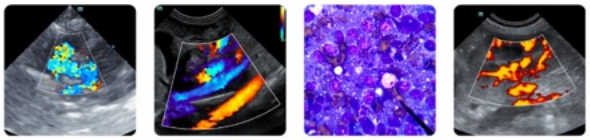


PATIENT

Ollie Scranton

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

5 years

WEIGHT

15 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Anshu Gupta

HOSPITAL NAME

Liverpool Village AH

REFERRING VET

Dr. Gupta

INVOICE

73982

DATE

3/31/26

PRESENTING CLINICAL SIGNS

- Chronic intermittent hematemesis
- previous tentative diagnosis of IBD, responsive to prednisolone and symptomatic therapy
- EPI diagnosis based on low TLI
- Normal CBC/Chem in January Texas GI panel: Low TLI, hypocobalaminemia

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended, with a thin, smooth wall. The urine is turbid with a small amount of echogenic sediment. The bladder neck and proximal urethra appear normal. No calculi or evidence of inflammatory or neoplastic changes are identified.

The left kidney is normal in shape and size (4.02×2.66 cm), with a cortical thickness of 0.40 cm in the sagittal plane. The right kidney is normal in shape and size (4.54×2.78 cm), with a cortical thickness of 0.46 cm in the sagittal plane.

Both kidneys: The cortex is hyperechoic compared to the liver parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. A marked medullary rim sign is present. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Doppler color evaluation shows a normal perfusion pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.21 cm at the cranial pole and 0.23 cm at the caudal pole. The right adrenal gland measures cm at the cranial pole and cm at the caudal pole.

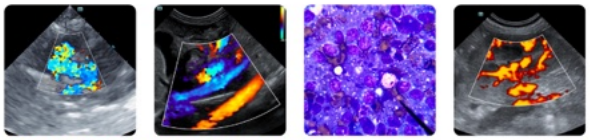
Spleen

Splenic thickness is 1.02 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

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

The gallbladder is normally distended. The wall is thin, and the contents are anechoic with a very small amount of biliary sludge. The common bile duct is mildly dilated at its proximal portion.



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Gastrointestinal

The stomach is moderately distended with fluid and partially digested ingesta. Gastric wall thickness measures 1.66–2.19 mm, with preserved layering. No focal defects suggestive of ulceration are identified. Mild hyperechogenicity of the surrounding gastric and proximal duodenal fat is noted.

Duodenum: 2.05 mm. Jejunum: 2.87 mm (mucosa 1.32 mm, submucosa 0.89 mm, muscularis 0.44 mm). Ileum: 1.96 mm (mucosa 0.65 mm, submucosa 0.65 mm, muscularis 0.51 mm). Ileocecal junction: 3.36 mm (muscularis 1.02 mm). Wall layering is preserved throughout. The intestinal lumen contains material with a food pattern, with subjectively increased motility. These findings, together with the presence of gastric content, may reflect either incomplete fasting or delayed gastric emptying and should be clinically correlated.

Colon: 0.78 mm, with formed feces in the descending segment.

Pancreas

The pancreas is not clearly visualized; however, the evaluated regions do not show evidence of overt inflammation or focal lesions.

Free Abdomen

No abdominal effusion or peritonitis is identified.

Cranial mesenteric lymph nodes measure 4.74–5.31 mm, and ileocecal lymph nodes measure 2.80 mm; all are normal in shape and echogenicity. Mild perinodal fat hyperechogenicity is noted. The iliac trifurcation appears normal.

PRIMARY FINDINGS

- Mild hyperechogenicity of gastric/duodenal and perinodal fat.
- Subjectively increased intestinal motility with digestive food pattern.
- Gastric fluid and ingesta (fasting vs delayed emptying).

SECONDARY FINDINGS

- Bilateral renal cortical hyperechogenicity with medullary rim sign
- Turbid urinary bladder contents

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastrointestinal findings are mild and nonspecific. Intestinal wall thickness and layering are within accepted reference ranges, and muscularis-to-mucosa ratios are within normal limits, which does not support muscularis hypertrophy.

The presence of gastric fluid and ingesta, together with increased motility, may reflect incomplete fasting or delayed gastric emptying. Given the history of chronic hematemesis, a functional gastric

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disorder or gastritis remains possible; however, ultrasonography is limited in detecting mucosal ulceration.

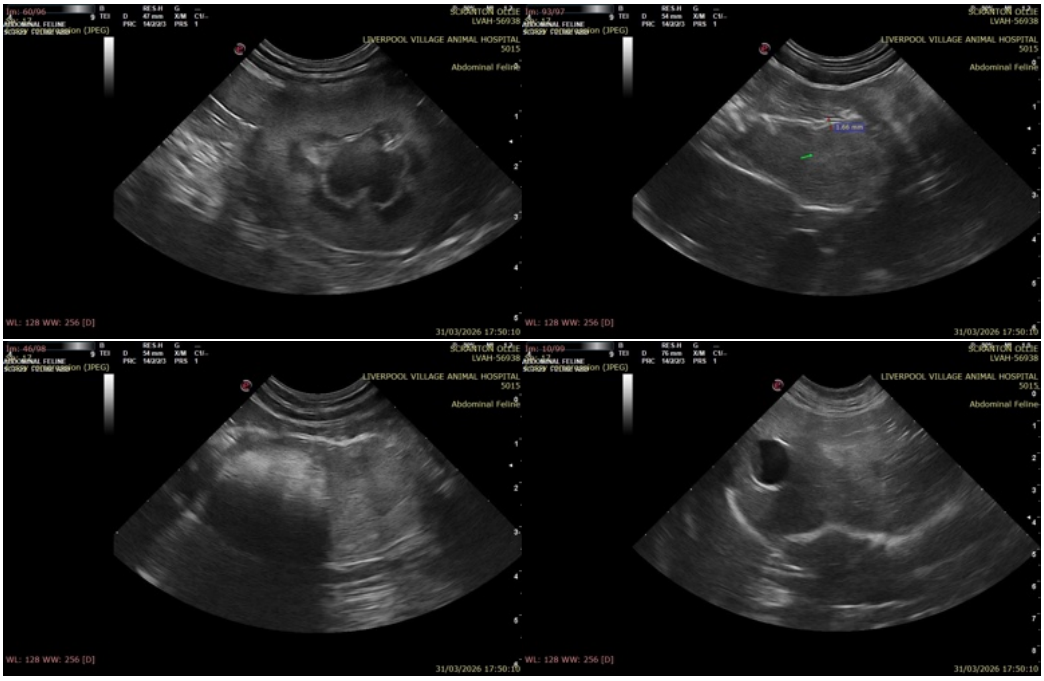
There are no ultrasonographic features to suggest infiltrative neoplasia at this time. While early small cell lymphoma cannot be entirely excluded based on imaging alone, current findings do not support this as a primary differential.

Overall, the findings are most consistent with a functional or mild inflammatory enteropathy, which aligns with the patient's history of steroid-responsive disease and concurrent hypocobalaminemia and EPI.

Recommendations

- Correlate with fPLI to assess for concurrent pancreatitis.
- Consider dietary management and cobalamin supplementation in the context of EPI.
- Given the history of hematemesis, consider gastroprotective therapy.
- If clinical signs persist or worsen, consider endoscopic evaluation with biopsies for a definitive diagnosis.
- Monitor renal values.

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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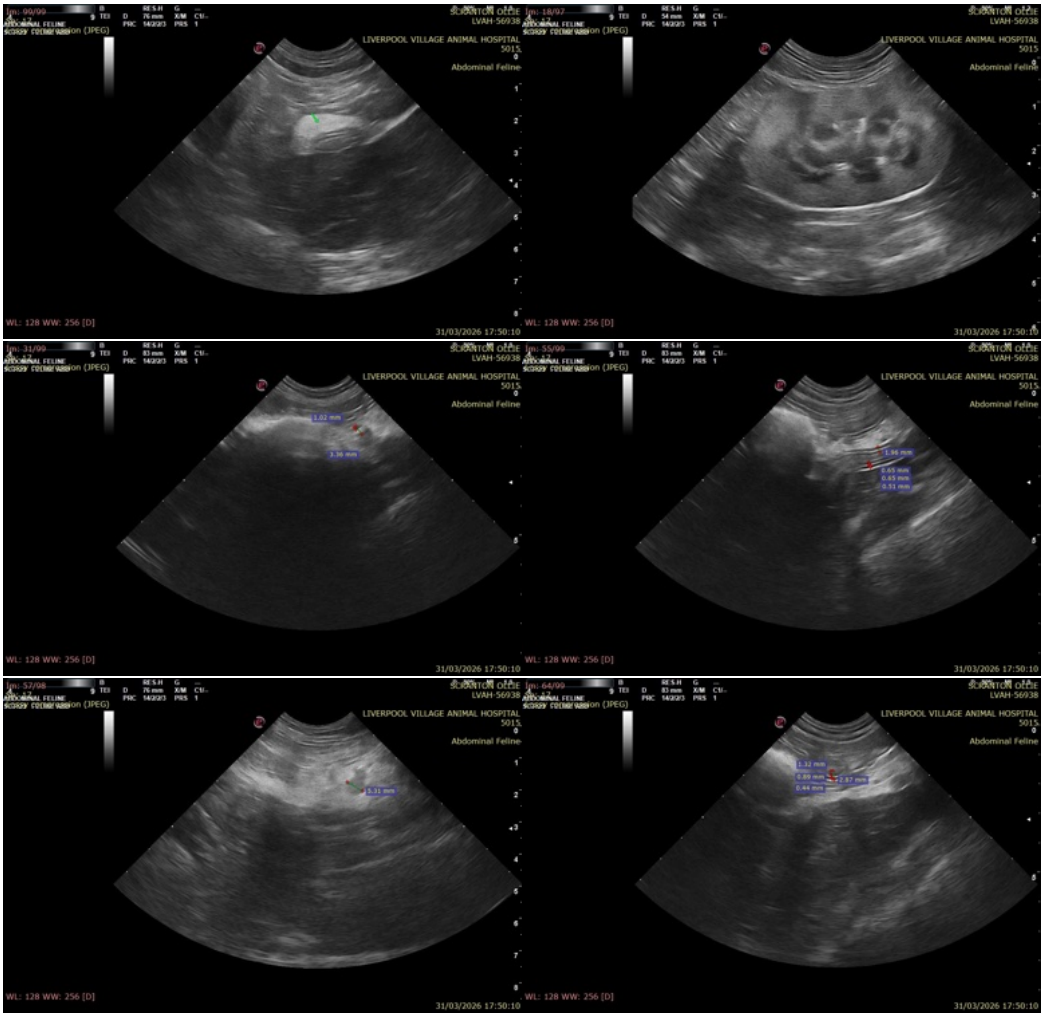

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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