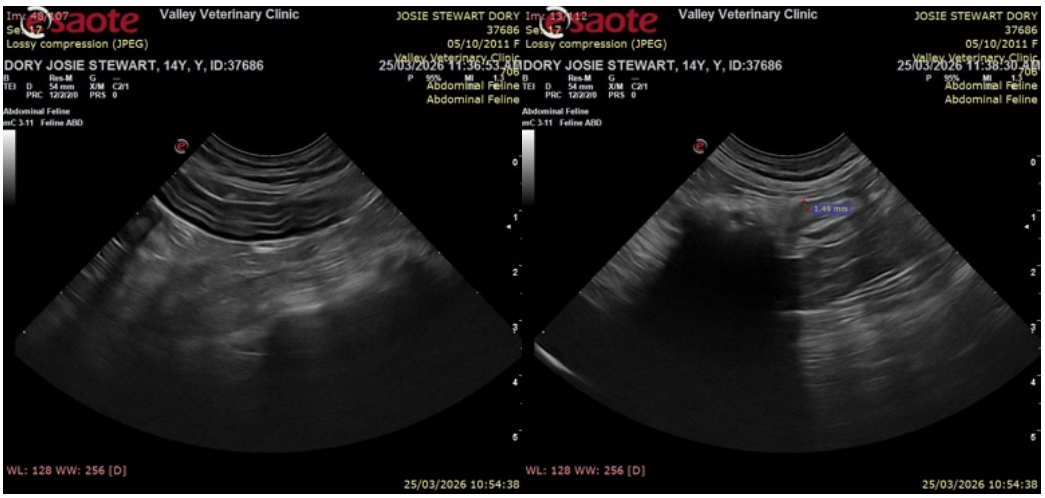

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com