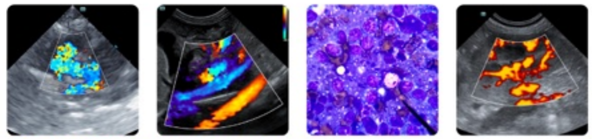


PATIENT
Liesel Bunn

SPECIES
Feline

BREED
Siberian

SEX
Spayed female

AGE
13 years

WEIGHT
11 lbs

INTERPRETED BY
Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY
Rachel Dunn, DVM

HOSPITAL NAME
Wellesley AH

REFERRING VET
Dr. Bunn

INVOICE
74534

DATE
4/16/26

PRESENTING CLINICAL SIGNS

History: Chronic vomiting at least 1-2 years or maybe lifelong, slowly progressive in frequency, no weight loss, good appetite. No response to 0.5mg budesonide SID, incomplete response to cerenia 4mg SID. Normal CBC/Chem/T4/UA 1 year ago.
Abnormal PE/Chem/CBC/UA Results: none
User Name: WellesleyAHSonoreport

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the wall appears thin and smooth. The urine is anechoic. 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 3.07×1.98 cm in the sagittal plane, with a cortical thickness of 0.32 cm. The cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio and definition are preserved. No pyelectasia, nephroliths, or hydronephrosis are observed. Color Doppler demonstrates a normal vascular pattern.

The right kidney is normal in shape and size, measuring 3.24×1.96 cm in the sagittal plane, with a cortical thickness of 0.31 cm. The cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio and definition are preserved. No pyelectasia, nephroliths, or hydronephrosis are observed. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

Not confidently visualized; however, the adrenal regions appear unremarkable.

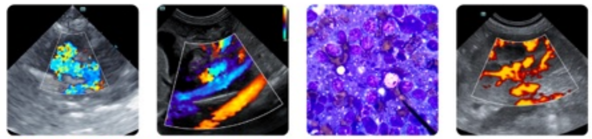
Spleen

Splenic thickness is 0.94 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 parenchyma is homogeneous and isoechoic relative to the falciform fat. Multiple cystic lesions are identified, measuring approximately 1.87×2.48 cm, 2.20×2.69 cm, and up to 2.69×3.18 cm (largest dimensions recorded from three representative lesions).

The gallbladder is normally distended, with a thin wall. The contents are predominantly anechoic with a small amount of biliary sludge. No dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach contains a small amount of ingesta, with a mural thickness of 1.51 mm and preserved wall layering. The pylorus measures 3.46 mm. Duodenum: 2.27 mm. Jejunum: 2.72 mm (mucosa 1.81 mm; submucosa 0.64 mm; muscularis propria 0.45 mm). Ileum: 1.55 mm (mucosa 0.54 mm; submucosa 0.66 mm; muscularis propria 0.29 mm), with preserved wall layering. The ileocecal junction measures 1.62 mm. No ultrasonographic evidence of inflammation, ileus, or foreign material is identified. Colon: 0.65 mm, containing formed feces.

Pancreas

The evaluated pancreatic areas do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

No abdominal effusion or ultrasonographic evidence of peritonitis is observed. Cranial mesenteric lymph nodes are not visualized, but the surrounding regions appear unremarkable. Ileocecal lymph nodes measure 3.62–4.02 mm and are normal in shape and echogenicity. Caudal abdominal (iliac/caudal mesenteric) lymph nodes measure approximately 0.43–0.46 cm and maintain normal morphology and echogenicity.

PRIMARY FINDINGS

- Multiple hepatic cystic lesions (up to 2.69×3.18 cm)
- Mild enlargement of caudal abdominal lymph nodes with normal morphology and echogenicity.

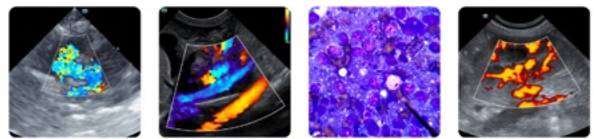
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Multiple hepatic cystic lesions are identified. Across all evaluated images, these lesions are well-defined, anechoic, and thin-walled, with consistent distal acoustic enhancement and no internal complexity. This appearance is most consistent with multiple simple hepatic cysts, a common incidental finding in older cats.

The gastrointestinal tract is within normal limits, with appropriate wall thickness and preserved layering throughout. The jejunal muscularis (0.45 mm vs mucosa 1.81 mm; ratio ~0.25) and ileal layers are within expected limits, providing no ultrasonographic support for inflammatory bowel disease or infiltrative disease. No evidence of obstruction or motility disorder is identified.

Mild enlargement of caudal abdominal lymph nodes is noted; however, given their normal shape, echogenicity, and preserved architecture, this is most consistent with reactive or clinically insignificant change, particularly in the absence of gastrointestinal abnormalities.

Overall, there is no ultrasonographic explanation for the patient's chronic vomiting. In this context, functional gastrointestinal disease (chronic gastritis, dietary intolerance, or motility-related disorder) remains more likely than structural pathology. Early or mild inflammatory disease cannot be completely



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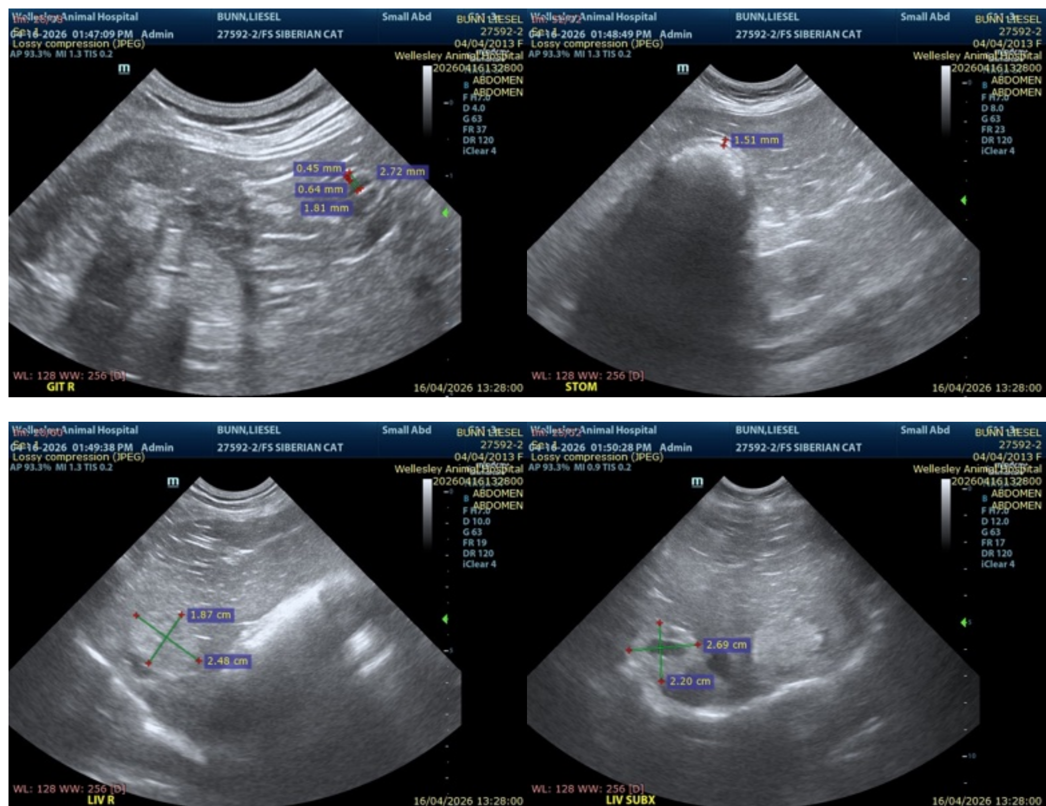
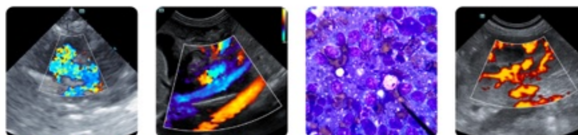
excluded, as ultrasound may be normal in such cases, but there is no supportive evidence on this study.

Recommendations

- Consider dietary trial (novel protein or hydrolyzed diet) as a first-line approach for chronic vomiting.
- If not already performed, consider gastrointestinal laboratory testing (cobalamin, folate, ± TLI)
- Symptomatic management (antiemetics, gastric protectants) may be continued as needed.
- If clinical signs persist despite medical and dietary management consider endoscopic evaluation with biopsies to assess chronic gastritis or early inflammatory bowel disease.
- Periodic monitoring of the hepatic cystic lesions.

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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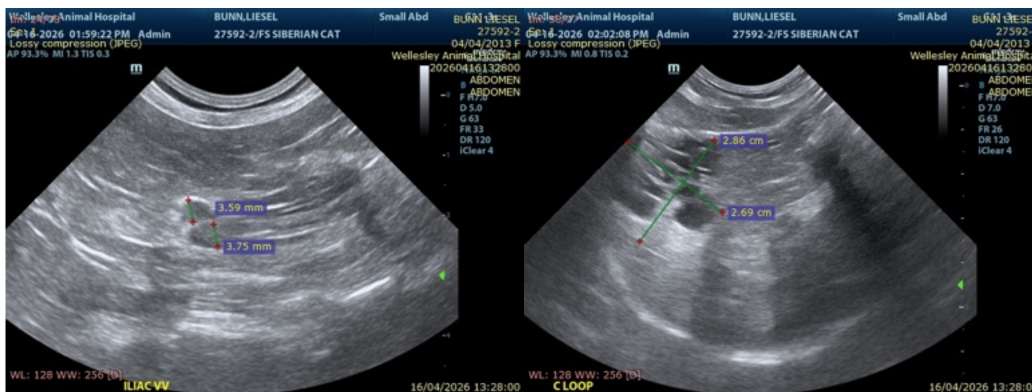

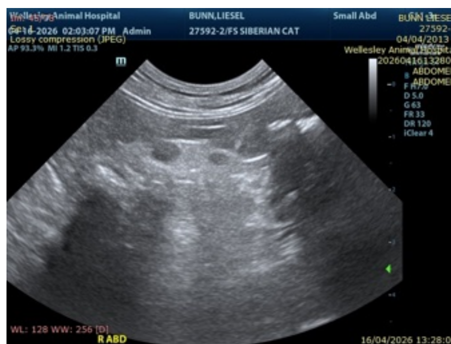

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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