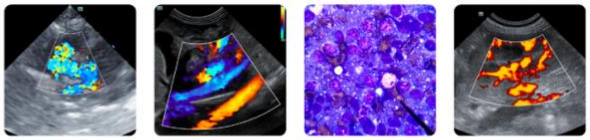


PATIENT

Mia Weber

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

15 Years

WEIGHT

5.4 pounds

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Justin Eckenrode DVM

HOSPITAL NAME

Carlisle Small Animal Veterinary Clinic

REFERRING VET

Justin Eckenrode DVM

INVOICE

15199

DATE

04/17/26

PRESENTING CLINICAL SIGNS

Vomiting, anorexia and weight loss. Hx of renal insufficiency, hyperthyroidism, anemia (non-regenerative). Patient History : Presented 72 hours ago for vomiting, decreased appetite with an increase in water intake. Improved briefly w/ maropitant. Primary concern or rule out: IBD/Lymphoma (neoplasia), pancreatitis, progressive renal disease. Discussion today since give Vit B12 and oral prednisolone is that Mia is eating and defecated formed stool. No vomiting. No cardiac murmur

Abnormal PE/Chem/CBC/UA Results: RBC 5.72; HCT 28.1% WBC 17.48 Neut 13.76; Mono 0.85; Eos 0.13 Plt 56,000 SDMA 15; Creat 2.3; BUN 57 ALT 48; ALKP <10; Tbil 0.5 T4 2.7

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is moderately 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 3.11×2.07 cm in the sagittal plane, with a cortical thickness of 0.27 cm.
The right kidney is normal in shape and size, measuring 3.54×2.22 cm in the sagittal plane, with a cortical thickness of 0.29 cm.

In both kidneys, the cortex is mildly hyperechoic 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

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.31 cm at the cranial pole and 0.28 cm at the caudal pole. The right adrenal gland measures 0.29 cm at the cranial pole and 0.30 cm at the caudal pole.

Spleen

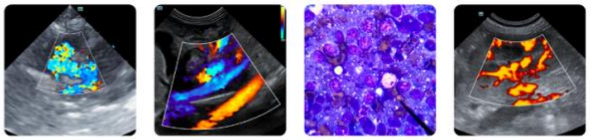
Splenic thickness is 0.55 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

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.

The gallbladder is normally distended. The wall is thickened (1.85 mm) and contains multiple small hyperechoic foci with acoustic shadowing, consistent with mural mineralization. The contents are predominantly anechoic. No significant dilation of the cystic duct or common bile duct is observed.

Gastrointestinal



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The stomach is moderately distended with fluid, with a mural thickness of 1.39 mm and preserved wall layering.

The pylorus measures 3.31 mm.
Duodenum: 2.44 mm.
Jejunum: 2.10 mm (mucosa 1.42 mm; submucosa 0.45 mm; muscularis propria 0.62 mm).
Ileum: 2.67 mm (mucosa 0.85 mm; submucosa 0.86 mm; muscularis propria 1.02 mm).
Ileocecal junction: 2.84 mm (mucosa 0.76 mm; muscularis 0.98 mm).

All small intestinal segments are mildly to moderately distended with fluid and demonstrate a “to-and-fro” luminal motion pattern. Wall layering is preserved throughout.

Colon: 0.68 mm, containing formed feces in the descending segment.

Pancreas

The pancreas measures approximately 5.96 mm in thickness. The parenchyma is isoechoic relative to the surrounding fat. The pancreatic duct is not dilated. No peripancreatic fat changes are identified.

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation region is unremarkable.

PRIMARY FINDINGS

- Diffuse small intestinal fluid distension with “to-and-fro” motility.
- Gastric fluid distension.
- Gallbladder wall thickening with mural mineralization.

SECONDARY FINDINGS

- Mild diffuse renal cortical hyperechogenicity.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is diffuse fluid distension of the small intestine with a “to-and-fro” luminal motion pattern, which is most consistent with functional ileus, likely secondary to systemic or inflammatory disease. Intestinal wall layering is preserved, and no discrete obstructive lesion or foreign body is identified in the submitted study; however, a partial obstructive gastrointestinal process cannot be completely excluded, particularly in the context of underlying intestinal inflammation or infiltrative disease. Muscularis prominence, particularly in the ileum (muscularis-to-mucosa ratio >1), is noted. This finding may be associated with chronic enteropathy (IBD vs low-grade lymphoma) in cats and could represent a concurrent underlying condition.

The gallbladder wall is thickened (1.85 mm) and contains multiple hyperechoic foci with acoustic shadowing, consistent with mural mineralization. In cats, this is an uncommon finding and may be associated with chronic cholecystitis, mucosal gland hyperplasia, or dystrophic mineralization. Correlation with clinical and biochemical findings is recommended to determine its clinical significance.

The pancreas does not show overt ultrasonographic evidence of pancreatitis; however, this condition

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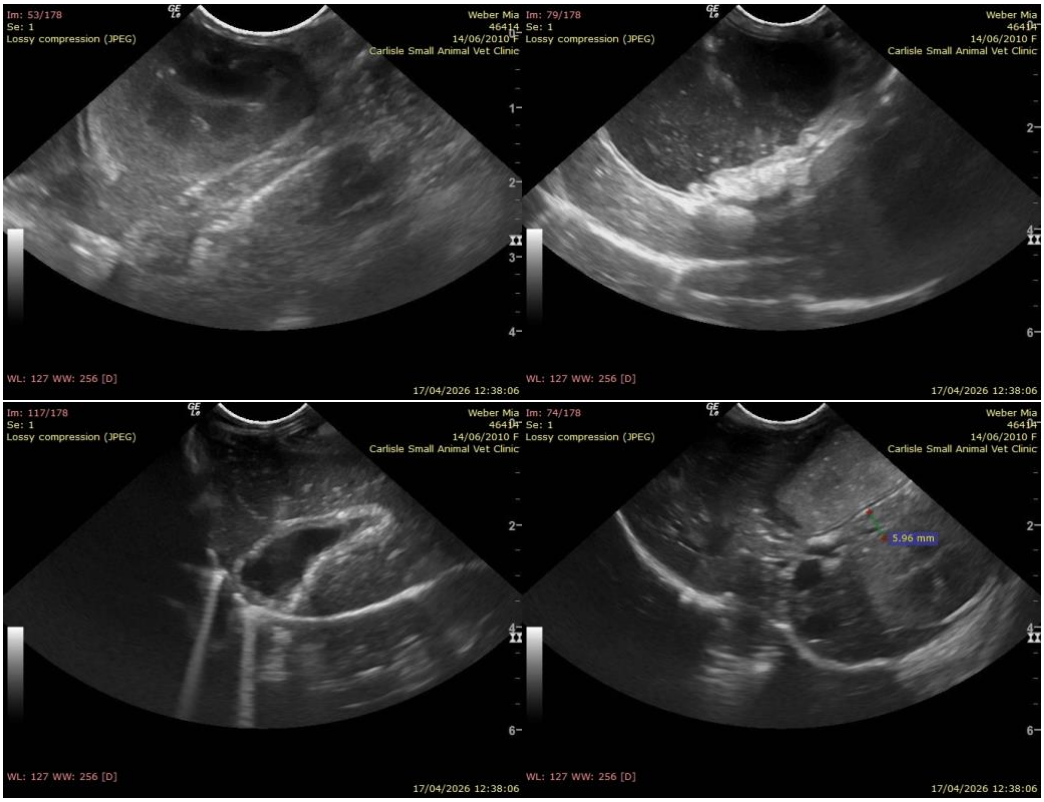
cannot be excluded, particularly in cats where ultrasonographic changes may be subtle or absent.

Recommendations

- Continue current medical management, as clinical improvement has been reported.
- Recommend clinical monitoring, particularly for recurrence of vomiting, anorexia, or weight loss.
- Consider repeat abdominal ultrasound only if clinical signs recur or fail to continue improving.
- If gastrointestinal signs persist or relapse, further investigation (intestinal biopsy to differentiate inflammatory vs neoplastic enteropathy) may be considered.

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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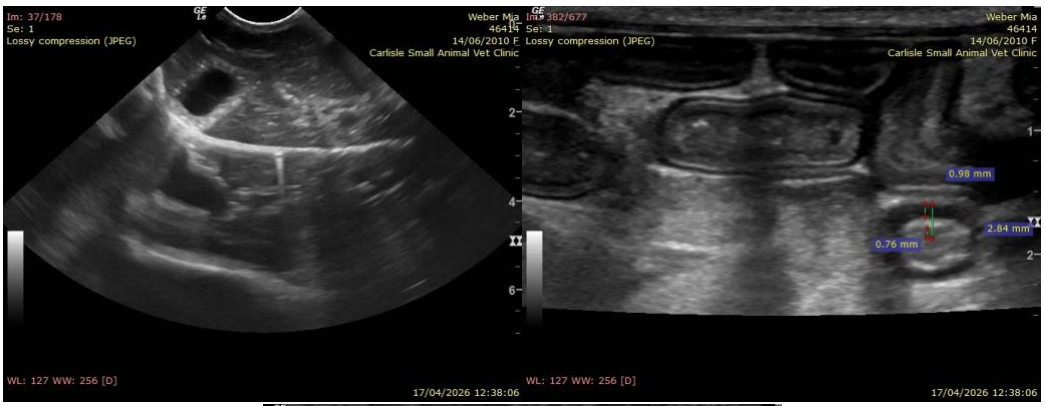

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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