



## PATIENT

Bella Boucher

## SPECIES

Feline

## BREED

DSH

## SEX

Spayed Female

## AGE

12 Years 6 Months

## WEIGHT

8.3 lbs

## INTERPRETED BY

Alicia Angosto  
Guerrero, DMV,  
PgDip, MSc.

## IMAGING PERFORMED BY

Dr. Warner

## HOSPITAL NAME

VT-NH Veterinary  
Clinic

## REFERRING VET

Dr. Warner

## INVOICE

74375

## DATE

4/10/26

## PRESENTING CLINICAL SIGNS

Bella presented for ultrasound of her abdomen due to an increase in her chronic diarrhea with weight loss. She is straining as if to defecate, not always in the litter box, and doesn't always produce stool. She has abdominal spasms during this. Hyperthyroid cat on felimazole 5mg PO BID. Solensia for arthritis, Revolution Plus. Last full senior panel run Nov 2024. In 2025 had a chem17 w/T4, and a kidney panel w/T4. 3/11/25 10.2lbs (has lost 1.9lbs). Previous unsuccessful trials for chronic diarrhea include pumpkin, psyllium, B12, Hill's i/d (current diet).

Abnormal PE/Chem/CBC/UA Results: No x-rays have been taken Senior wellness panel recommended, declined today Texas GI Panel pending 1/3/26 FEC negative 10/17/25 FEC negative 10/16/25 bacteruria, struvites w/hematuria, USG 1057 9/16/25 kidney panel normal, T4 2.6 7/18/25 creatinine 0.7 (low), SDMA 13 (normal), BUN 17 (normal), T4 9.1 (high), all other values WNL

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder is normally distended, with a thin and smooth wall. The urine is anechoic. The bladder neck and proximal urethra have a normal ultrasonographic appearance. No uroliths are identified, and there is no evidence of inflammatory or neoplastic change.

Both kidneys are normal in shape and size. The left kidney measures 3.56×2.23 cm with a cortical thickness of 0.35 cm, and the right kidney measures 3.58×2.17 cm with a cortical thickness of 0.40 cm (sagittal plane). The renal cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is within normal limits and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

### Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.26 cm at the cranial pole and 0.27 cm at the caudal pole. The right adrenal gland measures 0.26 cm at the cranial pole and 0.25 cm at the caudal pole.

### Spleen

Splenic thickness is 0.67 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 moderately distended, with a thin wall and anechoic contents. The common bile duct measures 4.26–2.29 mm from proximal to distal.

### Gastrointestinal

The stomach is empty and folded, with a wall thickness of 1.89 mm and preserved layering.



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The duodenum measures 1.84 mm. The jejunum measures 2.35 mm, with mucosa 1.32 mm, submucosa 0.39 mm, and muscularis propria 0.31 mm. The ileum measures 2.12 mm, with mucosa 0.64 mm, submucosa 0.68 mm, and muscularis propria 0.82 mm. The ileocecal junction measures 3.0 mm, with mucosa 0.59 mm and muscularis propria 1.60 mm.

Wall layering is preserved throughout.

No evidence of obstruction, ileus, or foreign material is identified.

The colon shows variable thickness: ascending 1.15 mm, transverse 1.65 mm, with a focal segment reaching up to 4.26 mm, although wall layering remains preserved. The descending colon measures 1.38 mm and contains very soft fecal material.

### **Pancreas**

Pancreatic thickness ranges from 5.11–6.36 mm. The parenchyma is mildly hypoechoic relative to the surrounding mesenteric fat. The pancreatic duct measures 1.26 mm. No peripancreatic fat inflammation is identified.

### **Free Abdomen**

No abdominal effusion or peritonitis is observed. Cranial mesenteric lymph nodes measure 3.38–4.90 mm, and ileocecal lymph nodes 1.74–2.19 mm, with normal shape and echogenicity.

### **PRIMARY FINDINGS**

- Increased muscularis thickness in ileum and ileocecal junction.
- Markedly increased muscularis-to-mucosa ratios (ileum and ileocecal region).
- Focal colonic wall thickening (up to 4.26 mm) with preserved layering.

### **SECONDARY FINDINGS**

- Mild pancreatic duct dilation (1.26 mm) with pancreatic hypoechoogenicity.
- Mild common bile duct prominence (up to 4.26 mm proximally).

### **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The ileum shows a muscularis-to-mucosa ratio of approximately 1.28, and the ileocecal junction approximately 2.7. These values are markedly elevated (normal <0.3–0.4), indicating disproportionate muscularis thickening. Despite preserved wall layering, this pattern is highly suggestive of infiltrative disease, most commonly severe chronic enteropathy (IBD) or small cell lymphoma.

The presence of focal colonic thickening with preserved layering and clinical signs of tenesmus suggests concurrent large bowel involvement, which may occur with diffuse enteropathy or lymphoma affecting multiple segments.

The pancreas shows mild duct dilation and subtle hypoechoogenicity, and the common bile duct is mildly prominent. While nonspecific, these findings may reflect early or mild concurrent pancreatobiliary involvement (triaditis spectrum), which is common in cats with chronic enteropathy.

Lymph nodes are within normal limits in size and morphology, which does not exclude lymphoma, particularly low-grade forms.



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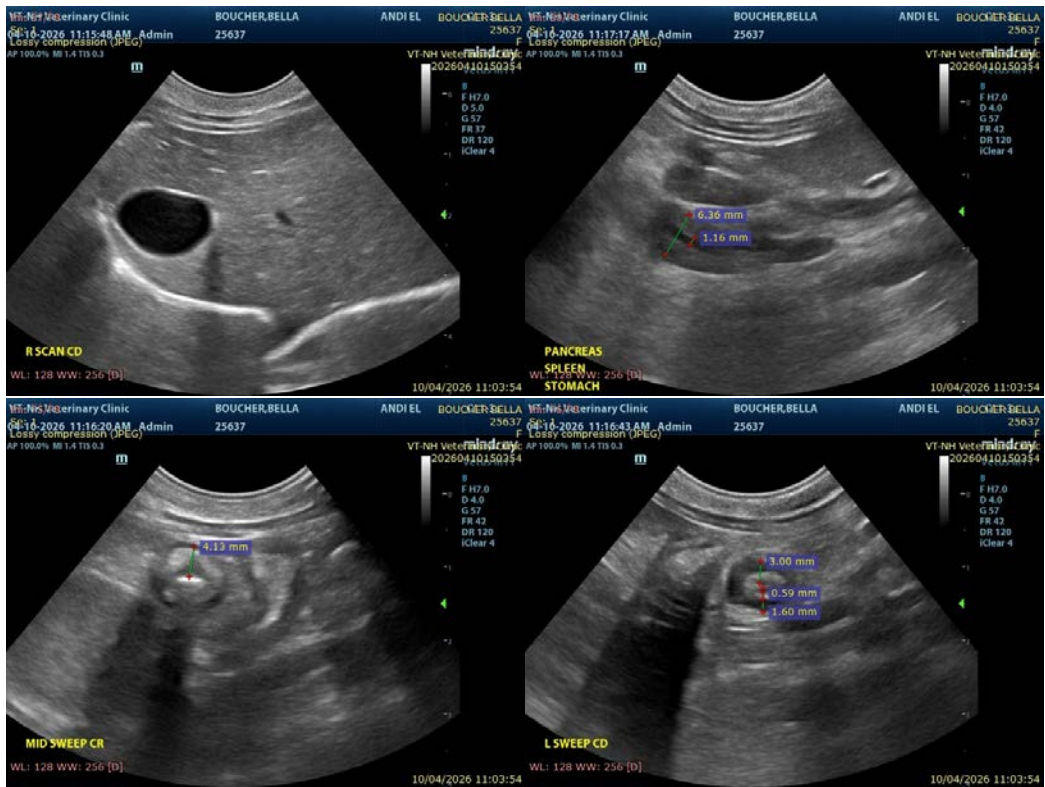
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**Recommendations:**

- Definitive diagnosis is recommended, ideally via intestinal biopsies.
- If biopsy is not pursued, empirical therapy may be considered.
- Comprehensive gastrointestinal panel (pending) and cobalamin supplementation if low.
- Reassessment of thyroid control (given history of hyperthyroidism and weight loss).
- Monitoring for 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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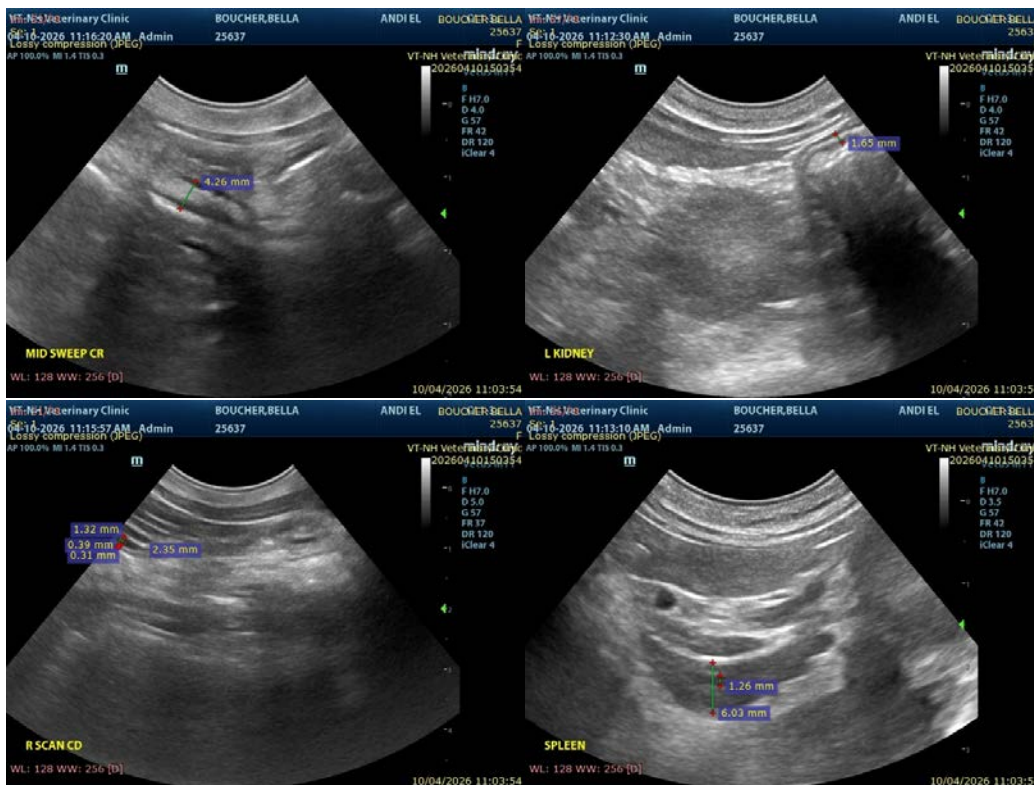
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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