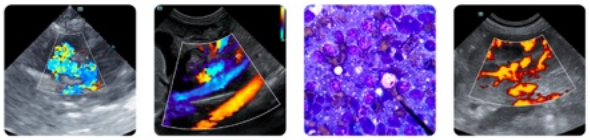


PATIENT

Denali Allard

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

4 ½ years

WEIGHT

5.52 kg

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Danielle RVT

HOSPITAL NAME

Orchard VC

REFERRING VET

Dr. Ernst

INVOICE

74324

DATE

4/8/26

PRESENTING CLINICAL SIGNS

History: Chronic diarrhea since mid to late February
- Currently on hydrolyzed protein kibble food trial for approximately 2 months
- Stool temporarily improves on metronidazole but returns to liquid consistency about one week after discontinuing antibiotic
- Stool consistency described as liquid, yellowish color, rated as 7 on fecal scoring chart, usually sits around 5 on the fecal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is slightly underdistended, with a thin and 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 (3.85×2.03 cm), with a cortical thickness of 0.32 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 (3.48×2.38 cm), with a cortical thickness of 0.32 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

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.26 cm at the cranial pole and 0.25 cm at the caudal pole. The right adrenal gland measures 0.27 cm at the cranial pole and 0.28 cm at the caudal pole.

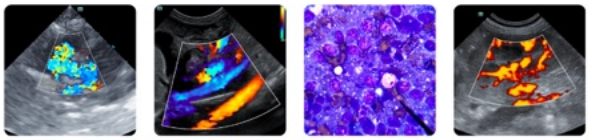
Spleen

Splenic thickness is 0.76 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 lumen is normally distended. The wall is thin and the contents are primarily anechoic No evident dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach is empty and folded, with a wall thickness of 2.12 mm and preserved layering. The pylorus measures 2.81 mm. The duodenum measures 1.97 mm and appears mildly corrugated. The jejunum measures 2.61 mm in total thickness, with mucosa 0.78 mm, submucosa 0.79 mm, and muscularis propria 0.97 mm. The ileum measures 2.68 mm in total thickness, with mucosa 0.76 mm, submucosa 0.77 mm, and muscularis propria 1.11 mm. Wall layering is preserved throughout. The ileocecal junction measures 3.68 mm, with a muscularis layer of 1.09 mm. No ultrasonographic evidence of obstruction, foreign material, or severe inflammatory change is identified. The colon measures 1.37 mm in the ascending segment and is empty; formed feces are present in the descending colon.

Pancreas

The pancreas measures approximately 4.03 mm in thickness. Parenchyma is isoechoic relative to the adjacent omental fat. The pancreatic duct is not dilated. No peripancreatic fat changes are identified.

Free Abdomen

No abdominal effusion or peritonitis is identified. Cranial mesenteric lymph nodes measure 3.55 mm and are normal in shape and echogenicity. Ileocecal lymph nodes are not visualized, and the surrounding regions appear unremarkable. The iliac trifurcation appears unremarkable.

PRIMARY FINDINGS

- Moderate relative thickening of the jejunal and ileal muscularis layers.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This study demonstrates mild to moderate intestinal changes, primarily characterized by relative thickening of the muscularis layer in the jejunum and ileum, with preserved wall layering and overall wall thickness within normal limits.
The muscularis-to-mucosa ratio in the jejunum is approximately 1.2, and in the ileum approximately 1.5, indicating disproportionate muscularis thickening, more pronounced in the ileum.
This pattern is clinically relevant and consistent with chronic enteropathy in cats, including inflammatory bowel disease and, less likely given the patient's age, low-grade (small cell) lymphoma.

The mild duodenal corrugation may reflect functional or inflammatory change, and can be seen in association with gastrointestinal disease, including dysbiosis or parasitic/infectious processes.

Given the history of chronic diarrhea with only transient response to metronidazole and lack of sustained response to a hydrolyzed diet, these findings most strongly support chronic inflammatory or dysbiotic enteropathy. A transient response to antimicrobial therapy may reflect modulation of intestinal microbiota rather than a primary infectious etiology. Additional infectious causes, including Tritrichomonas foetus, should be considered if not already excluded.

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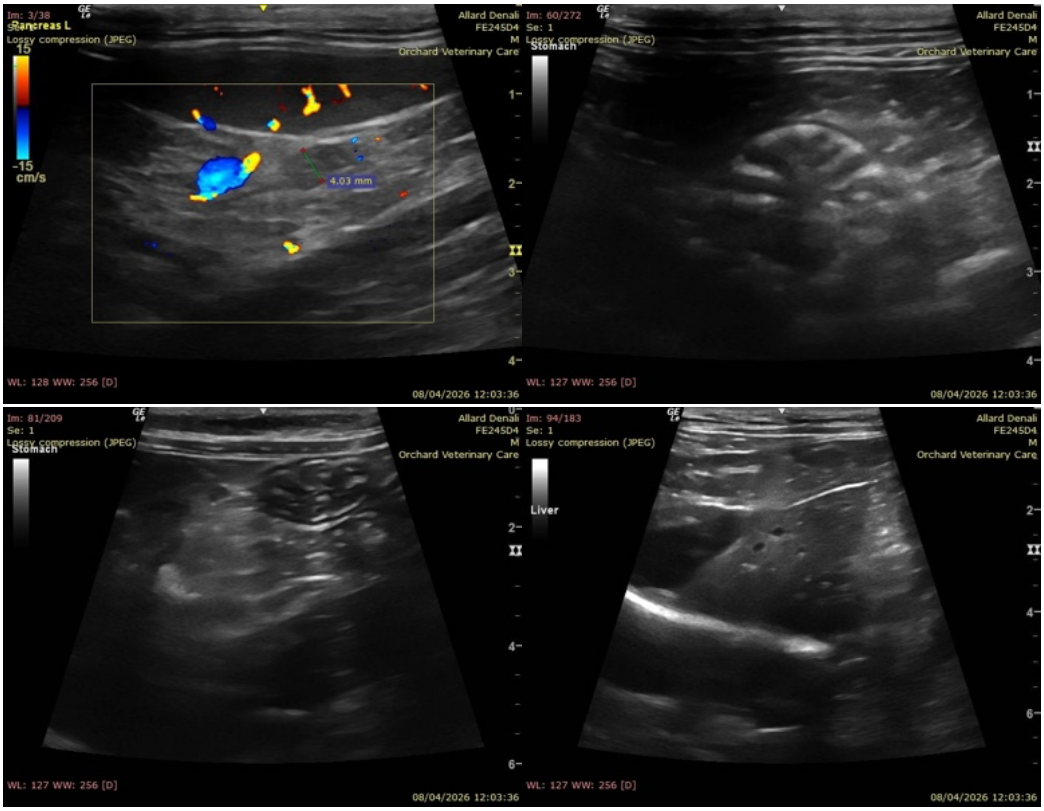
Overall, findings are most consistent with chronic enteropathy, with inflammatory and dysbiotic etiologies favored over neoplastic disease.

Recommendations
- PCR testing for Tritrichomonas foetus is recommended if not already performed.
- Evaluation of serum cobalamin (± folate) is recommended.
- Further therapeutic strategies targeting dysbiosis or chronic enteropathy may be considered.
- If clinical signs persist or worsen despite appropriate management, intestinal biopsy may be considered for definitive diagnosis.

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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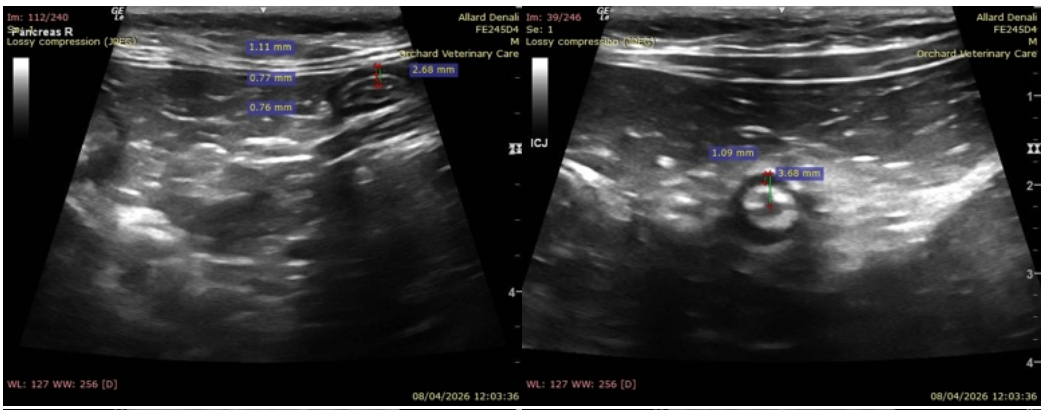

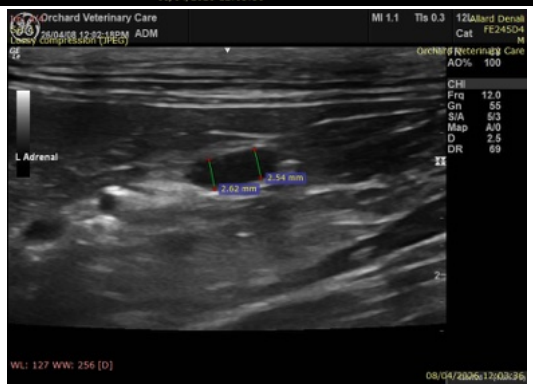

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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