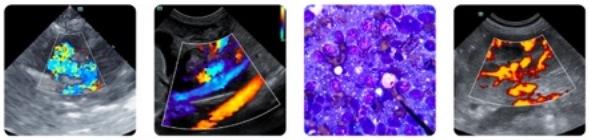


PATIENT

Miss Kitty Tibbetts

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

9 years

WEIGHT

7.4 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Jenn Copp

HOSPITAL NAME

Westside AH

REFERRING VET

Dr. Copp

INVOICE

74140

DATE

74140

PRESENTING CLINICAL SIGNS

- Chronic diarrhea since young (~ 1-2 yr). Negative response to Fiber, did trial of HP/budesonide and briefly had formed stools, but diet has been difficult for owner to be strict with. Recently on budesonide/HP, but appetite has been off so owner has been tempting with limited ingredient wet foods. Trialed Prednisolone and metronidazole and would get soft stools, but never formed. Consistent weight loss since 2024 (12.5lbs--> 7.4lbs). Appetite off. Chronic diarrhea.
- Previous diarrhea PCR- negative Fecals- Negative June 2025 CBC/Chem- NSF, T4 2.5 December 2025 GI panel: Normal B12, spec FPL, but Folate > 24 Resubmitted fasted GI panel, Senior profile along with AUS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended. The bladder wall is thin, smooth, and regular. The luminal contents are anechoic. The bladder neck and proximal urethra have a normal appearance. No evidence of urolithiasis or inflammatory or proliferative changes is identified.

The left kidney is normal in shape and size, measuring 3.68×2.30 cm in the sagittal plane. Cortical thickness is 0.41 cm. The right kidney is normal in shape and size, measuring 4.02×2.06 cm in the sagittal plane. Cortical thickness is 0.39 cm. Both kidneys cortex shows normal echogenicity. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

Not confidently visualized.

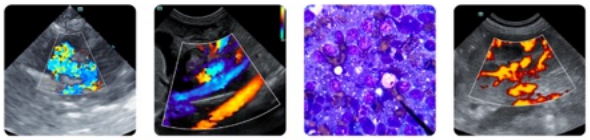
Spleen

Splenic thickness is 0.80 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 adequately distended. The wall is thin and regular. The luminal contents contain a moderate amount of biliary sludge. The common bile duct measures 2.22 mm.



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Gastrointestinal

The stomach is empty and folded, with a wall thickness of 1.51 mm and preserved layering. The pylorus measures 2.74 mm.

Duodenum: 1.70 mm. Jejunum: 1.84-2.04 mm, with mucosa 1.09 mm, submucosa 0.48 mm, and muscularis propria 0.45 mm. Ileum: 1.21-1.34 mm, with mucosa 0.44 mm, submucosa 0.82 mm, and muscularis propria 0.33 mm. Wall layering is preserved. The ileocecal junction is not visualized. No evidence of ileus, obstruction, or intraluminal foreign material is identified.

Colon: 0.52 mm, containing formed fecal material within the lumen.

Pancreas

Pancreatic thickness ranges from 6.07–6.74 mm. Pancreatic parenchyma is mildly hypoechoic relative to the adjacent mesenteric fat and is subtly heterogeneous, with scattered small hyperechoic foci. The pancreatic duct measures 1.23–2 mm in diameter. No peripancreatic fat changes are identified.

Free Abdomen

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

PRIMARY FINDINGS

- Mild pancreatic hypoechogenicity and subtle heterogeneity with mildly prominent pancreatic duct (up to 2 mm).
- Moderate biliary sludge.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastrointestinal tract does not show ultrasonographic features that support clinically significant structural enteropathy. Wall thicknesses are within accepted feline reference ranges (generally ≤2.5–3.0 mm depending on segment), and the muscularis-to-mucosa ratios are maintained. Overall, there is no consistent or convincing pattern of muscularis hypertrophy. Wall layering is preserved and there is no lymphadenopathy. These findings do not provide imaging support for moderate-to-severe IBD or intestinal lymphoma, although mild or early intestinal disease cannot be excluded, as ultrasound lacks sensitivity for functional or low-grade inflammatory conditions (including mild or diffuse inflammatory bowel disease, food-responsive enteropathy, and microbiome-related enteropathy). Elevated folate levels further support the presence of intestinal dysbiosis, which may contribute to the clinical signs and coexist with underlying chronic enteropathy.

Pancreatic findings are compatible with chronic pancreatopathy, which is common in cats and may contribute to chronic gastrointestinal signs. Even if pancreatic lipase is currently within normal limits, these imaging features support chronic pancreatic change. While mild pancreatic heterogeneity can be

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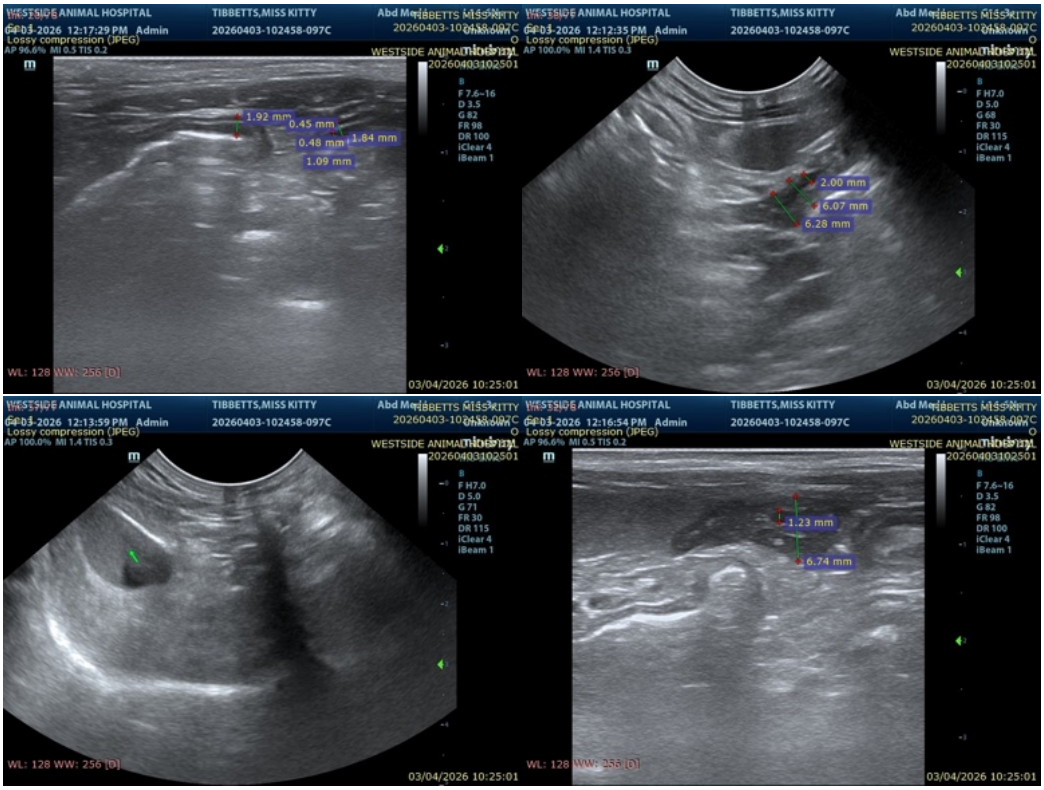
age-related in some patients, in this case the findings raise suspicion of previous or recurrent episodes of pancreatitis contributing to the current appearance.

Overall, despite the severity of the clinical presentation (chronic diarrhea, weight loss, poor response to therapy), the ultrasound is largely unremarkable for primary intestinal disease. This clinicopathologic-imaging discordance is relevant. It should be noted that recent or ongoing corticosteroid therapy may reduce the ultrasonographic expression of intestinal disease, potentially underestimating the severity of inflammatory or lymphoproliferative processes.

Recommendations

- Intestinal biopsy would be required for a definitive diagnosis, particularly given the chronicity, weight loss, and incomplete response to therapy.
- Strict adherence to a hydrolyzed or novel protein diet remains essential, as inconsistent feeding may significantly limit both diagnostic interpretation and therapeutic response.
- Re-evaluation of cobalamin/folate and consideration of a dysbiosis index may help further characterize underlying enteropathy.

All recommendations should be interpreted in light of clinical priorities.



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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