

PATIENT

Spunky Hook

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

18 Years 3 Months

WEIGHT

8.7 pounds

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Dr. Brittney Beigel
DVM

HOSPITAL NAME

Bayside Animal
Medical Center

REFERRING VET

Dr. Brittney Beigel
DVM

INVOICE

15108

DATE

04/14/26

PRESENTING CLINICAL SIGNS

Loose stool despite propectalin/supportive care. Wt loss. P was fasted for US scan. No sedation needed

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

The left kidney is normal in shape and size, measuring 4.17×2.22cm, with a cortical thickness of 0.41cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 4.41×2.25cm, with a cortical thickness of 0.35cm in the sagittal plane.

Both kidneys: The cortex is mildly hyperechoic relative to the liver parenchyma. The corticomedullary ratio is within normal limits and corticomedullary definition is preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified.

Adrenal Glands

Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.47 cm at the cranial pole and 0.36 cm at the caudal pole. The right adrenal gland measures 0.39 cm at the cranial pole and 0.37 cm at the caudal pole.

Spleen

Splenic thickness is 1.15 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 margins and a regular contour. The hepatic parenchyma is homogeneous and isoechoic relative to the falciform fat, with normal echotexture. No hepatic lymphadenopathy is identified.

The gallbladder is moderately distended, with a thin wall and predominantly anechoic contents. There is marked dilation of the cystic duct and common bile duct extending to the level of the major duodenal papilla. Mild dilation of intrahepatic bile ducts is also present.

Gastrointestinal

The stomach is empty and folded, with a wall thickness of 1.99mm and preserved layering. The pylorus measures 4.91mm.

The duodenum measures 1.22mm in thickness. The major duodenal papilla is enlarged and dilated, with dilation of the common bile duct (4.5mm) and pancreatic duct (1.7mm) at their insertion.

The jejunum measures 2.05mm (mucosa 1.24mm, submucosa 0.51mm, muscularis propria 0.45mm), with preserved wall layering.



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The ileum measures 1.80mm (mucosa 0.51mm, submucosa 0.51mm, muscularis propria 0.58mm), with preserved wall layering.

The ileocecal junction measures 2.83mm, with a muscularis thickness of 1.24mm.

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Some small intestinal segments are mildly fluid- and gas-distended.

The colon measures 1.32mm in wall thickness and contains a small amount of semiliquid fecal material.

Pancreas

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The pancreas measures 0.97–1.0cm in thickness, with irregular margins. The parenchyma is hypoechoic relative to adjacent mesenteric fat. The pancreatic duct is dilated, measuring 1.8–2.5mm. No hyperechogenicity or inflammatory changes are observed in the surrounding peripancreatic fat.

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Free Abdomen

No abdominal effusion or peritonitis is identified.

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Cranial mesenteric lymph nodes measure 3.74–5.07mm, are normal in shape, and mildly hypoechoic. Ileocolic lymph nodes are not visualized; the surrounding region appears unremarkable. The iliac trifurcation region is normal.

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PRIMARY FINDINGS

- Diffuse dilation of the extrahepatic biliary tract (cystic duct and common bile duct up to 4.5mm) with mild intrahepatic bile duct dilation
- Enlargement of the major duodenal papilla with concurrent dilation of the common bile duct and pancreatic duct.
- Pancreatic enlargement (0.97–1.0cm), irregular margins, hypoechoic parenchyma, and pancreatic duct dilation.
- Ileal muscularis thickening.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is clear evidence of biliary and pancreatic duct dilation, localizing the process to the duodenal papilla/ampullary region. This supports partial extrahepatic biliary obstruction, most likely secondary to inflammatory disease (pancreatitis or duodenitis), although early periampullary neoplasia cannot be completely excluded in this geriatric patient. The normal bilirubin concentration can be explained by the presence of a partial, early, or intermittent biliary obstruction, allowing at least some bile flow. In cats, biochemical changes—particularly hyperbilirubinemia—may lag behind structural abnormalities, so ductal dilation may precede laboratory evidence of cholestasis.

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The pancreas is enlarged, hypoechoic, irregular, and duct-dilated, consistent with chronic pancreatitis, with possible reactivation or acute-on-chronic inflammatory changes.

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Intestinal findings show segmental muscularis thickening, most pronounced in the ileum (ratio >1) and ileocecal region, which is abnormal. This pattern is compatible with chronic enteropathy or small cell lymphoma, with recognized ultrasonographic overlap.

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Overall, the findings are most consistent with a triaditis-type process. However, neoplasia cannot be definitively excluded based on ultrasound alone.

Recommendations



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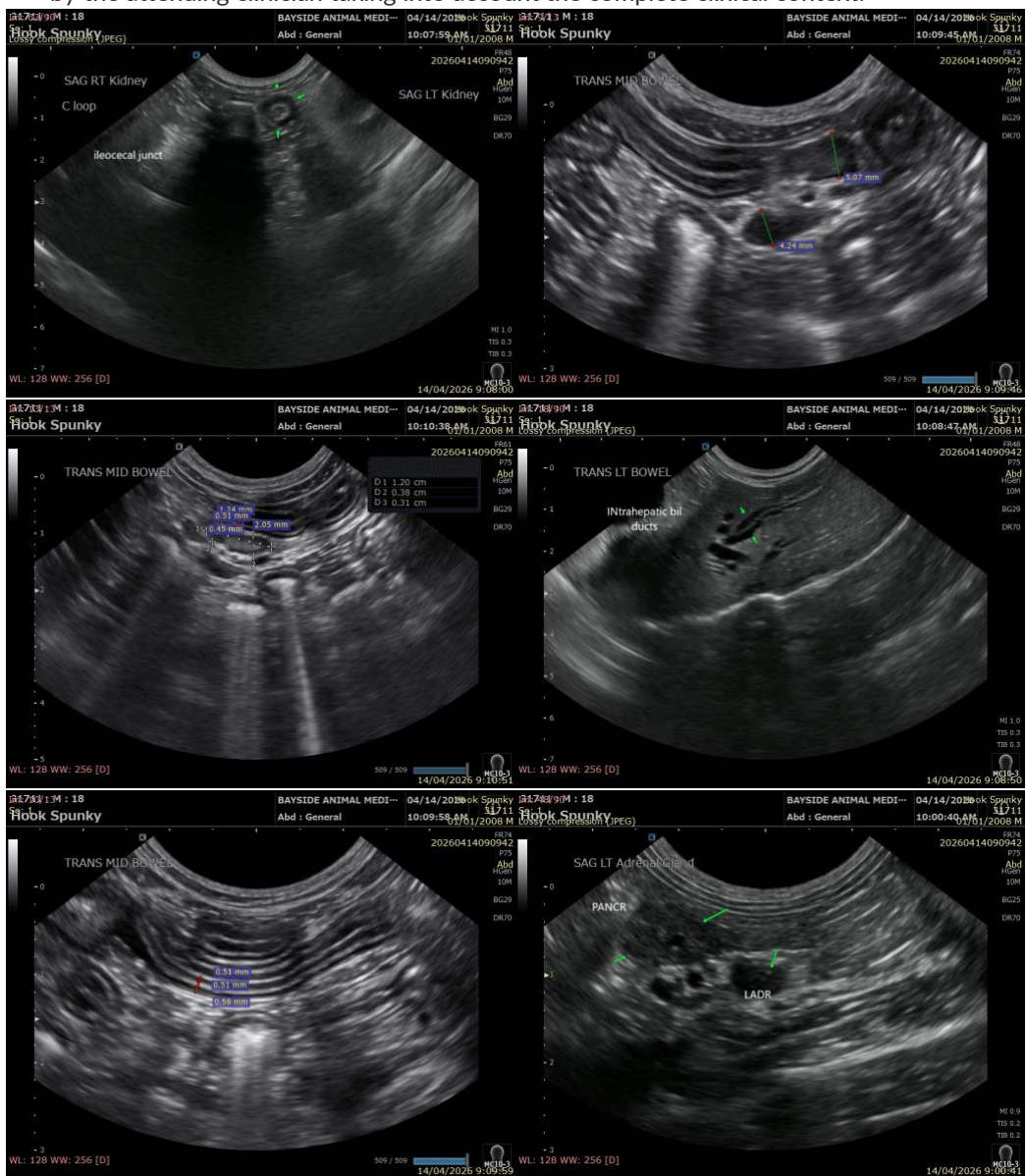
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- Spec fPL to support pancreatitis.
- Cobalamin/folate testing and supplementation as indicated.
- Ultrasound follow-up to monitor biliary and pancreatic duct progression.
- Therapeutic decisions (initiation of corticosteroids or antimicrobial therapy) should be made by the attending clinician taking into account the complete clinical context.





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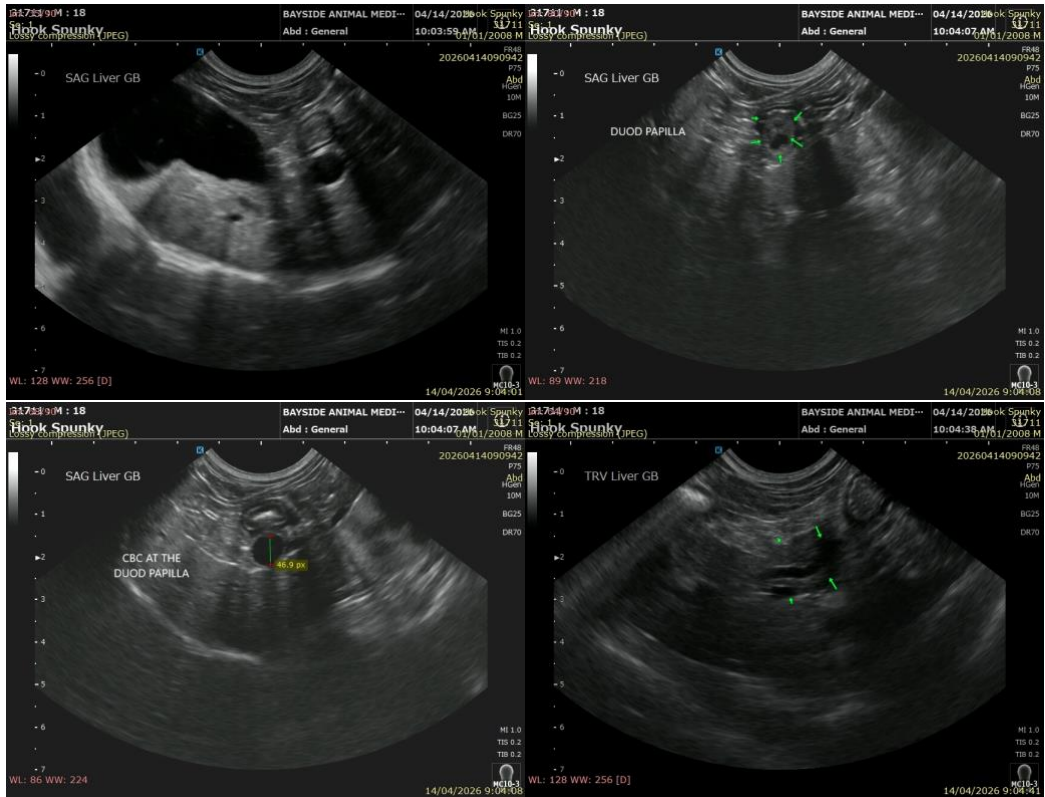
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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