



PATIENT

Momo Crager

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

8 years

WEIGHT

10.81 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Celia Galanti, DVM

HOSPITAL NAME

Craig Road AH

REFERRING VET

Dr. Johnson

INVOICE

74489

DATE

4/15/26

PRESENTING CLINICAL SIGNS

History: Momo is a 8 yr 8 mo old MN Tabby presenting for vomiting this AM, not being interested in eating and acting lethargic/isolating himself. P is usually food motivated but O noted that P vomited once this morning and is unsure if P ate this AM. O got home and P was acting our normal self and P was not interested in eating which is very unlike P so O brought P to be evaluated. History of soft tissue sarcoma surgically removed, subsequently Left hindlimb amputated with margins in October 2023. Owner reports no known diarrhea, coughing, or sneezing.

Patient is not on any medications or supplements.

Patient has no recent travel history.

Past pertinent medical history: injection site sarcoma LHL; crystalluria

There are no known vaccine or medication allergies. Current diet is Hill's C/D.

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 turbid, with abundant suspended sediment. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 3.94×2.42 cm in the sagittal plane, with a cortical thickness of 0.48 cm. The right kidney is normal in shape and size, measuring 4×2.58 cm in the sagittal plane, with a cortical thickness of 0.48 cm. Both kidneys show mildly increased cortical echogenicity compared to the liver parenchyma. The corticomedullary ratio and definition are preserved. A medullary rim sign is present. No pyelectasia, nephroliths, or hydronephrosis are observed.

Adrenal Glands

Both adrenal glands have normal shape and echogenicity, with a small focal mineralization in the left adrenal gland. Dorsoventral diameters measured in the sagittal plane: the left adrenal gland measures 0.36 cm at the cranial pole and 0.39 cm at the caudal pole; the right adrenal gland measures 0.39 cm at the cranial pole and 0.40 cm at the caudal pole.

Spleen

Splenic thickness is 0.64 cm. The parenchyma has normal echogenicity and a fine, homogeneous echotexture without focal abnormalities. The 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 lumen is normally distended. The wall is thin and the contents are primarily anechoic with a small amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty, containing a small amount of fluid and gas, with a mural thickness of 1.90 mm and preserved wall layering. Duodenum: 1.47–1.91 mm, mildly corrugated with a spastic appearance. Jejunum: 1.63 mm; mucosa 0.99 mm; submucosa 0.43 mm; muscularis thickness not specified. Ileum: 2.61 mm; mucosa 0.67 mm; submucosa 1.06 mm; muscularis 0.61 mm; wall layering preserved. The small intestines are mildly dilated with fluid content and increased peristalsis. The ileocecal junction was not visualized. Colon: 0.75 mm, containing formed feces in the descending segment.

Pancreas

Pancreatic thickness ranges from 5.94–7.64 mm. The parenchyma is mildly hypoechoic relative to the adjacent omental fat. The pancreatic duct measures 1.12 mm in diameter. No peripancreatic fat hyperechogenicity or evidence of active inflammation is observed.

Free Abdomen

No abdominal effusion or ultrasonographic evidence of peritonitis is observed.

Cranial mesenteric lymph nodes measure 4.30–4.52 mm, and ileocecal lymph nodes measure 2.09 mm in thickness; all are normal in shape and echogenicity. The iliac trifurcation region is unremarkable.

PRIMARY FINDINGS

- Turbid urine with abundant suspended sediment
- Mild small intestinal fluid distension with increased peristalsis and duodenal corrugation
- Mild pancreatic enlargement (5.94–7.64 mm), hypoechogenicity, and pancreatic duct dilation (1.12 mm)

SECONDARY FINDINGS

- Mild bilateral renal cortical hyperechogenicity with medullary rim sign

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Findings are most consistent with a functional gastrointestinal disorder, characterized by mild small intestinal fluid distension, increased peristalsis, and duodenal corrugation. This pattern supports enteritis (dietary, inflammatory, or less likely infectious) rather than mechanical obstruction, as there is no focal transition point, no marked segmental dilation, and motility is increased rather than reduced.

The pancreas is mildly enlarged and hypoechoic, with a pancreatic duct measuring 1.12 mm (mildly



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increased; typical feline values are ≤ 1.0 mm). In combination, these findings are may compatible with pancreatitis, acknowledging that the absence of peripancreatic fat changes does not exclude pancreatic inflammation in cats.

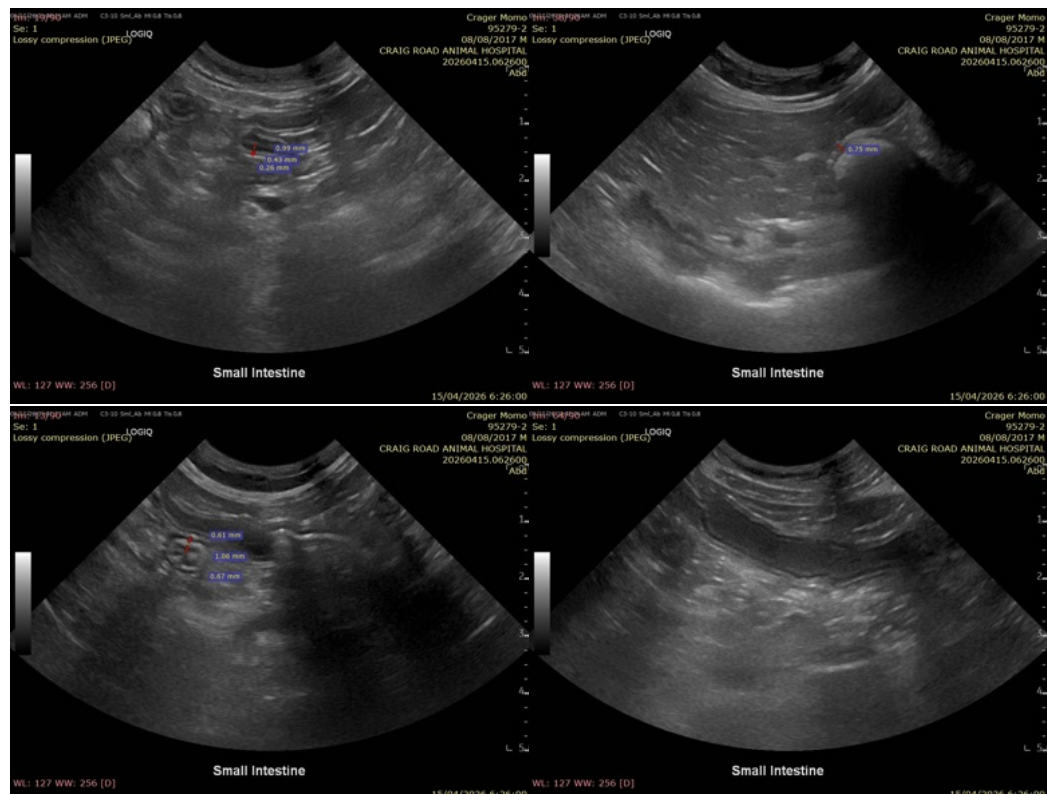
Renal changes (mild cortical hyperechogenicity and medullary rim sign) are nonspecific, described in association with early renal change, dehydration, or incidental variation, with preserved architecture.

There is no ultrasonographic evidence of gastrointestinal obstruction or metastatic disease. Overall, the findings support a likely reversible acute gastrointestinal process, with possible concurrent mild pancreatopathy as a contributing factor.

Recommendations

- Supportive management for acute enteritis \pm mild pancreatitis (fluid therapy, antiemetics, analgesia as clinically indicated).
- Consider fPLI testing to further assess pancreatic involvement.
- Monitor clinical response over 24–48 hours; if signs persist or worsen, repeat evaluation is recommended.
- Monitor crystalluria.

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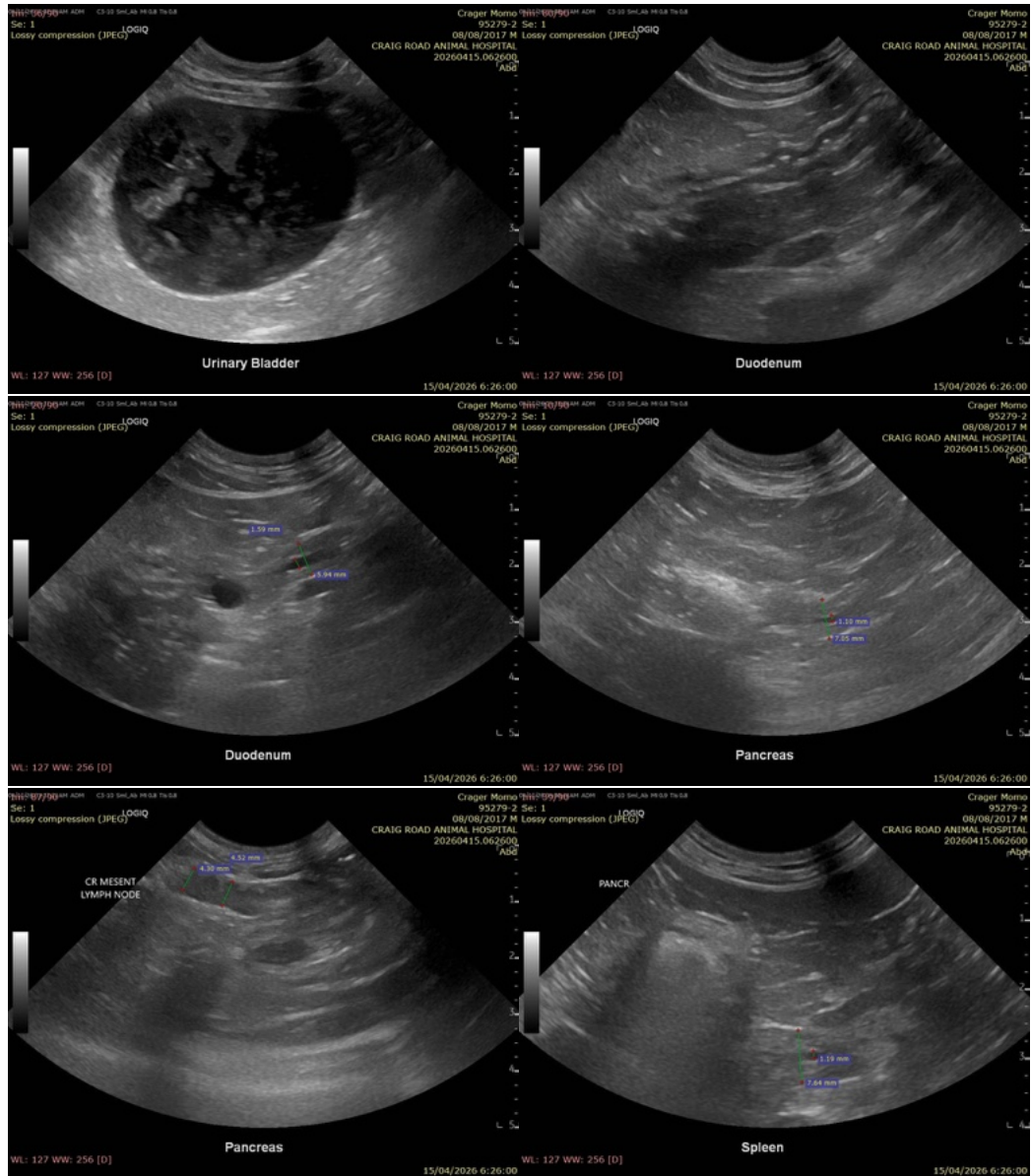
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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