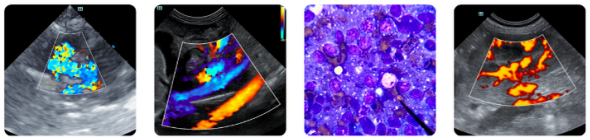


PATIENT

Pete Paul

SPECIES

Feline

BREED

DLH

SEX

MN

AGE

16 years 5 months

WEIGHT

14.86 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Melinda Persson

HOSPITAL NAME

At Home Veterinary

REFERRING VET

Dr. Melinda Persson

INVOICE

11844

DATE

4/30/2026

PRESENTING CLINICAL SIGNS

Acute-onset vomiting, complete inappetence, lethargy, hypothermia. Mild anemia of 28%, neutrophilia 12,500, mild azotemia. No response to Cerenia, Zorbium and Mirataz.

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 4.05×2.36 cm, with a cortical thickness of 0.35 cm in the sagittal plane.
The right kidney is normal in shape and size, measuring 3.94×2.21 cm, with a cortical thickness of 0.32 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 0.38 cm at the cranial pole and 0.41 cm at the caudal pole. The right adrenal gland measures 0.36 cm at the cranial pole and 0.39 cm at the caudal pole.

Spleen

Splenic thickness is 0.90 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

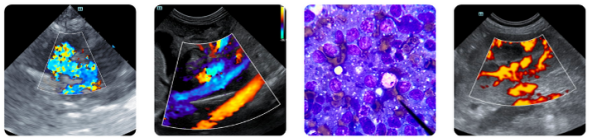
Liver

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 is mildly dilated in its proximal portion (no distal dilation identified).

Gastrointestinal

The stomach is empty and folded, with a mural thickness of 2.11 mm and preserved wall layering. The pylorus measures 3.16 mm.
Duodenum: 2.21 mm. Immediately distal to the pylorus, within the proximal duodenal lumen, there is a persistent intraluminal structure measuring approximately 1.27×1.69 cm. This structure has a soft tissue echotexture, heterogeneous and mildly hypoechoic relative to surrounding luminal contents, with a somewhat spongiform appearance and minimal detectable vascularity on Doppler interrogation. It is consistently visualized throughout the study and does not demonstrate characteristics of freely mobile ingesta. No clear attachment to the wall is definitively identified, although close apposition to the mucosa is suspected.



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Jejunum: 1.99 mm (mucosa 1.24 mm, submucosa 0.34 mm, muscularis propria 0.46 mm).
Ileum: 2.05 mm (mucosa 0.63 mm, submucosa 0.95 mm, muscularis propria 0.38 mm). Wall layering is preserved. Ileocecal junction: 2.98 mm, with muscularis measuring 0.41 mm.

Colon: 0.61 mm, with formed fecal material in the descending segment.

Pancreas

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

Free Abdomen

A mild amount of fluid is present in the retroperitoneal/perirenal regions bilaterally. This is associated with mild regional peritoneal reactivity.
Cranial mesenteric lymph nodes measure 3.54–3.92 mm, ileocecal lymph nodes measure 3.58 mm, and the pancreaticoduodenal lymph node measures 3.37 mm; all are normal in size, shape, and echogenicity. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Persistent intraluminal proximal duodenal soft tissue structure
- Mild proximal common bile duct dilation.
- Retroperitoneal/perirenal effusion with regional inflammatory change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This study identifies a persistent intraluminal structure within the proximal duodenum. The lesion is consistently present, non-mobile, and demonstrates a heterogeneous, spongiform appearance with minimal vascularity; however, the exact origin (intraluminal vs mucosal-based) cannot be definitively determined on ultrasound.
The main differential considerations include:
• Intraluminal foreign material (non-radiopaque or organic material) that is not freely mobile.
• Duodenal polyp or mucosal proliferative lesion (less common in cats, but possible).
• Atypical neoplastic process, although the lack of clear wall invasion and absence of lymphadenopathy make an aggressive neoplasm less likely based on imaging.
Given its location at the proximal duodenum/pyloric outflow, even a partially obstructive lesion could contribute to persistent vomiting, anorexia, and lack of response to antiemetics.

The mild proximal common bile duct dilation may reflect functional or transient obstruction at the level of the duodenal papilla, potentially secondary to this lesion or regional inflammation; however, there are no ultrasonographic signs of complete extrahepatic biliary obstruction at the moment.

Separately, there is a mild amount of retroperitoneal/perirenal fluid with regional inflammatory change. This distribution is most consistent with a retroperitoneal or systemic process, including:

- Hemodynamic changes (hypoperfusion or early shock states).
- Retroperitoneal inflammatory processes, such as pancreatic or peripancreatic inflammation, which in cats may occur without overt ultrasonographic pancreatic abnormalities.
- Hypoproteinemia.

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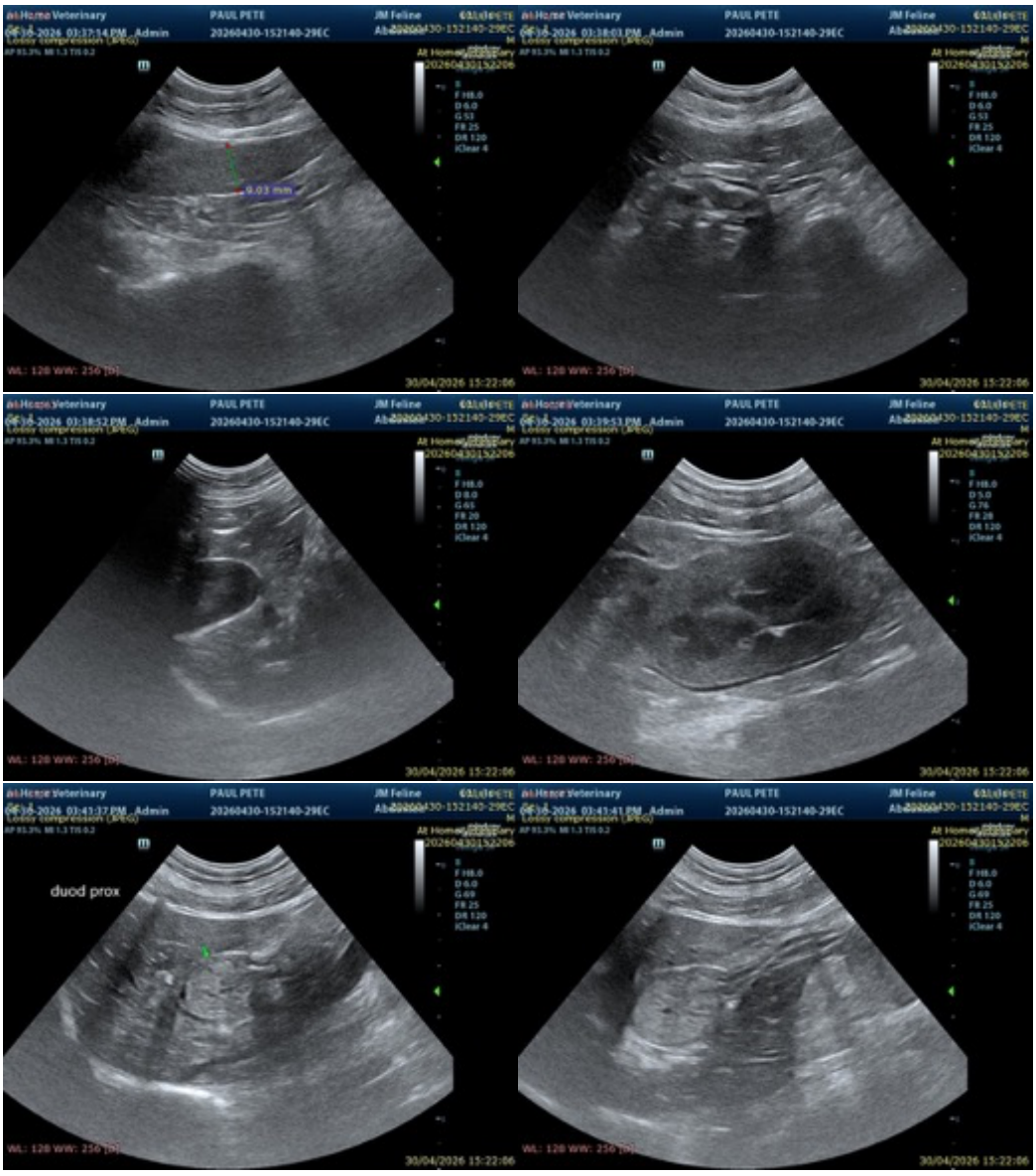
Recommendations

- Aggressive supportive care and stabilization are strongly recommended.
- Further evaluation of the proximal duodenal lesion, ideally via upper gastrointestinal endoscopy, to allow direct visualization and potential retrieval (if intraluminal material) or biopsy (if mucosal lesion).
- If the lesion cannot be adequately reached or characterized endoscopically, surgical exploration may be considered, although this would depend on clinical progression and response to stabilization.

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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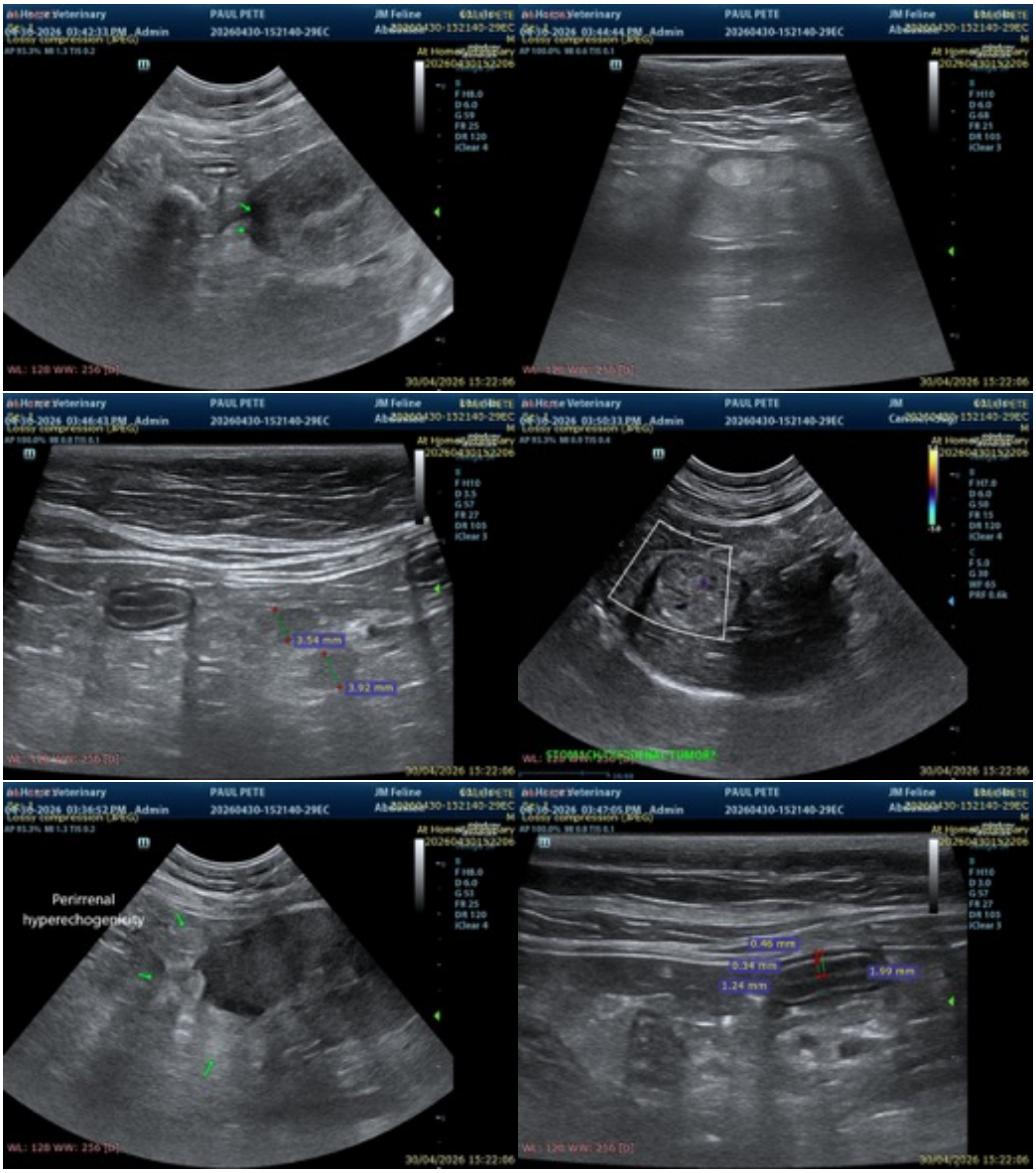

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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