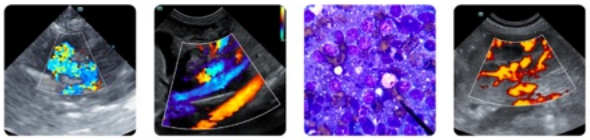


PATIENT

Teddy Dennison

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

9 years

WEIGHT

17.2 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Amy Isaac

HOSPITAL NAME

Valley West & Elk Valley VH

REFERRING VET

Dr. Isaac

INVOICE

75032

DATE

4/30/26

PRESENTING CLINICAL SIGNS

History of chronic constipation and vomiting. Currently on a ZD food trial but owner is also feeding OTC canned food with 1/4 tsp miralax daily.
Abnormal PE/Chem/CBC/UA Results: Obese on physical exam. CBC/Chem/T4/UA unremarkable other than mild proteinuria

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is thin and smooth. The urine is turbid with abundant suspended echoes. 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 3.67×2.03 cm, with a cortical thickness of 0.31 cm in the sagittal plane. 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.

The right kidney is normal in shape and size, measuring 4.07×2.42 cm, with a cortical thickness of 0.35 cm in the sagittal plane. 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.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.32 cm at the cranial pole and 0.34 cm at the caudal pole. The right adrenal gland measures 0.26 cm at the cranial pole and 0.25 cm at the caudal pole.

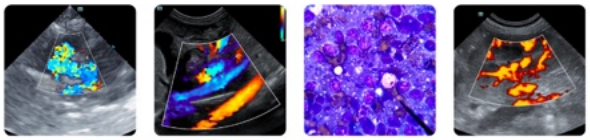
Spleen

Splenic thickness is 1.06 cm. The parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture. A small, well-defined hyperechoic lesion measuring 2.26×2.28 mm is present, compatible with a myelolipoma-like lesion. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The hepatic parenchyma is homogeneous and isoechoic relative to falciform fat, with normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder is normally distended. The wall is thin and the contents are predominantly anechoic with a small amount of biliary sludge. There is no evidence of dilation of the cystic duct or common bile duct.



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Gastrointestinal

The stomach is empty and folded, with a mural thickness of 2.96 mm at the gastric body and preserved wall layering. The pylorus measures 6.9–9.4 mm in total thickness, predominantly due to mucosal thickening (mucosa measuring up to 3.56 mm). In a focal region, there is mild loss of normal wall layer distinction. Duodenum: 2.82 mm, mildly distended with a small amount of fluid. Jejunum: 2.64 mm (mucosa 1.35 mm, submucosa 0.73 mm, muscularis propria 0.34 mm). Ileum: 1.96 mm (mucosa 0.62 mm, submucosa 0.84 mm, muscularis propria 0.39 mm). Wall layering is preserved. The ileocecal junction is not visualized. No evidence of mechanical ileus or foreign material is identified. Colon: 0.85–1.06–1.07 mm, containing formed fecal material throughout all segments, without evidence of current impaction or marked distension.

Pancreas

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

Free Abdomen

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

PRIMARY FINDINGS

- Marked pyloric thickening (6.9–9.4 mm), predominantly mucosal, with focal mild loss of layering
- Mild duodenal fluid distension.

SECONDARY FINDINGS

- Turbid urine with abundant suspended echoes.
- Small incidental splenic hyperechoic nodule (myelolipoma-like).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most significant finding in this study is the marked pyloric wall thickening, measuring up to 9.4 mm, which clearly exceeds expected feline gastric wall thickness (typically ≤2–3 mm). The thickening is predominantly mucosal, with a focal area of mild loss of normal wall layering. This pattern raises concern for infiltrative or proliferative disease at the pylorus, rather than simple inflammatory change. In cats, mucosal-predominant thickening can be seen with chronic gastritis or inflammatory disease, but the degree of thickening and the suggestion of focal architectural disruption increase concern for early neoplasia (lymphoma or less commonly adenocarcinoma). Ultrasonographic differentiation between severe inflammatory disease and infiltrative neoplasia is limited, particularly when changes are localized.

The remainder of the small intestine is within normal thickness limits, with preserved wall layering and muscularis-to-mucosa ratios within normal range (jejunum ~0.25; ileum ~0.63, the latter mildly increased but without additional supporting features of diffuse infiltrative disease). This suggests that

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the pyloric lesion may be focal.

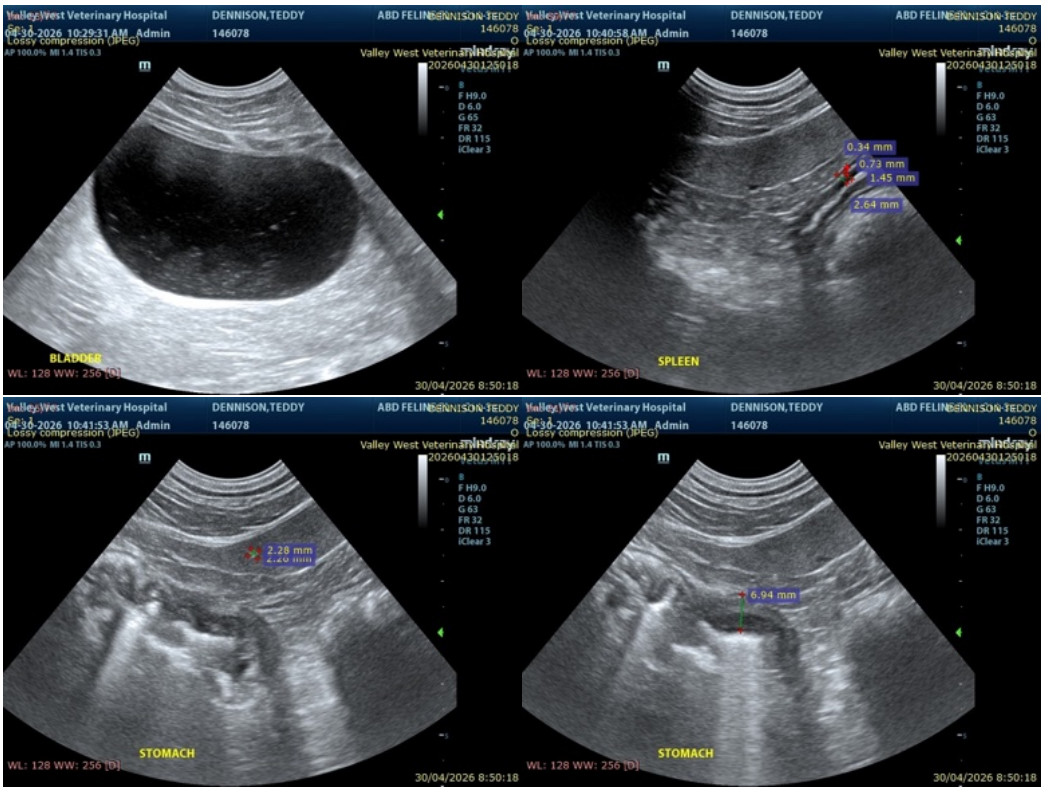
The colon contains formed feces without distension or wall abnormalities, indicating that there is no current evidence of active constipation or megacolon at the time of examination, despite the clinical history. Chronic constipation in this patient is therefore more likely functional or intermittent, rather than due to a fixed obstructive lesion at this time.

The urinary bladder contains turbid urine with abundant suspended echoes, which may represent crystalluria, cellular debris, or sediment, and should be correlated with urinalysis.

Recommendations

- Further evaluation of the pyloric lesion is recommended, ideally via upper gastrointestinal endoscopy with biopsy, if clinically appropriate.
- If endoscopy is not immediately pursued, close clinical monitoring (vomiting frequency, appetite, and weight) is recommended, along with follow-up ultrasound after medical management of the gastric changes, as progression would increase concern for neoplasia.
- Continue management of chronic constipation, but no sonographic evidence of current obstruction or megacolon is identified. Optimization of diet consistency (strict adherence to a single diet) is recommended, as the current mixed feeding limits clinical assessment.
- Perform urinalysis to further characterize the bladder sediment.

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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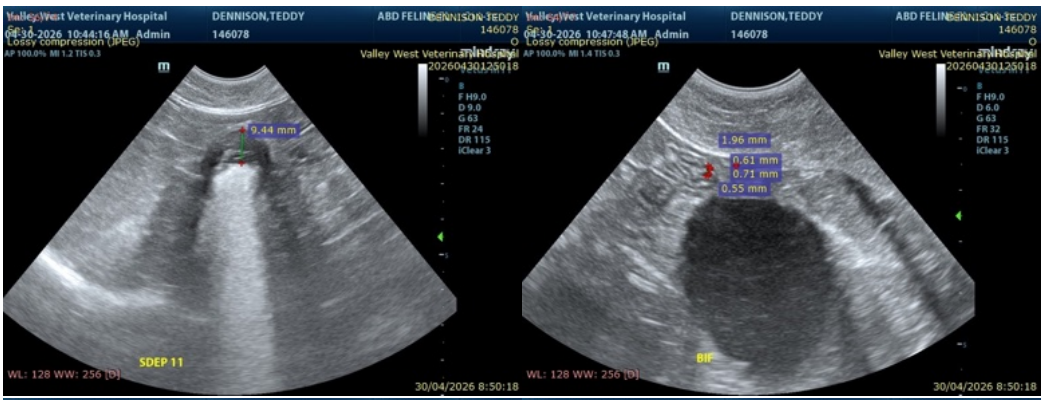

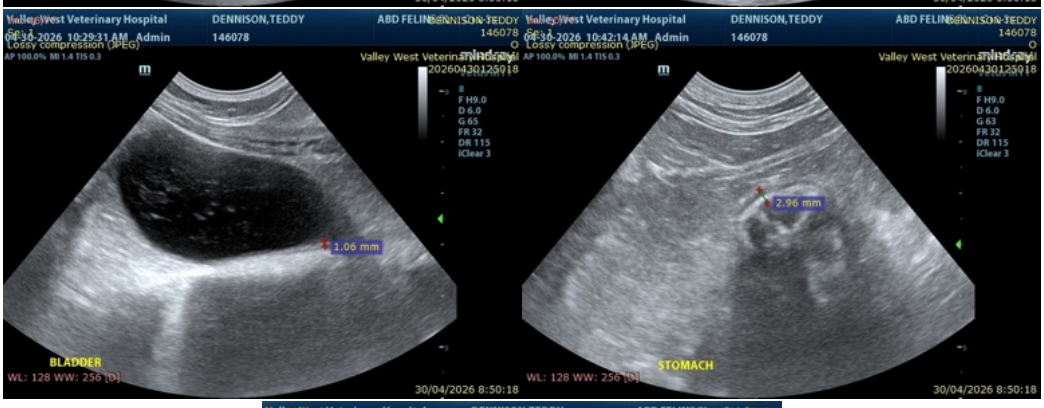

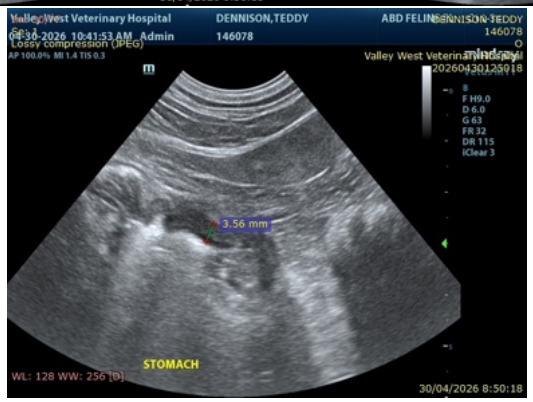

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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