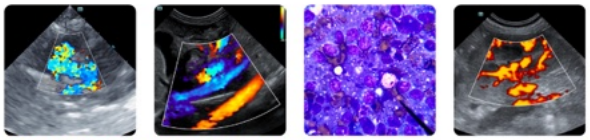


PATIENT

Patches Rasbeck

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

15 years

WEIGHT

4.8 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Anshu Gupta

HOSPITAL NAME

Liverpool Village AH

REFERRING VET

Dr. Fahey

INVOICE

74192

DATE

4/6/26

PRESENTING CLINICAL SIGNS

- 6 mo hx of weight loss and waxing/waning gi signs (soft stool and hyporexia, rarely vomits).
- on zd diet exclusively until recently
- on 2 mg methylpred po q 24 hours.
- P has lost 2 pounds since December 2025
- on 2.5 mg methimazole in am and 5 mg in pm.
- abnormal gait RH where the knee turns in sometimes or p holds it back, hesitating to jump
- PE: bilateral MPLs, ropey and gassy intestines on abdominal palpation CBC - severe neutrophilia (57K/uL), Hct 25% possibly regenerative AXR - gas dilation of small intestinal loops, but not overtly distended. loss of serosal detail.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended, with a thin, smooth wall. The urine is anechoic. The bladder neck and proximal urethra have a normal appearance. No calculi are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic disease.

The left kidney is normal in shape and size (3.66×2.05 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 within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

The right kidney is normal in shape and size (3.70×2.28 cm), with a cortical thickness of 0.36 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

The left adrenal gland is not confidently identified. The right adrenal gland measures 0.25 cm at the cranial pole and 0.29 cm at the caudal pole in the sagittal plane, which is within normal limits for a cat.

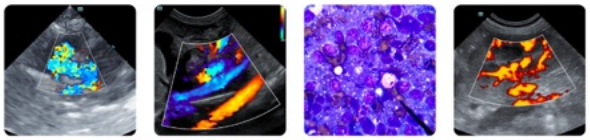
Spleen

Not visualized.

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 hepatic lymphadenopathy is identified.

The gallbladder is normally distended. The wall is thin, and the contents are predominantly anechoic with a small amount of echogenic biliary sludge. No dilation of the cystic duct or common bile duct is identified.



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Gastrointestinal

The stomach contains a small amount of fluid and echogenic material consistent with ingesta. The gastric wall measures 1.11 mm and layering is preserved.

The duodenum measures 2.37 mm, which is within normal limits for a cat. The small intestinal loops are diffusely dilated and contain mixed fluid and gas. The intestinal wall thickness ranges from 2.48–2.72 mm, with preserved layering in some segments, to 3.26 mm in others where layering is poorly defined. Intestinal motility appears subjectively increased. The quality of the study limits detailed evaluation and precludes exclusion of focal lesions such as a foreign body, mass, or focal perforation.

The colon measures 0.70 mm in wall thickness and is distended with fluid.

Pancreas

The pancreas is not identified due to marked intestinal gas artifact.

Free Abdomen

Anechoic abdominal effusion is present. Additionally, there is subjectively increased caliber of abdominal vasculature.

PRIMARY FINDINGS

- Diffuse small intestinal dilation with mixed fluid and gas
- Mild-to-moderate intestinal wall thickening (up to 3.26 mm) with segmental loss of layering
- Subjectively increased intestinal motility
- Anechoic abdominal effusion
- Subjective dilation of abdominal vasculature

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The combination of diffuse intestinal dilation, mural thickening with segmental loss of layering, abdominal effusion, and apparent vascular engorgement raises concern for a severe abdominal process. The ultrasonographic pattern is most consistent with a marked inflammatory or infectious enteropathy with secondary intestinal compromise, including the possibility of ischemia and/or early perforation. In this context, bacterial translocation across a severely compromised intestinal wall represents a plausible and clinically relevant mechanism, particularly given the diffuse nature of the intestinal changes and the presence of free abdominal fluid. This may result in secondary septic peritonitis even in the absence of a clearly identifiable focal perforation on ultrasound.

While chronic enteropathy (such as inflammatory bowel disease or low-grade lymphoma) could account for the patient's longstanding clinical signs, the current findings indicate acute decompensation and/or superimposed pathology, rather than a stable chronic process alone.

The absence of detectable pneumoperitoneum does not exclude intestinal perforation, particularly in

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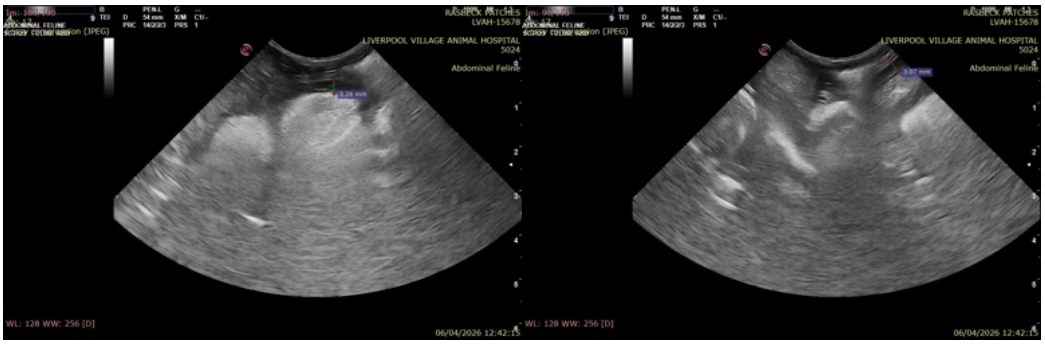
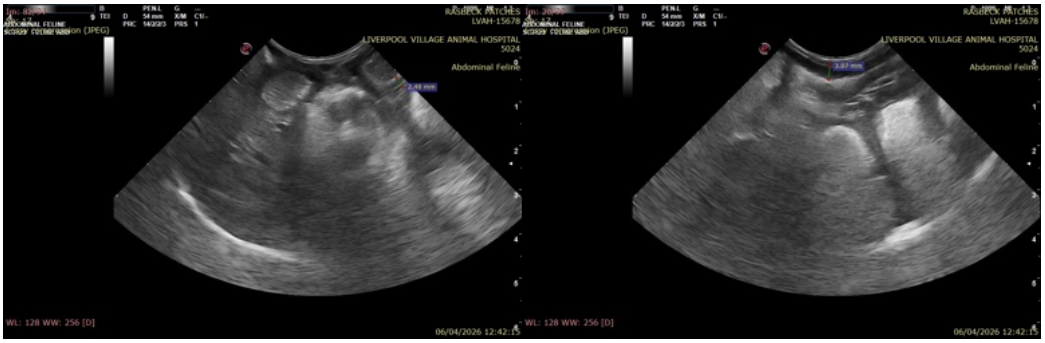
cases of early, contained, or microscopic leakage, or when severe intestinal disease allows for bacterial translocation without overt rupture.

Recommendations
Given the severity of imaging and clinical findings, exploratory laparotomy should be strongly considered; especially if septic peritonitis is confirmed.

- Abdominocentesis for cytologic evaluation of effusion, including assessment for septic inflammation (degenerate neutrophils, intracellular bacteria).
- Correlation with laboratory data (including lactate, if available) is advised to further assess for possible ischemia or sepsis.

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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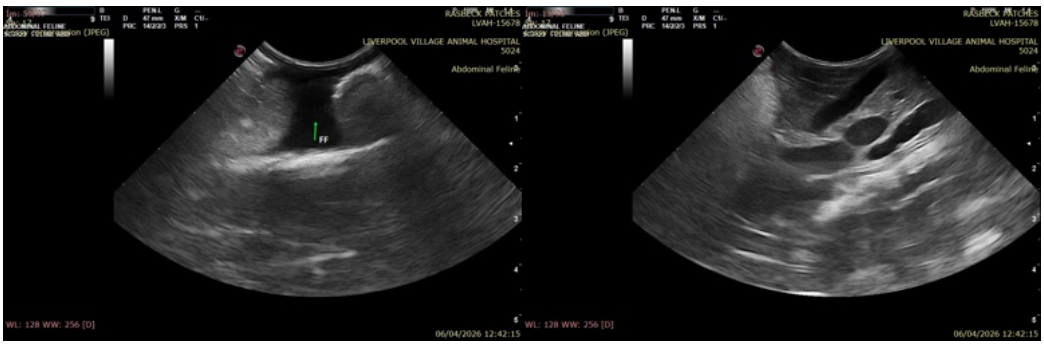

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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