



PATIENT

John Wascisin
Hathaway

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

15 years

WEIGHT

10 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Allison Maxey

HOSPITAL NAME

Evergreen AH

REFERRING VET

Dr. Maxey

INVOICE

74036

DATE

4/1/26

PRESENTING CLINICAL SIGNS

- Presented 1 month ago with hx of vomiting for several weeks.
- Vomiting was occurring several times per week
- Good appetite per owner
- No know diarrhea
- Owner was also hearing significant borborygmi sounds
- Radiographs at that time showed marked stomach distension with mineral granular opacity in pylorus.
- Recheck fasted radiographs today showed empty stomach, no sign of previously noted mineral material
- Pet has continued to have intermittent vomiting symptoms and has lost 0.5 lbs.
- Unremarkable CBC and chemistry Elevated fPL - 10.6 Total T4 - 3.8

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is thin, smooth, and regular. The luminal contents are anechoic. Normal appearance of the bladder neck and proximal urethra. No evidence of urolithiasis or inflammatory or proliferative changes is identified.

The left kidney is normal in shape and size, measuring 4.33×2.46 cm in the sagittal plane. Cortical thickness is 0.49 cm. The right kidney is normal in shape and size, measuring 4.56×2.14 cm in the sagittal plane; cortical thickness was not obtained.

Both kidneys show increased cortical echogenicity compared to the hepatic parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. The medulla shows prominent hyperechoic striations (medullary striated pattern). There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

Dorsoventral diameters measured in the sagittal plane: the left adrenal gland measures 0.44 cm at the cranial pole and 0.40 cm at the caudal pole, with small focal mineralizations. The right adrenal gland is not confidently visualized.

Spleen

Splenic thickness is 0.75 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 looks 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. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and folded, with subjectively increased mural thickness (3.99 mm), a mildly edematous appearance, and fluid within the lumen. Wall layering is preserved. The pylorus measures 6.61 mm.

Duodenum: 2.92–3.67 mm. Jejunum: 2.89 mm, with mucosa 1.25 mm, submucosa 0.81 mm, and muscularis propria 0.59 mm. Ileum: 3.26 mm, with mucosa 1.11 mm, submucosa 0.98 mm, and muscularis propria 1.26 mm. Wall layering is preserved. The ileocecal junction was not clearly visualized. No evidence of ileus or foreign material is identified.

Colon: 0.85 mm, containing formed feces in the descending segment.

Pancreas

The evaluated pancreatic areas do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

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

PRIMARY FINDINGS

- Ileal muscularis thickening (muscularis-to-mucosa ratio ≥ 1).
- Mild gastric wall thickening with fluid-filled lumen.

SECONDARY FINDINGS

- Bilateral renal cortical hyperechogenicity.
- Renal medullary striated pattern.
- Incidental left adrenal mineralization.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The ileum shows marked muscularis thickening. This pattern is strongly associated with chronic enteropathy, including both IBD and low-grade (small cell) lymphoma, and does not allow reliable



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differentiation between these entities on ultrasound alone. The jejunum shows only mild changes, suggesting a segmental or ileal-predominant process, which is well described in feline chronic enteropathy.

The stomach is mildly thickened (3.99 mm; upper reference typically ~2–3 mm in cats) with a fluid-filled, mildly edematous appearance, which may reflect secondary gastritis or altered gastric motility, likely related to the underlying enteropathy and/or pancreatitis.

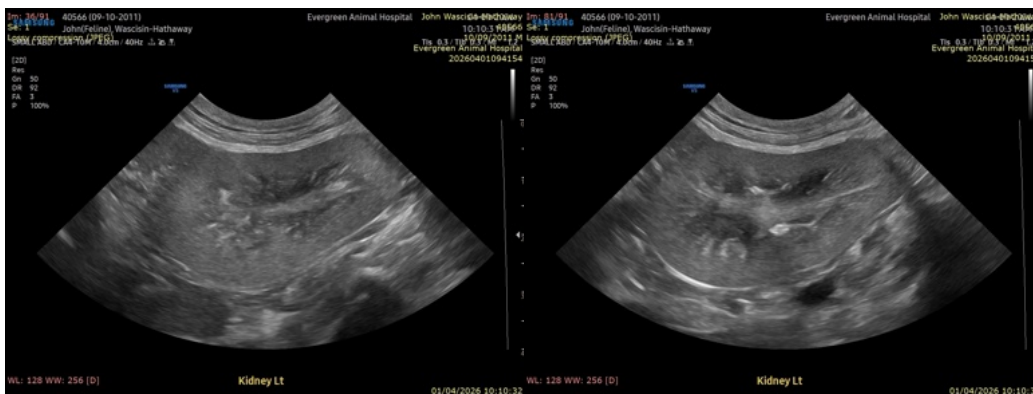
Despite a markedly elevated fPL, the pancreas appears ultrasonographically unremarkable. This does not exclude pancreatitis, as feline pancreatitis frequently lacks overt imaging changes, particularly in chronic or mild forms.

Renal findings include bilateral cortical hyperechogenicity and a medullary striated pattern, which is a recognized but nonspecific finding associated with tubulointerstitial changes, including chronic nephropathy or inflammatory processes. Renal architecture is preserved, suggesting early or mild disease.

Adrenal mineralization is noted and is most consistent with age-related or incidental change.
Recommendations

- Empirical treatment: (Antiemetics, analgesia if needed, diet).
- GI Panel and cobalamin supplementation if low.
- Consider escalation to immunomodulatory therapy.
- Intestinal biopsy if poor response or clinical progression.

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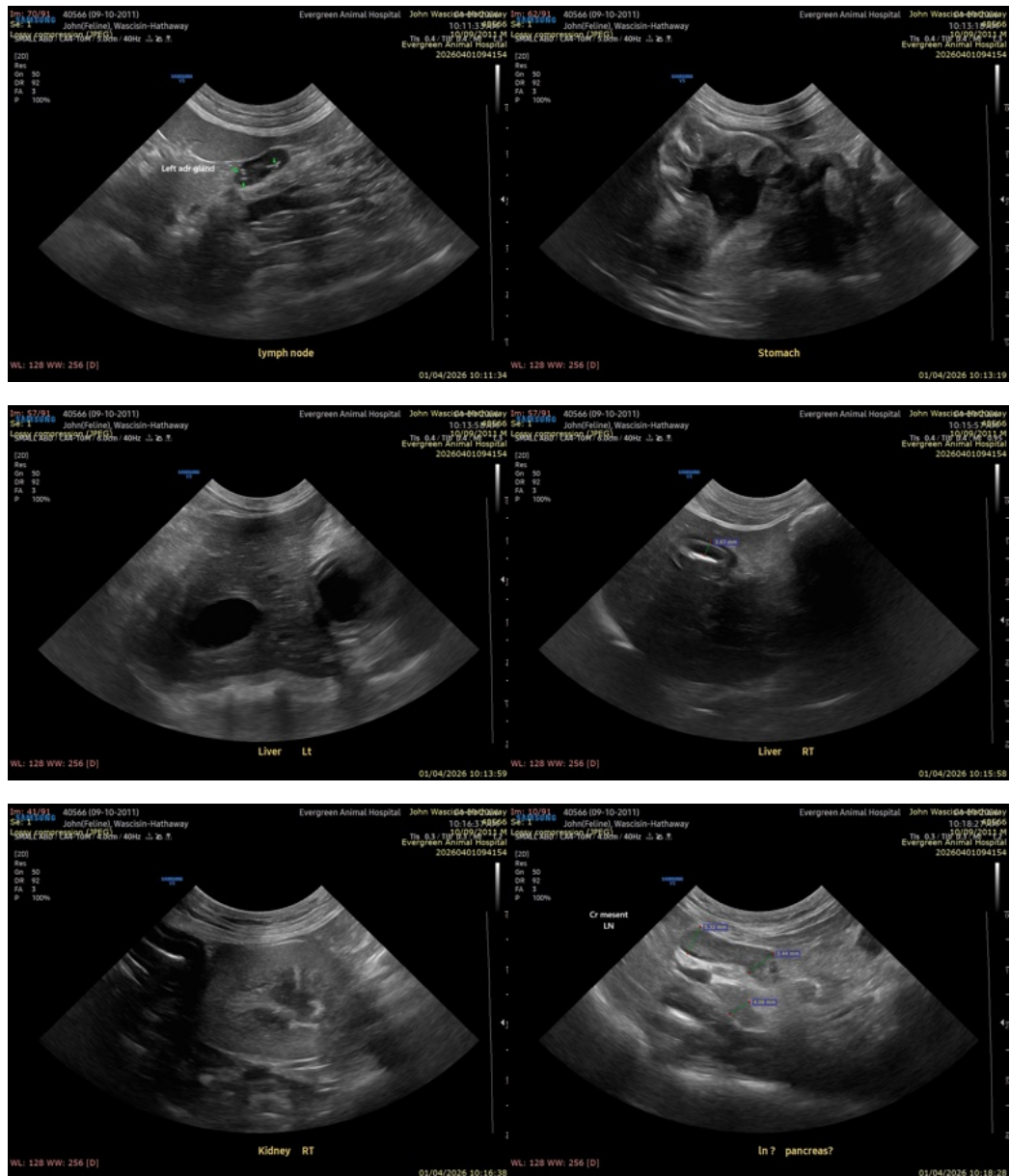
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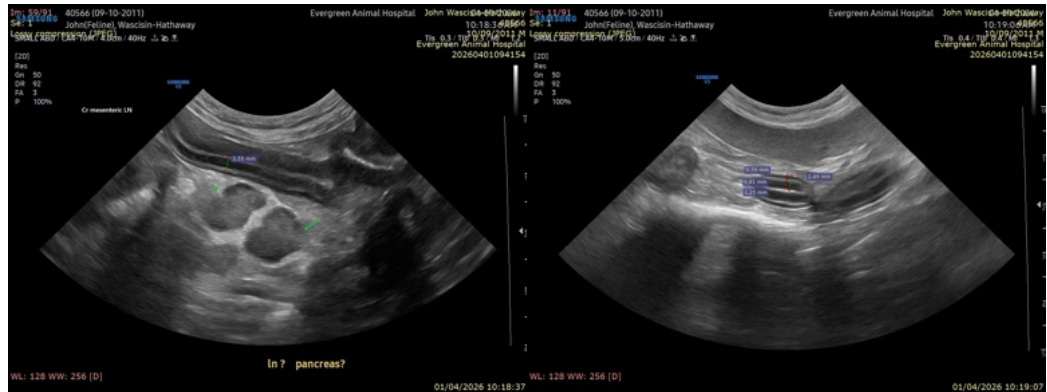
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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