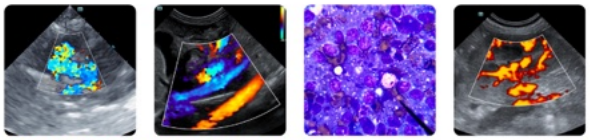


PATIENT

Percival Wilson

SPECIES

Feline

BREED

Domestic Medium Hair

SEX

Neutered male

AGE

11 months

WEIGHT

2.9 kg

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Danielle RVT

HOSPITAL NAME

Orchard VC

REFERRING VET

Dr. Gudelot

INVOICE

74972

DATE

4/29/26

PRESENTING CLINICAL SIGNS

History: Percival was from a cat rescue and since a kitten he has had chronic diarrhea, and upper respiratory concerns. Fecal was negative for parasites, but positive for C. perfringens, been treated with probiotics, antibiotics/tylan, different GI foods.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is thin and smooth. The urine is anechoic. The bladder neck and proximal urethra have a normal appearance. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 3.15×1.80 cm, with a cortical thickness of 0.29 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.45×1.52 cm, with a cortical thickness of 0.25 cm in the sagittal plane. In both kidneys, the cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. 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 0.20 cm at the cranial pole and 0.21 cm at the caudal pole. The right adrenal gland measures 0.23 cm at the cranial pole and 0.24 cm at the caudal pole.

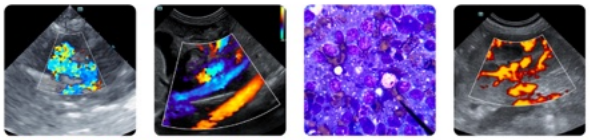
Spleen

Splenic thickness is 0.65 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 thin and the contents are predominantly anechoic. The common bile duct measures 2.82–2.38–1.55 mm along its course.



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Gastrointestinal

The stomach is empty and folded, with a mural thickness of 1.16 mm and preserved wall layering. Duodenum: 1.96 mm. Jejunum: 2.11 mm (mucosa 1.35 mm, submucosa 0.36 mm, muscularis propria 0.32 mm). Ileum: 1.66 mm (mucosa 0.70 mm, submucosa 0.58 mm, muscularis propria 0.29 mm). Wall layering is preserved. Ileocecal junction: 2.66 mm, with muscularis measuring 0.96 mm. Colon: ascending colon 0.99 mm, mildly distended with fluid; transverse colon 0.82 mm with moderate gas; descending colon 0.74 mm containing small amounts of soft fecal material.

Pancreas

The pancreas measures 3.99 mm in thickness. The parenchyma is hypoechoic relative to adjacent omental fat. The pancreatic duct measures 0.86 mm in diameter. No hyperechogenicity or inflammatory change of the peripancreatic fat is identified.

Free Abdomen

No abdominal effusion or evidence of peritonitis is present.

Cranial mesenteric lymph nodes measure 0.40–0.46 cm in thickness, and ileocecal lymph nodes measure 2.51–3.42 mm. All are normal in shape and mildly hypoechoic. The iliac trifurcation region is unremarkable.

PRIMARY FINDINGS

- Mild fluid distension of the colon.
- Subtle disproportionate thickening of the muscularis layer at the ileocecal junction.
- Mild pancreatic hypoechogenicity with pancreatic duct measuring 0.86 mm.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine is overall within normal thickness limits and maintains normal wall layering. The ileocecal junction, however, shows disproportionate muscularis thickening (0.96 mm within 2.66 mm total thickness). In this patient, this finding is interpreted as a focal response to chronic luminal stimulation (dietary, microbial, or inflammatory). This region is functionally active and commonly involved in chronic enteropathies at this age. The colon is mildly fluid-filled, consistent with the reported diarrhea, without overt mural abnormalities.

Mesenteric and ileocecal lymph nodes are within normal size limits but mildly hypoechoic, which is compatible with low-grade reactive change secondary to chronic gastrointestinal antigenic stimulation. Their size, shape, and echotexture do not support infiltrative or malignant involvement.

The pancreas is mildly hypoechoic with a duct measuring 0.86 mm, which remains within acceptable limits for cats. The absence of peripancreatic fat changes makes clinically significant pancreatitis unlikely; in feline patients, these findings are nonspecific and may reflect mild reactive change or normal variation.

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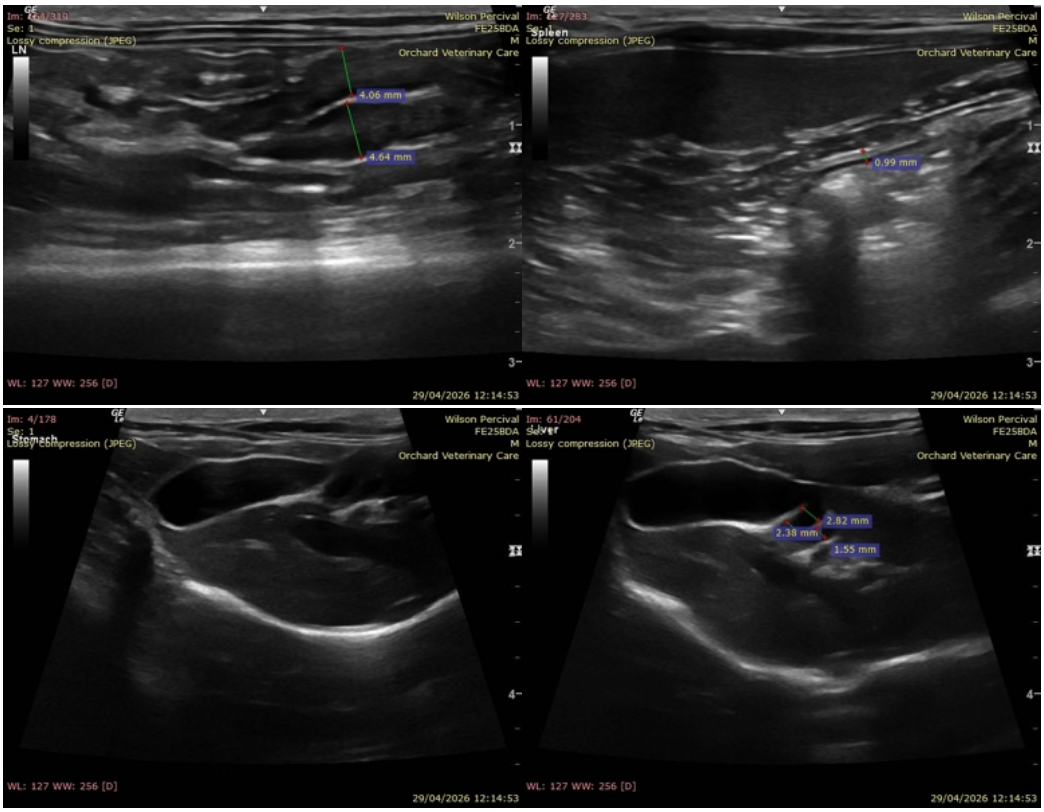
Overall, the findings are most consistent with a chronic enteropathy of mild structural expression, likely driven by dietary or microbiota-related factors. Given the patient's age and history, food-responsive enteropathy and microbiota-associated enteropathy remain the leading differentials.
Importantly, infectious causes of chronic diarrhea in young cats—particularly Tritrichomonas foetus—cannot be excluded. The ultrasonographic findings are compatible but nonspecific. Clarification of large bowel signs (hematochezia, mucus, increased frequency, tenesmus) would further support this differential.

Recommendations

- Consider performing a PCR for Tritrichomonas foetus on fresh feces, given the age, chronicity, and incomplete response to prior therapies.
- Ensure a strict elimination diet trial (novel or hydrolyzed protein) if not already rigorously implemented.
- Assess serum cobalamin (± folate) to evaluate functional malabsorption and guide supplementation.
- Continue or reassess microbiota-directed therapy based on clinical response.

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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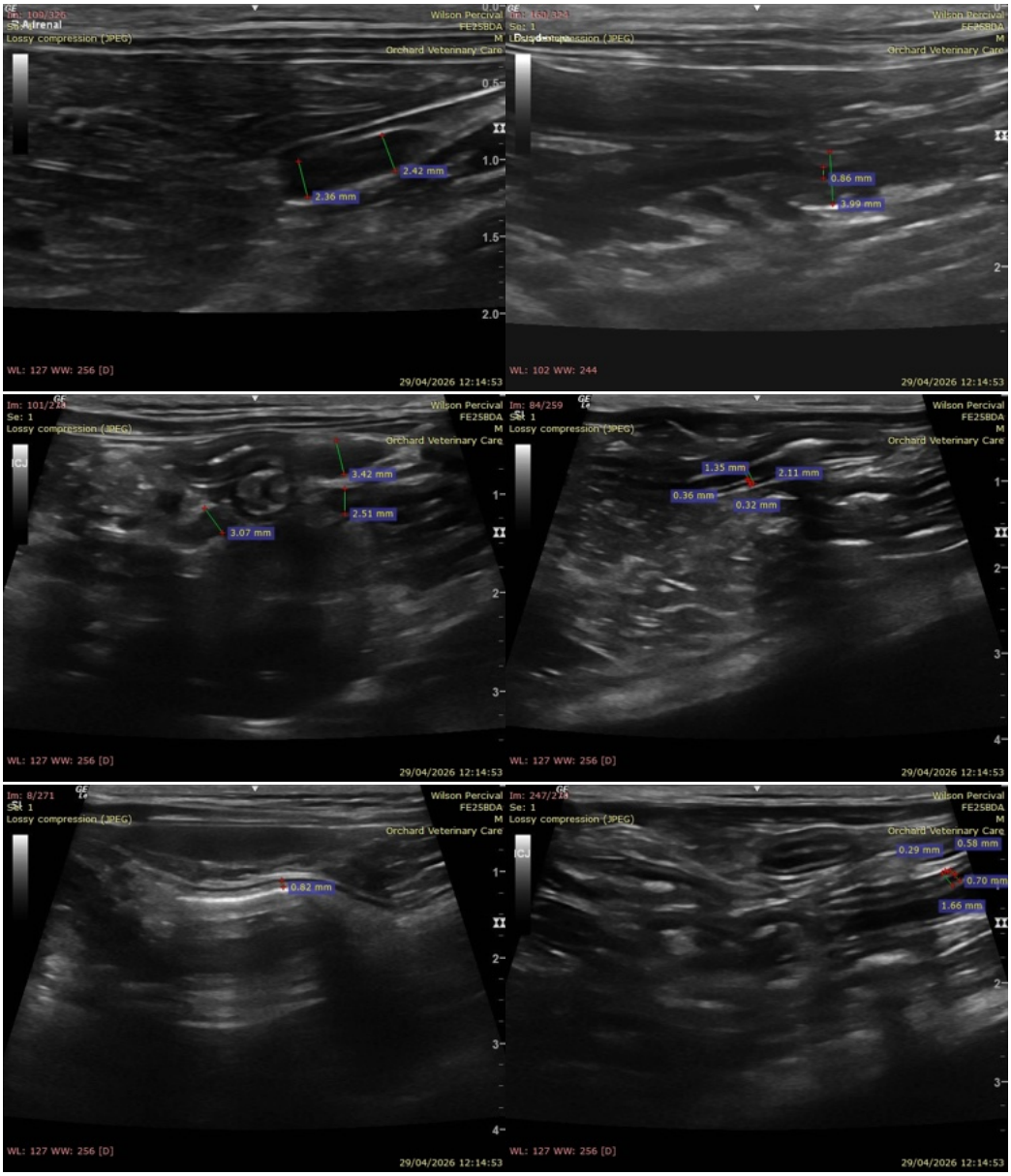

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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