



PATIENT

Meatball Jenkins

SPECIES

Feline

BREED

Maine Coon Mix

SEX

Neutered male

AGE

11 years

WEIGHT

13.68 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Saum Hadi

HOSPITAL NAME

Nimbus PH

REFERRING VET

Dr. Sophia Sullivan

INVOICE

74110

DATE

4/2/26

PRESENTING CLINICAL SIGNS

- Meatball presents with an acute increase in vomiting and has been unable to keep any food down for the past 3–4 days. His physical examination was unremarkable, and blood work was also unremarkable. He had a mildly elevated creatinine of 1.7, which is unchanged from his previous blood work in October 2025.
- The owner reports that his energy levels remain good, and he is still interested in food but is unable to keep it down. He vomits within 30–60 minutes after eating, often with considerable effort.
- He has a history of chronic intermittent vomiting that previously improved with feeding small, frequent meals.
- NSF on in house chem 17, CBC, lytes 4

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is thin, smooth, and regular. The luminal contents are predominantly anechoic with scant suspended echoes. Normal appearance of the bladder neck and proximal urethra. No evidence of urolithiasis or inflammatory or proliferative changes is identified.

The left kidney is normal in shape and size, measuring 4.16×2.59 cm in the sagittal plane. Cortical thickness is 0.40 cm. The right kidney is normal in shape and size, measuring 4.15×2.70 cm in the sagittal plane. Cortical thickness is 0.42 cm. Both kidneys show mildly increased cortical echogenicity relative to the hepatic parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. A mild medullary rim sign is present. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

Dorsoventral diameters measured in the sagittal plane: the left adrenal gland measures 0.33 cm at the cranial pole and 0.34 cm at the caudal pole, with a small focal mineralization. The right adrenal gland was not adequately visualized.

Spleen

Splenic thickness is 0.61 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 a normal echotexture. No focal lesions or hepatic lymphadenopathy are identified.



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The gallbladder is normally distended. The wall is thin and regular. The luminal contents are anechoic. No dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and folded, with a wall thickness of 2.13 mm and preserved layering. The pylorus measures 3.92 mm.

Duodenum: 2.75 mm. Jejunum: 2.52 mm, with mucosa 1.27 mm, submucosa 0.65 mm, and muscularis propria 0.61 mm. Ileum: 2.36 mm, with mucosa 0.97 mm, submucosa 0.77 mm, and muscularis propria 0.62 mm. Wall layering is preserved. One ileal segment measures up to 4.16 mm in total thickness, with muscularis propria measuring 1.63 mm. Another small intestinal segment demonstrates marked corrugation. No intraluminal linear hyperechoic interface or other convincing evidence of a linear foreign body is identified on detailed evaluation, and this appearance is considered more likely secondary to intestinal inflammation.

Colon: 0.64 mm, containing formed feces in the descending segment.

Pancreas

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

Free Abdomen

No abdominal effusion or signs of peritonitis are present. Cranial mesenteric lymph nodes measure 3.72–4.05 mm, with normal shape and echogenicity. Ileocecal lymph nodes are not visualized. The iliac trifurcation appears normal.

PRIMARY FINDINGS

- Focal ileal wall thickening with marked muscularis thickening.
- Segmental small intestinal corrugation.

SECONDARY FINDINGS

- Mild bilateral renal cortical hyperechogenicity with subtle medullary rim sign.
- Small focal left adrenal mineralization.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The focally abnormal ileal segment observed measures 4.16 mm in total thickness, exceeding accepted feline small intestinal reference values, with marked muscularis thickening (1.63 mm). This results in a clearly abnormal muscularis-to-mucosa ratio and supports chronic enteropathy, including both inflammatory bowel disease and low-grade lymphoma.



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The corrugated intestinal segment is most likely inflammatory in origin. Although corrugation can raise concern for a linear foreign body, the absence of a visible linear interface, plication, obstructive pattern, or focal luminal abnormality makes inflammation more likely in this case.

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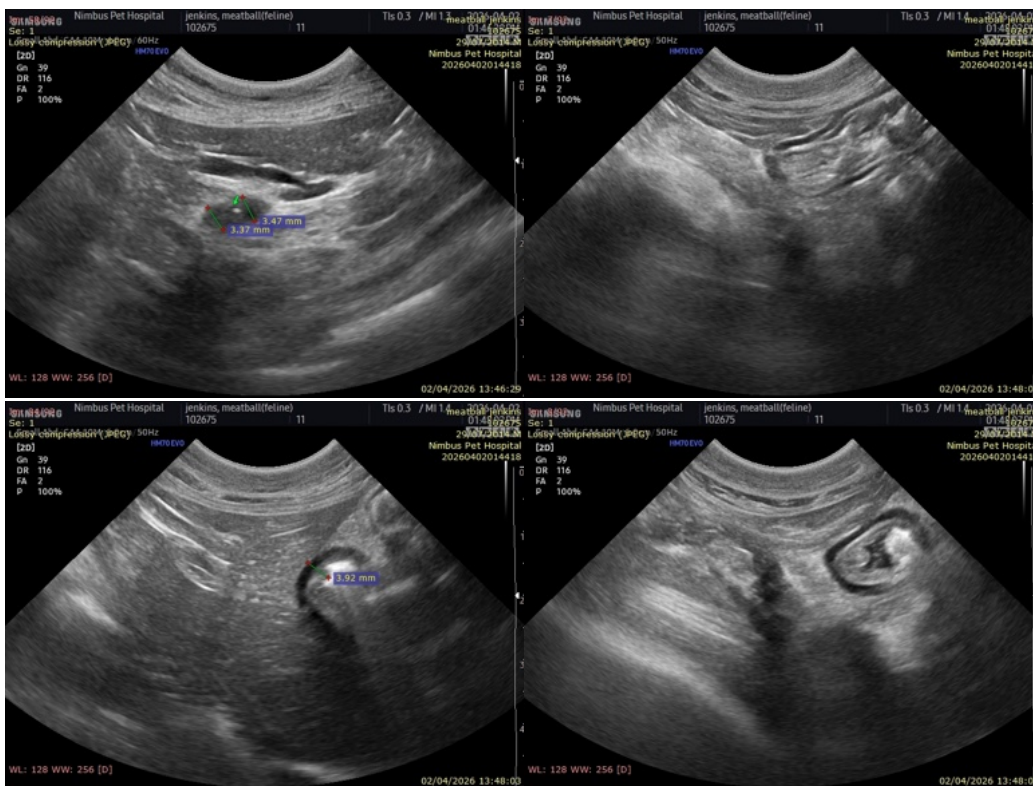
No mass lesion, obstructive lesion, abdominal effusion, or lymphadenopathy is identified. Normal lymph node size and preserved wall layering do not exclude low-grade lymphoma, particularly in a cat with chronic signs.

Overall, the findings are most consistent with chronic enteropathy with segmental distal small intestinal involvement, with IBD and low-grade lymphoma remaining the principal overlapping differentials.

Recommendations

- Symptomatic management for vomiting is appropriate, together with dietary modification and supportive care.
- GI panel with cobalamin assessment is recommended if not already performed.
- Intestinal biopsy should be considered to differentiate inflammatory from infiltrative disease.
- Alternatively, empirical immunomodulatory treatment for chronic enteropathy may be considered if biopsy is not pursued.

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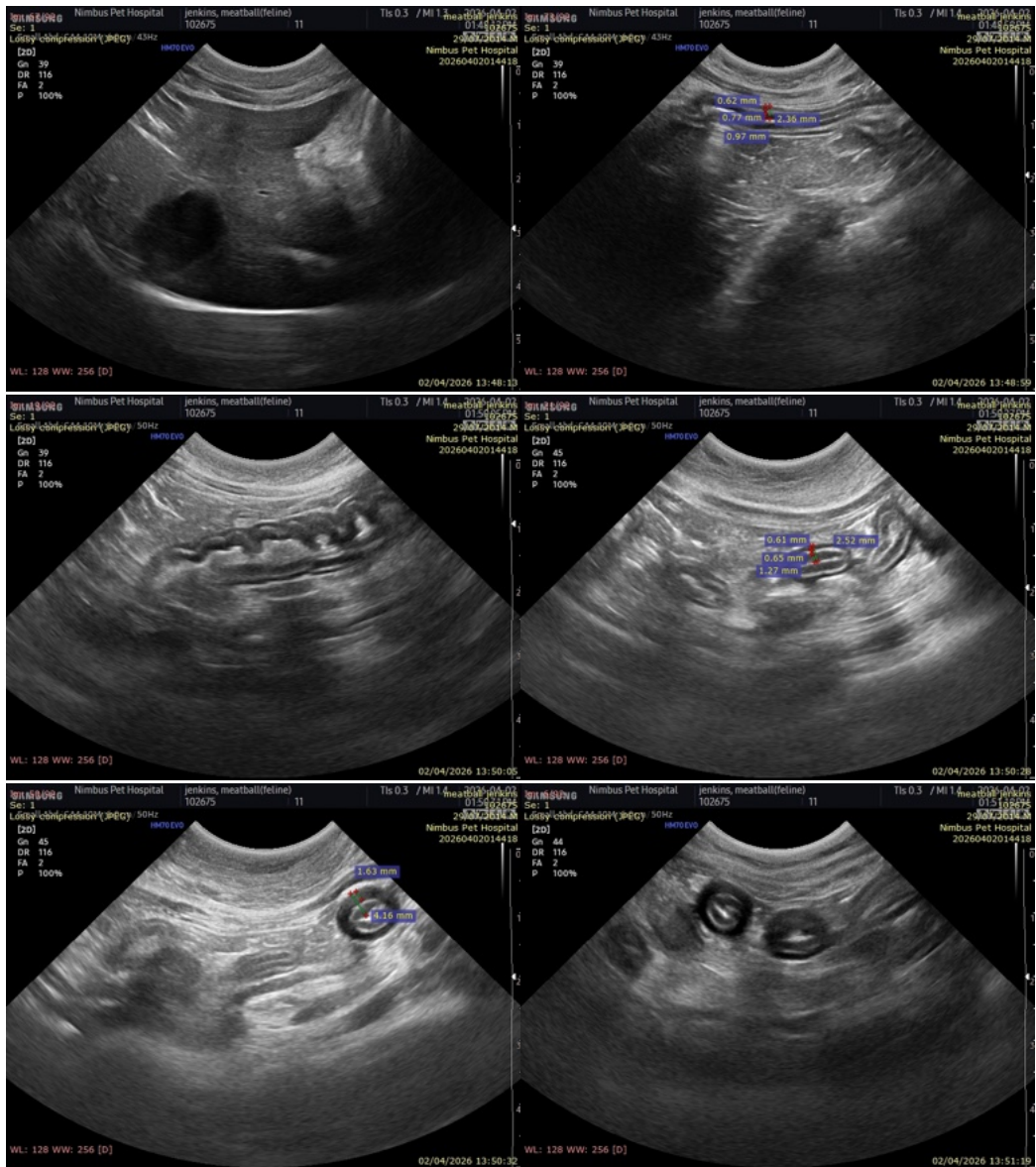
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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