



## PATIENT

Trish Conrad

## SPECIES

Feline

## BREED

DSH

## SEX

Spayed Female

## AGE

15

## WEIGHT

6.6 pounds

## INTERPRETED BY

Alicia Angosto  
Guerrero, DMV,  
PgDip, MSc.

## IMAGING PERFORMED BY

Dr. Kathy Cronin

## HOSPITAL NAME

Ark Animal Homecare

## REFERRING VET

Dr. Kathy Cronin

## INVOICE

15200

## DATE

04/17/26

## PRESENTING CLINICAL SIGNS

weight loss (1# since August), decreased appetite, vomiting once a day, has been going on for a few months, diarrhea earlier this week, has resolved, no vomiting the last few days

Abnormal PE/Chem/CBC/UA Results: Distended abdomen on palpation CBC/chem/T4 on 4/16/26: RBCs 6.36, WBC 22.7, monocytes 1.18, eosinophils 7.491, basophils 0.704, platelets 725, creatinine 0.7, calcium 8.1, sodium 158, chloride 128, Total protein 4.6, albumin 1.8, globulin 2.8, ALT 25

## 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 with occasional suspended echoes. 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 3.84×2.60 cm in the sagittal plane, with a cortical thickness of 0.35 cm. The cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio and definition are preserved. Mild echogenic sediment is noted within the collecting system. No pyelectasia or hydronephrosis is observed.

The right kidney is normal in shape and size, measuring 3.40×2.62 cm in the sagittal plane, with a cortical thickness of 0.37 cm. The cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio and definition are preserved. No pyelectasia, nephroliths, or hydronephrosis are observed.

### Adrenal Glands

Not confidently visualized.

### Spleen

Splenic thickness is 0.78 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 poorly distended. The wall is thickened (1.60 mm). The contents are predominantly anechoic. The common bile duct appears subjectively dilated and tortuous; however, accurate measurement was not possible due to limited differentiation from adjacent vasculature without color Doppler.

### Gastrointestinal

The stomach is moderately distended with ingesta, with a mural thickness of 1.49 mm and preserved wall layering.

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The pylorus measures 4.12 mm.

Duodenum: 3.79 mm.

Jejunum: 4.09 mm (mucosa 1.71 mm; submucosa 0.96 mm; muscularis propria 1.51 mm).

Ileum: 4.84 mm (mucosa 1.81 mm; submucosa 0.56 mm; muscularis propria 2.50 mm).

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There is marked diffuse thickening of the small intestinal wall, with preservation of layering but prominent muscularis expansion (muscularis-to-mucosa ratio >1, particularly in the ileum). Some segments demonstrate a corrugated appearance.

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Colon: 1.05 mm, containing apparent formed feces.

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The pancreas measures approximately 0.88 cm in thickness. The parenchyma is isoechoic relative to surrounding fat. The pancreatic duct measures 1.68 mm (mildly prominent for a cat). No peripancreatic fat changes are identified. No overt ultrasonographic evidence of pancreatitis is observed.

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**Free Abdomen**

Moderate abdominal effusion is present. Cranial mesenteric lymph nodes measure 7.39–7.52 mm, are rounded, and mildly hypoechoic. Ileocecal lymph nodes are not confidently visualized. The iliac trifurcation region is unremarkable.

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6.6 pounds

**PRIMARY FINDINGS****INTERPRETED BY**

Alicia Angosto  
Guerrero, DMV,  
PgDip, MSc.

Marked diffuse small intestinal thickening with muscularis predominance (ratio >1).

- Corrugated intestinal segments.
- Moderate abdominal effusion.
- Enlarged, rounded mesenteric lymph nodes.

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**SECONDARY FINDINGS**

- Thickened gallbladder wall with suspected biliary duct dilation.
- Mild pancreatic duct prominence.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

There is marked diffuse small intestinal wall thickening with prominent muscularis involvement, particularly in the ileum, with a muscularis-to-mucosa ratio exceeding 1. This pattern is highly suggestive of chronic infiltrative intestinal disease in cats, with primary differentials including chronic inflammatory enteropathy (IBD) and low-grade intestinal lymphoma.

The presence of moderate abdominal effusion and enlarged, rounded mesenteric lymph nodes increases concern for a more advanced or infiltrative process, and may support lymphoma over inflammatory disease, although overlap exists and differentiation is not possible on ultrasound alone. Intestinal corrugation may reflect active inflammation or motility disturbance and may be associated with the underlying enteropathy.

The gallbladder wall thickening and suspected common bile duct dilation raise concern for concurrent hepatobiliary involvement.

Mild pancreatic duct prominence is noted; although no overt ultrasonographic evidence of pancreatitis is present, pancreatic involvement cannot be excluded, particularly in cats where findings may be subtle.

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Overall, the findings are most consistent with a chronic infiltrative gastrointestinal disease with associated protein-losing enteropathy, correlating with the reported hypoalbuminemia and clinical signs.

**Recommendations**

- Abdominocentesis and fluid analysis to characterize the abdominal effusion.
- Intestinal biopsy (endoscopic or surgical) is recommended for definitive diagnosis (differentiation between inflammatory enteropathy and lymphoma).
- If advanced diagnostics are not pursued, empirical medical management may be considered, with the understanding that a definitive diagnosis will not be established.
- Supportive management, including nutritional support as needed and cobalamin supplementation.
- Close monitoring of serum protein levels, particularly albumin.

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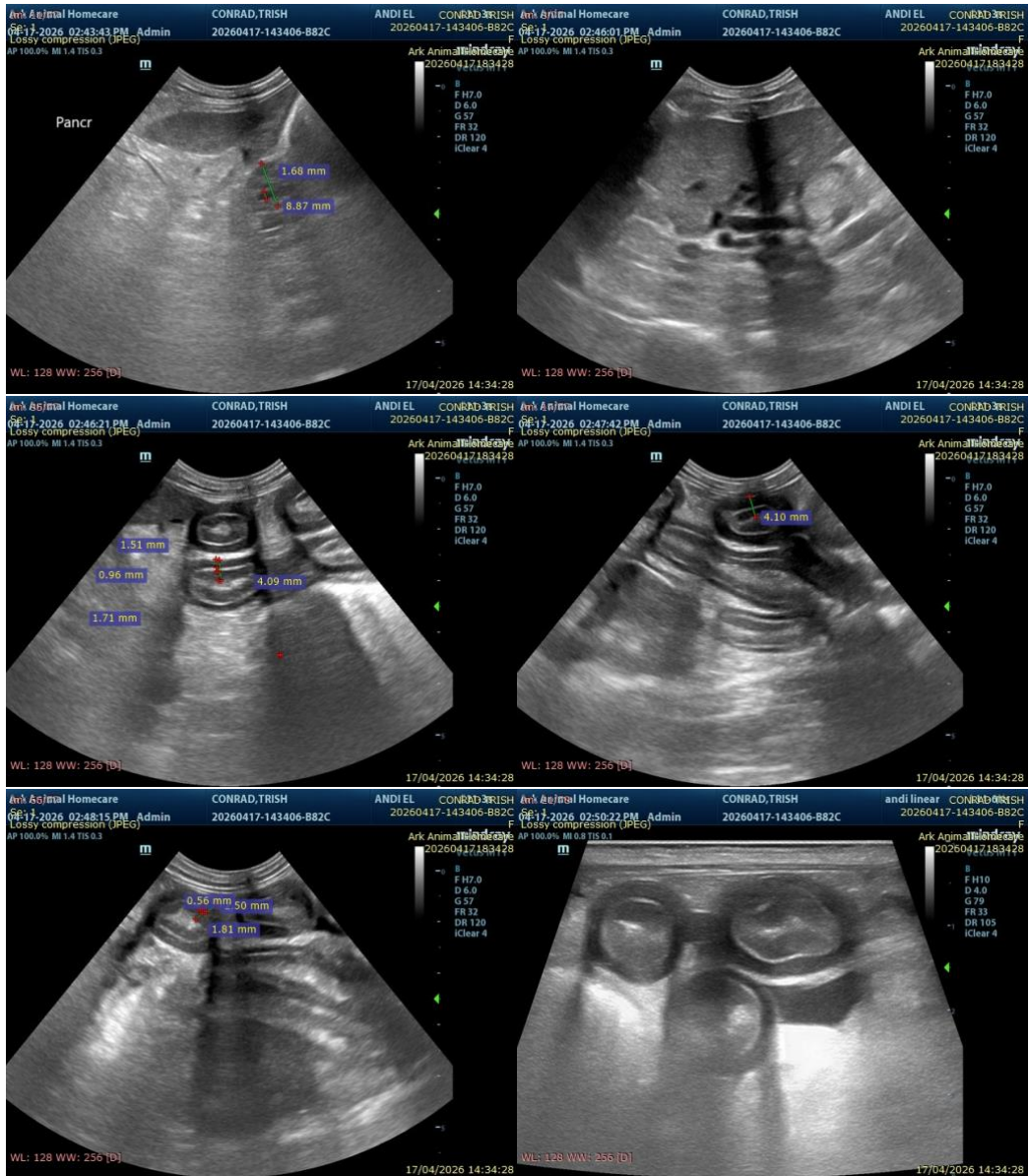
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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