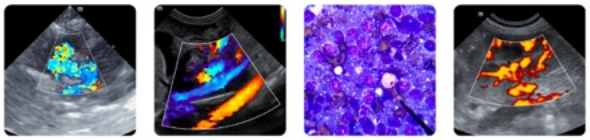


PATIENT

Evie Cyre

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

14 months

WEIGHT

4.52 kg

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Brooke Cory

HOSPITAL NAME

Cold Lake VC

REFERRING VET

Dr. Watson

INVOICE

74440

DATE

4/13/26

PRESENTING CLINICAL SIGNS

History: Presenting complaint: Concerned she ate a ribbon or maybe has pancreatitis.
- Seems to happen every 3 months for the past year
- Is missing a ribbon from the house that the O cannot find.
- Interested in eating but vomits it right back up.
- This episode started Friday AM and continued to get worse and worse.
- Interested in eating but immediately vomits it up. Vomiting water up. Had one soft stool.

CBC WNL, Pancreatic Lipase WNL. ABD X -ray some gas in the colon.
- at this point concern for either IBD, GI lymphoma, or foreign body.

Abnormal PE/Chem/CBC/UA Results: Chem Panel: Phos mildly low TP mildly low

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended, with a thin and smooth wall. The urine is mildly turbid with scant suspended echoes. The bladder neck and proximal urethra are unremarkable. No uroliths or evidence of inflammatory or neoplastic changes are identified.

The left kidney is normal in shape and size (4.15×2.29 cm), with cortical thickness measuring 0.45 cm in the sagittal plane. The cortex is isoechoic relative to the hepatic parenchyma. Corticomedullary ratio and definition are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. Doppler color shows a normal vascular pattern.

The right kidney is normal in shape and size (3.89×2.47 cm), with cortical thickness measuring 0.43 cm in the sagittal plane. The cortex is isoechoic relative to the hepatic parenchyma. Corticomedullary ratio and definition are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. Doppler color shows a normal vascular pattern.

Adrenal Glands

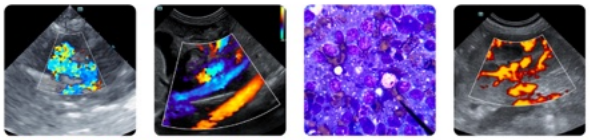
Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.34 cm at the cranial pole and 0.36 cm at the caudal pole. The right adrenal gland measures 0.24 cm at the cranial pole and 0.26 cm at the caudal pole.

Spleen

Splenic thickness is 1.06 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.



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The gallbladder is moderately distended, with a thin wall and predominantly anechoic contents. The appearance is compatible with a possible anatomical variation (bilobed gallbladder). The common bile duct measures 4.72–3.37 mm, which is mildly increased (normal typically ≤4 mm in cats), although this may be influenced by gallbladder distension.

Gastrointestinal

The stomach is empty and folded, with mural thickness of 1.53 mm and preserved wall layering (within normal limits). The duodenum measures 1.41 mm (within normal limits). The jejunum measures 3.32 mm, within normal limits for total wall thickness. Layer measurements: mucosa 2.03 mm, submucosa 0.79 mm, muscularis propria 0.39 mm (muscularis-to-mucosa ratio ≈0.19, within normal limits <0.5–0.6). The ileum measures 2.76 mm. Layer measurements: mucosa 0.49 mm, submucosa 0.66 mm, muscularis propria 1.06 mm, resulting in a muscularis-to-mucosa ratio ≈2.16, which is markedly increased. A segment of the ileum shows muscularis thickness up to 1.76 mm. Wall layering is preserved. The ileocecal junction is not visualized. The colon measures 0.89 cm in diameter and contains a small amount of soft fecal material.

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 is normal.

PRIMARY FINDINGS

- Markedly increased muscularis-to-mucosa ratio in the ileum.

SECONDARY FINDINGS

- Possible bilobed gallbladder (anatomical variant).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most significant finding is the marked disproportionate thickening of the ileal muscularis layer, with preservation of wall layering and normal overall wall thickness. The muscularis-to-mucosa ratio is clearly increased (normal <0.5–0.6 in cats), which is a well-recognized pattern associated with chronic enteropathy in feline patients, including inflammatory bowel disease and low-grade intestinal lymphoma.

No definitive ultrasonographic evidence of a linear foreign body is identified (no plication, no corrugated bowel, no focal obstructive pattern).

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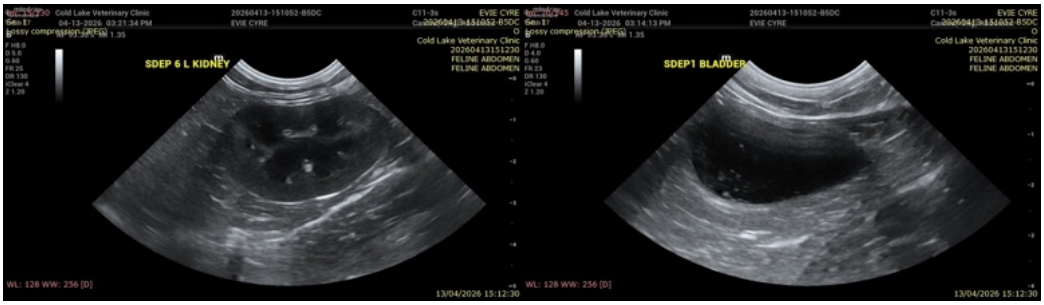
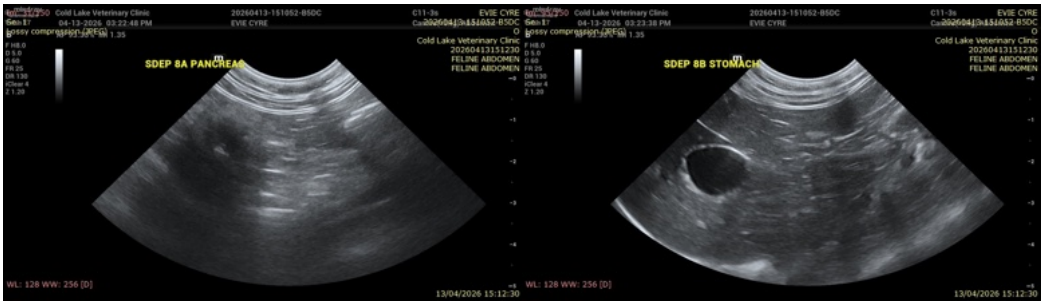
The gallbladder appearance is compatible with a likely anatomical variant (bilobed configuration), which is considered incidental. The common bile duct is mildly prominent; however, in the absence of additional findings such as intrahepatic biliary dilation or hepatocellular changes, this is of uncertain clinical significance and does not currently support clinically relevant biliary obstruction.

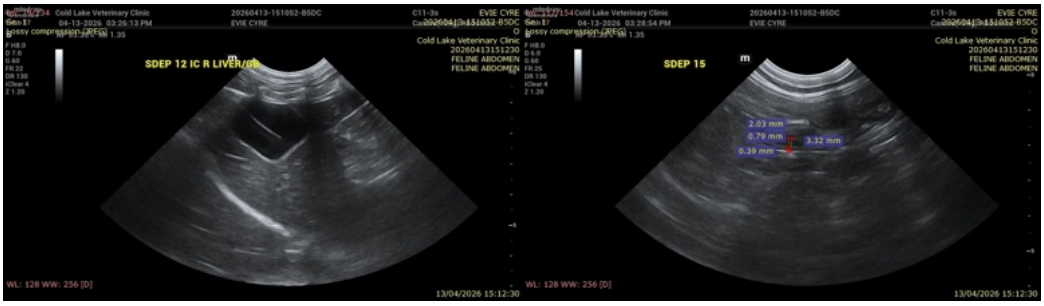
Recommendations

- Given the clinical suspicion of a possible linear foreign body and the limitations of ultrasound in early or subtle cases, close clinical monitoring is strongly recommended, with a low threshold for repeat imaging if vomiting persists or worsens.
- If clinical signs stabilize and a mechanical cause is excluded, further evaluation of the suspected chronic enteropathy may be considered, including serum cobalamin assessment and, if indicated, intestinal biopsy for definitive differentiation between inflammatory disease and low-grade lymphoma.
- Supportive care (antiemetics, fluid therapy, and dietary management) should be guided by the attending clinician, with reassessment based on clinical response.

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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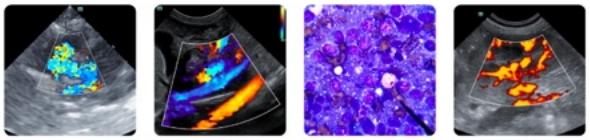

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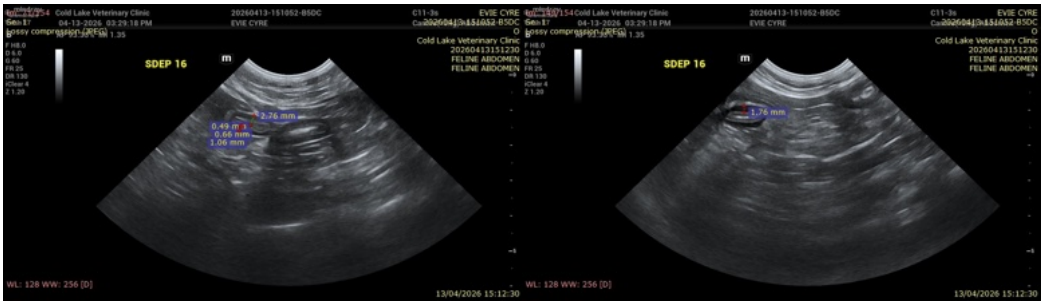

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com