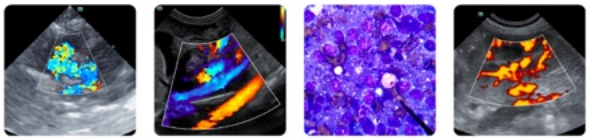


PATIENT

Mika Francis

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

14 years

WEIGHT

6.32 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Mueller

HOSPITAL NAME

Cold Lake VC

REFERRING VET

Dr. Mueller

INVOICE

78438

DATE

3/27/26

PRESENTING CLINICAL SIGNS

Case information:
Patient was referred to me for SDEP abdominal Ultrasound to look for underlying causes of IMHA. Patient presented with Weight loss, reduced appetite ADR, O unsure about litter box. No vomiting

Abnormal PE/Chem/CBC/UA Results: -Exam: tachycardic and pale mm - Comp: creatine (41umol/L) and urea (3.5mmol/L) are low, mild hyperglobulinemia(53g/L), low ALT(<10 U/L) - T4: WNL - USG: >1.050 - CBC: regenerative anemia - Slide agglutination: positive

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

The left kidney is normal in shape and size: 3.19×1.93 cm, with a cortical thickness of 0.33 cm in the sagittal plane. The right kidney is normal in shape and size: 3.62×2.02 cm, with a cortical thickness of 0.36 cm in the sagittal plane. In both kidneys, the cortex is mildly hyperechoic compared to the liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler demonstrates 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 0.31 cm at the cranial pole and 0.30 cm at the caudal pole. The right adrenal gland measures 0.27 cm at the cranial pole and 0.25 cm at the caudal pole.

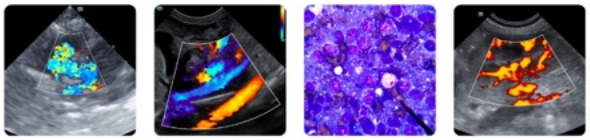
Spleen

Splenic thickness is 1.41–1.62 cm, with rounded margins. The parenchyma is diffusely hypoechoic, homogeneous. A very subtle, poorly defined focal area of slightly increased echogenicity is noted, resulting in a mild contour bulge. This finding is ill-defined and not measurable as a discrete nodule. The splenic capsule is smooth and regular.

Liver

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

The gallbladder is normally distended, with a thin wall. The contents are predominantly anechoic with a small amount of biliary sludge. The common bile duct measures 3.01–1.70 mm from proximal to distal.



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Gastrointestinal

The stomach is empty and folded, containing a moderate amount of fluid in the fundus and gas, with a mural thickness of 1.40 mm and preserved wall layering. The pylorus measures 4.25 mm. The duodenum measures 1.78 mm.

The jejunum measures 2.08–2.64 mm, with preserved wall layering (mucosa: 0.94 mm; submucosa: 0.47 mm; muscularis propria: 0.29 mm). The ileum measures 2.41 mm (mucosa: 0.76 mm; submucosa: 0.70 mm; muscularis propria: 0.85 mm), with preserved layering. The ileocecal junction measures 2.30 mm, with a muscularis thickness of 1.26 mm.

The colon measures 1.39 mm, with formed feces in the descending segment.

Pancreas

The right limb measures 4.11 mm and the left limb 4.95 mm in thickness. The pancreatic parenchyma is isoechoic relative to the adjacent omental fat. The pancreatic duct measures 1.15 mm. No evidence of peripancreatic fat inflammation is identified.

Free Abdomen

Very mild abdominal effusion is observed. No sonographic evidence of lymphadenomegaly is identified. The iliac trifurcation appears normal.

PRIMARY FINDINGS

- Diffuse splenomegaly with rounded margins and hypoechoic.
- Small abdominal effusion
- Mild ileal and ileocecal muscularis thickening

SECONDARY FINDINGS

- Turbid urinary bladder content

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is diffuse splenomegaly with rounded margins and mildly decreased echogenicity. A very subtle, poorly defined focal area of slightly increased echogenicity with mild contour bulging is noted within the splenic parenchyma. This finding is ill-defined and not measurable as a discrete nodule. These splenic changes may represent a reactive process in the context of IMHA, such as extramedullary hematopoiesis or splenic hyperplasia. However, a diffuse infiltrative process cannot be excluded, as these entities cannot be reliably distinguished on ultrasound.

A mild muscularis thickening of the ileum and ileocecal junction, with an increased muscularis-to-mucosa ratio is observed, supporting a chronic enteropathy pattern. While the changes are mild and there is no associated lymphadenopathy, it is important to note that ultrasonographic features of inflammatory bowel disease and low-grade lymphoma may overlap, and differentiation between these

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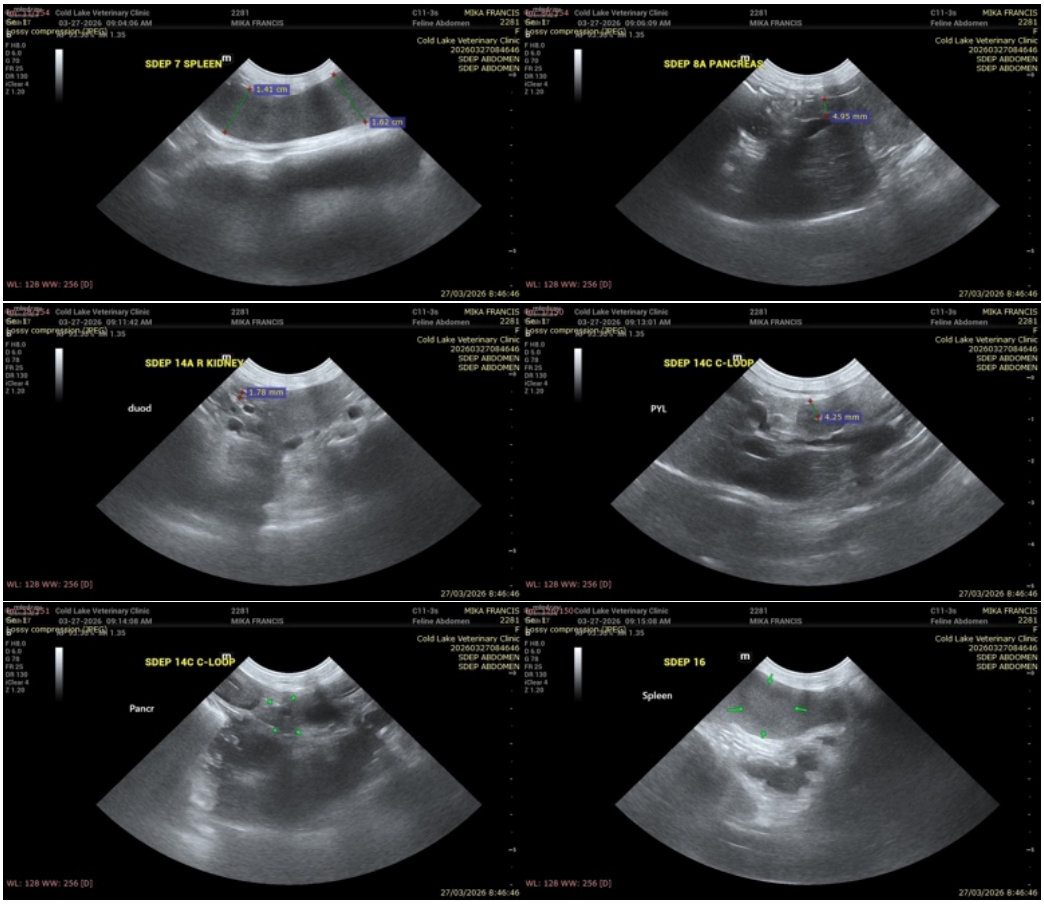
entities is not possible based on ultrasound alone.

Very mild abdominal effusion is present and is nonspecific but compatible with a systemic process.

Recommendations

- Given the diagnosis of IMHA and lack of a clear structural cause, screening for infectious etiologies (hemotropic Mycoplasma spp.) is recommended, as these will not be detected on ultrasound.
- In the absence of a discrete mass or clearly suspicious ultrasonographic features of neoplasia, definitive diagnosis cannot be achieved based on imaging alone. If clinical concern persists, tissue sampling may be considered, particularly splenic cytology, once the patient is clinically stabilized. Intestinal biopsy may be considered if gastrointestinal disease remains a concern, although this would require a more invasive approach.

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



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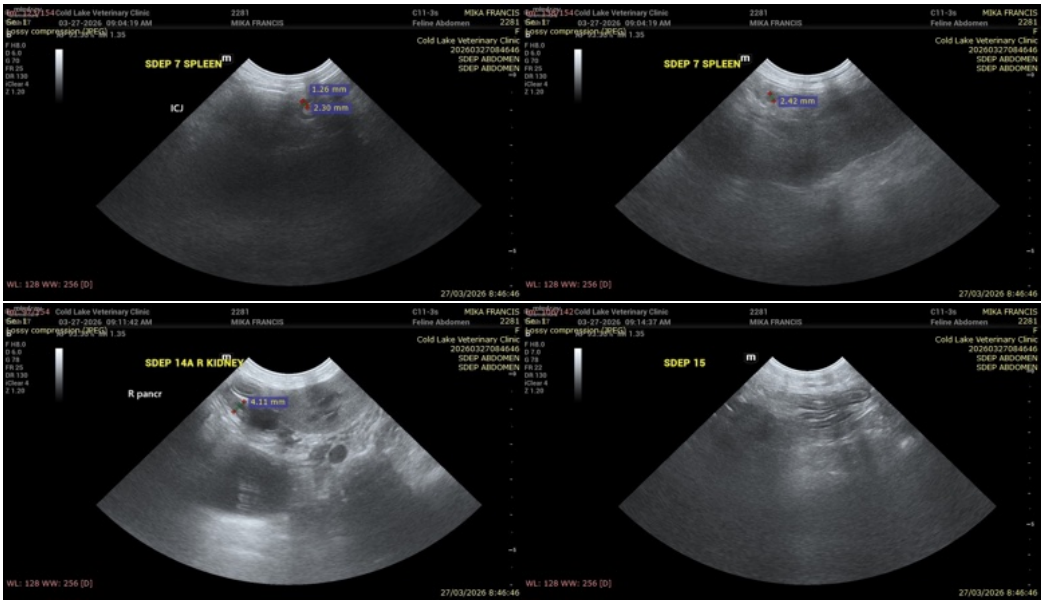

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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