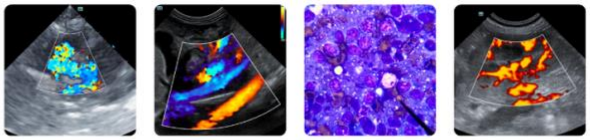


PATIENT

Callie Bowers

SPECIES

Feline

BREED

Feline

SEX

Spayed Female

AGE

13 Years

WEIGHT

6.3 pounds

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Amanda Olsen VMD

HOSPITAL NAME

Limestone Veterinary Hospital

REFERRING VET

Dr. Katherine Williams DVM

INVOICE

15101

DATE

04/14/26

PRESENTING CLINICAL SIGNS

Callie, almost 13 yr FS DMH, presented for evaluation of a weight loss x1 month. Callie has lost about 4 lbs since October. Callie has otherwise being doing well at home, no diarrhea, good appetite and water intake. Still active. Historically occasional vomits hairballs, intermittently with no significant changes. PE overall unremarkable. Blood work from 4/10/26 listed below.

TP: 3.6 (5.2-8.8) Albumin: 1.9 (2.5-3.9) Globulin: 1.7 (2.3-5.3); Calcium: 7.8 (8.2-10.8) RBC: 5.9 (5.92-9.93) HgB: 8.0 (9.3-15.9) HCT: 26% (29-48) Reticulocytes: 1.3 (0-1%) Absolute Reticuolocytes: 73800 (<45k) Platelet count: 688 (200-500), increased estimate Neutrophils: 9720 (2500-8500) T4: 1.3 (0.8-4.0); FT4: 46.3 (10-50); USG: 1.054; Protein: 1+; UPCR: 0.1

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the wall appears thin and smooth. The urine is predominantly anechoic with scant suspended echoes. Normal appearance of the bladder neck and proximal urethra. There are no calculi or evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size (3.12×2.31 cm), with a cortical thickness of 0.33 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis.

The right kidney is normal in shape and size (3.37×2.10 cm), with a cortical thickness of 0.32 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis.

Adrenal Glands

The left adrenal gland measures 0.21 cm at the cranial pole and 0.25 cm at the caudal pole, within normal feline reference ranges (<0.45 cm). The right adrenal gland is not confidently visualized.

Spleen

Splenic thickness is 0.58 cm. The parenchyma demonstrates decreased echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

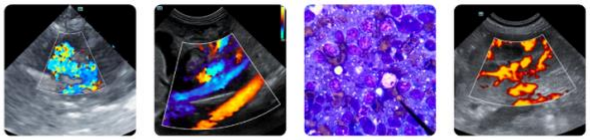
Liver

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.

Gallbladder

The gallbladder is normally distended, with a thin wall and a moderate amount of biliary sludge. The common bile duct measures 1.81 mm, within normal limits for a cat (<3 mm).

Gastrointestinal



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The stomach is empty and folded, with mural thickness of 2.35 mm and preserved wall layering, within acceptable limits. The pylorus measures 3.74 mm.

Duodenum: 1.51 mm (within normal limits).

Jejunum: 2.40 mm (within normal limits). Layer measurements: mucosa 1.40 mm, submucosa 0.62 mm, muscularis propria 0.28 mm. The muscularis-to-mucosa ratio is approximately 0.20, within normal limits (<0.5), not supportive of muscularis hypertrophy.

Ileum: 2.57 mm (mildly increased relative to typical feline reference values ~2.0–2.5 mm). Layer measurements: mucosa 0.89 mm, submucosa 0.76 mm, muscularis propria 0.80 mm. The muscularis-to-mucosa ratio is approximately 0.90, which is markedly increased and indicates significant muscularis thickening. There is a small intestine segment of at least 4.5 cm in length (possibly longer) with mural thickening measuring 4.01–5.04 mm and loss of normal wall layering.

The ileocecal junction measures 3.10 mm, with muscularis thickness of 1.94 mm, indicating marked muscularis hypertrophy.

Colon: 0.97 mm (within normal limits), mildly distended with liquid and very soft fecal material.

Pancreas

Pancreatic thickness ranges from 0.90–1.10 cm, mildly increased for a cat. The margins are irregular. The pancreatic parenchyma is hypoechoic relative to adjacent omental fat, and the surrounding peripancreatic fat is hyperechoic.

Free Abdomen

Abdominal effusion is present. The mesenteric fat is diffusely hyperechoic.

Cranial mesenteric lymph nodes measure 7.18 mm, are rounded and hypoechoic, with hyperechogenicity of the perinodal fat. Ileocecal lymph nodes are not visualized; however, the surrounding region appears unremarkable. The iliac trifurcation region is unremarkable.

PRIMARY FINDINGS

- Segmental intestinal thickening (4.01–5.04 mm) with loss of wall layering
- Marked ileal muscularis hypertrophy (ratio ≈0.90)
- Thickened ileocecal junction with severe muscularis expansion
- Cranial mesenteric lymphadenomegaly (7.18 mm), rounded and hypoechoic
- Abdominal effusion with hyperechoic mesentery
- Pancreatic enlargement, hypoechogenicity, irregular margins, and hyperechoic peripancreatic fat

SECONDARY FINDINGS

- Biliary sludge.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This is a markedly abnormal study consistent with a severe infiltrative intestinal disease.
The key finding is a segmental intestinal lesion (4.01–5.04 mm) with loss of wall layering, which in cats

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is highly suggestive of neoplasia, particularly lymphoma.
While muscularis thickening alone can overlap with IBD or small cell lymphoma, the loss of layering, segmental mass-like involvement and cranial mesenteric lymphadenomegaly, strongly favor a more aggressive infiltrative process.
These findings correlate well with the laboratory abnormalities, particularly the severe hypoproteinemia, supporting a protein-losing enteropathy secondary to intestinal disease.

The reactive mesenteric/peritoneal inflammation and the concurrent neutrophilia supports an active inflammatory response, and early bacterial translocation cannot be excluded despite the absence of overt perforation.

Concurrent pancreatitis is also present and likely contributes to clinical signs but does not explain the primary process.

Recommendations

- Abdominocentesis is recommended to characterize the abdominal effusion and exclude septic peritonitis. If the fluid is non-septic and consistent with hypoalbuminemia, ultrasound-guided cytology of the intestinal lesion and/or lymph nodes may be considered, although diagnostic yield may be limited in this context. If septic inflammation or bacterial translocation is suspected, a more aggressive surgical approach, including resection of the affected intestinal segment and full-thickness biopsies, would be more strongly indicated. Final decisions should be guided by the attending clinician based on clinical stability and overall case progression.
- Thoracic imaging ± further lymph node assessment
- Cobalamin supplementation
- Nutritional support
- Monitor for complications of hypoalbuminemia

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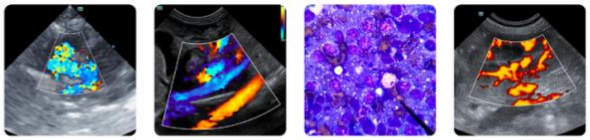

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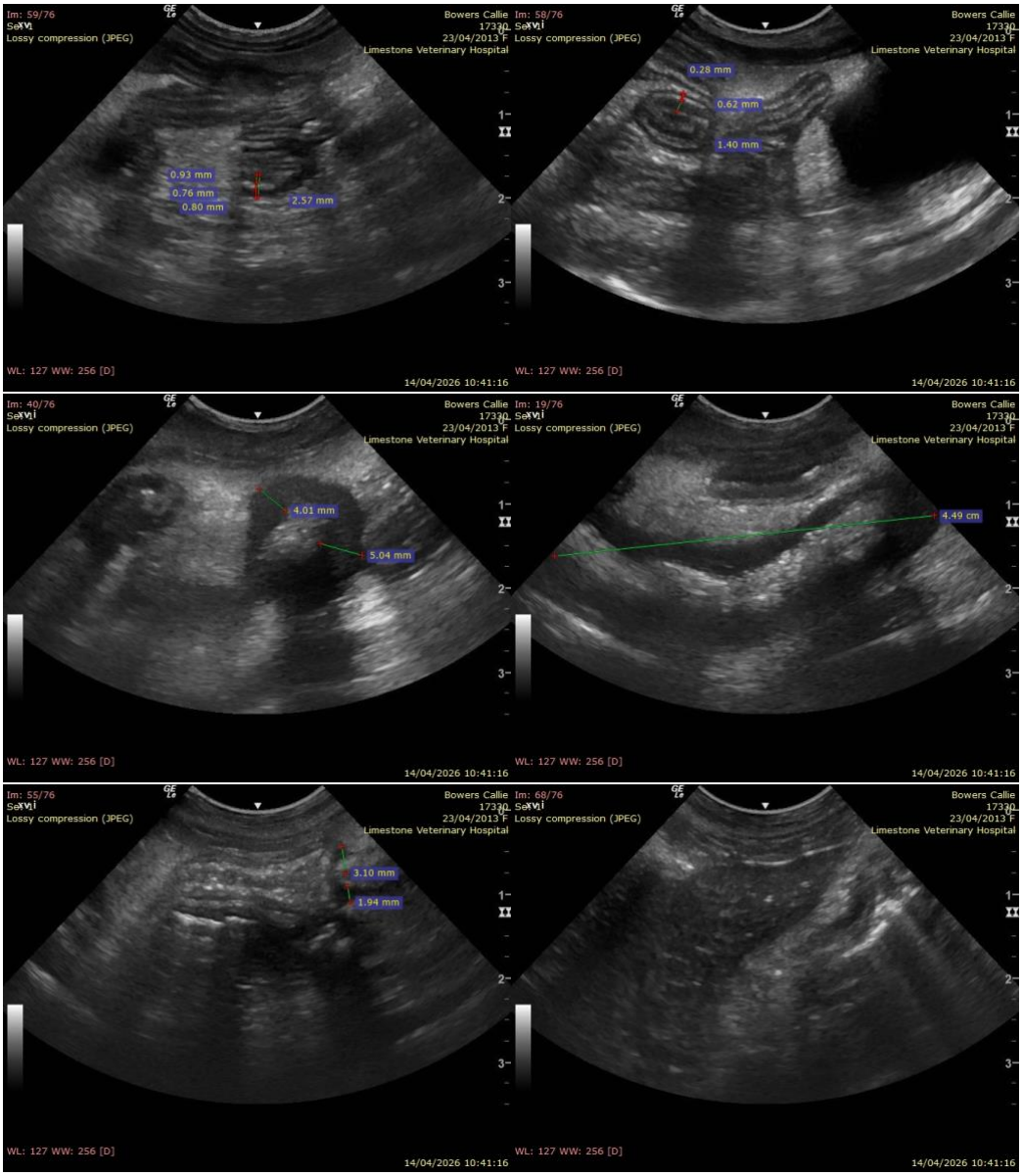

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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