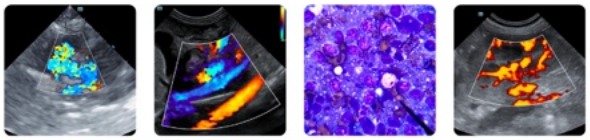




**PATIENT**

Emma Goodyear

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Spayed female

**AGE**

8 years

**WEIGHT**

9.24 lbs

**INTERPRETED BY**

Alicia Angosto Guerrero, DMV, PgDip, MSc.

**IMAGING PERFORMED BY**

Justin Eckenrode, DVM

**HOSPITAL NAME**

Carlisle Small Animal VC

**REFERRING VET**

Dr. Morrison

**INVOICE**

75347

**DATE**

5/12/26

## PRESENTING CLINICAL SIGNS

History: Major Medical Conditions : Unexplained acute vomiting, does stop with cerenia
Patient History : O reports that Emma started vomiting Friday through Monday. Cerenia injection was given and no vomit. But O reports she vomited Wednesday a.m. (food) and vomited the next day at 7 a.m. (white phlegm). O said normal b/m, drinking fine, urinating fine
O reports no new food or treats (does not eat treats).
Indoor only
Primary concern or rule out: IBD/lymphoma/pancreatitis/mass
Spayed/neutered : spayed
CBC/chem/T4 NSF, WBC 4.4 on 4/20/26

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is predominantly anechoic with scant suspended echoes. Normal appearance of the bladder neck and proximal urethra. No calculi are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic change.

The left kidney is normal in shape and size, measuring 3.37×2.10 cm, with a cortical thickness of 0.26 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.74×2.38 cm, with a cortical thickness of 0.32 cm in the sagittal plane. Both kidneys demonstrate cortical echogenicity similar to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved bilaterally. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler demonstrates a normal vascular pattern.

### *Adrenal Glands*

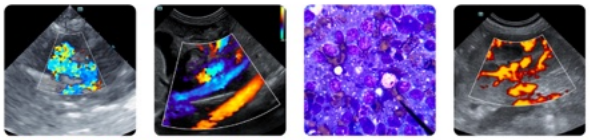
Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.27 cm at the cranial pole and 0.27 cm at the caudal pole. The right adrenal gland measures 0.25 cm at the cranial pole and 0.26 cm at the caudal pole.

### *Spleen*

Splenic thickness is 0.79 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular. Splenic vasculature appears normal.

### *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.





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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.

### *Gastrointestinal Tract*

The stomach is empty and folded, with mural thickness measuring 1.52 mm and preserved wall layering. The pylorus measures 3.63 mm. The duodenum measures 2.03 mm. The jejunum measures 2.82 mm in thickness, with preserved wall layering. The mucosa measures 1.03 mm, the submucosa 0.47 mm, and the muscularis propria 1.15 mm. The muscularis-to-mucosa ratio is approximately 1.1. The ileum measures 2.66 mm in thickness, with preserved wall layering. The mucosa measures 0.94 mm, the submucosa 0.68 mm, and the muscularis propria measures approximately 0.88-1.03 mm. The muscularis-to-mucosa ratio is approximately 0.9-1.1. The ileocecal junction measures 3.30 mm in thickness, with muscularis propria measuring 1.05 mm. No ultrasonographic evidence of mechanical ileus, obstructive foreign material, or focal gastrointestinal mass lesion is identified. Colon measures 0.80 mm in thickness. Some formed fecal material is present within the descending colon.

### *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

- Diffuse muscularis propria thickening involving the jejunum, ileum, and ileocecal junction with preserved wall layering

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The primary ultrasonographic abnormality is mild diffuse muscularis propria thickening affecting portions of the small intestine, particularly the jejunum, ileum, and ileocecal junction, while overall mural layering and intestinal architecture remain preserved. The muscularis-to-mucosa ratios are mildly increased, particularly within the jejunum and ileum.

This pattern is nonspecific but most commonly associated with chronic inflammatory enteropathy in cats, including lymphoplasmacytic enteritis/IBD. Low-grade alimentary lymphoma cannot be completely excluded sonographically, as there is recognized overlap between mild chronic enteropathy and early low-grade lymphoma in feline patients, particularly when muscularis thickening predominates.

Additionally, no ultrasonographic evidence of pancreatitis, gastrointestinal obstruction, or abdominal mass lesion is identified.

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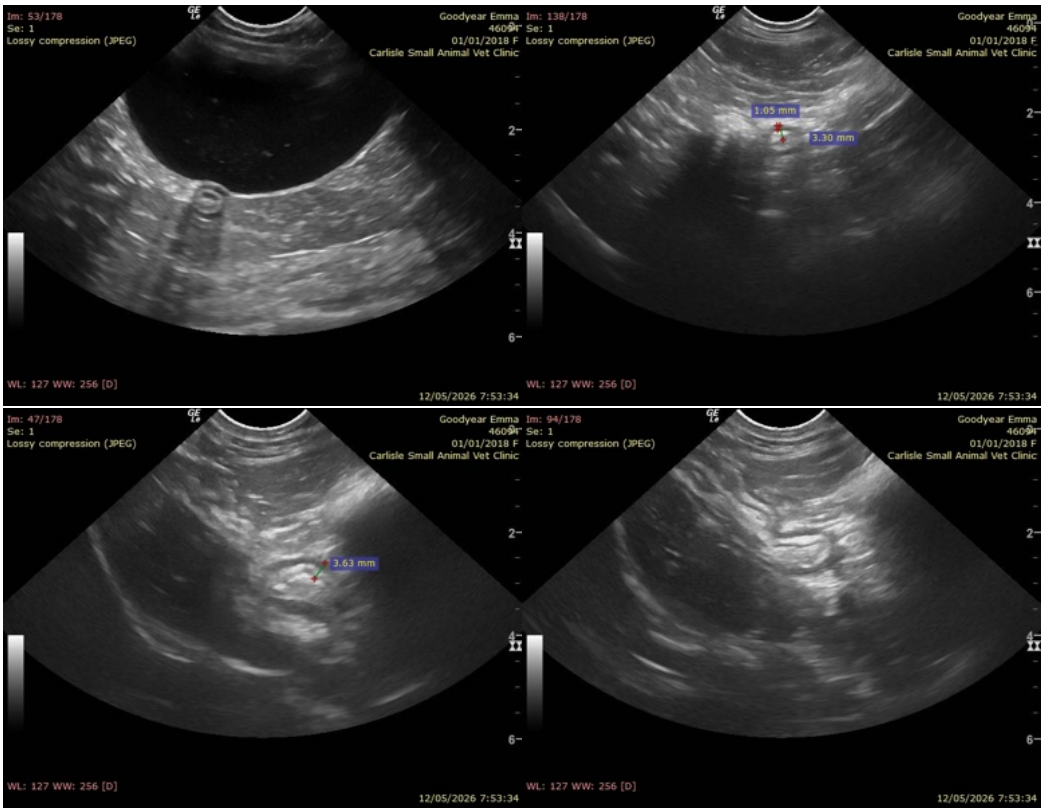
Recommendations

- Dietary management with a highly digestible or hydrolyzed diet trial may be beneficial if not previously attempted.
- Serum cobalamin and folate testing is recommended as functional gastrointestinal disease may occur despite relatively mild imaging findings.
- Given the diffuse muscularis thickening and ongoing clinical signs, further gastrointestinal investigation and/or empirical treatment for chronic enteropathy should be considered clinically, as dietary modification alone may not be sufficient in some cats with more established inflammatory intestinal disease.
- Gastrointestinal biopsies remain the only definitive method to differentiate chronic inflammatory enteropathy from low-grade lymphoma if clinical progression warrants 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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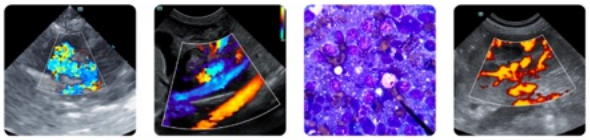

Clinical Sonography & Telecytology
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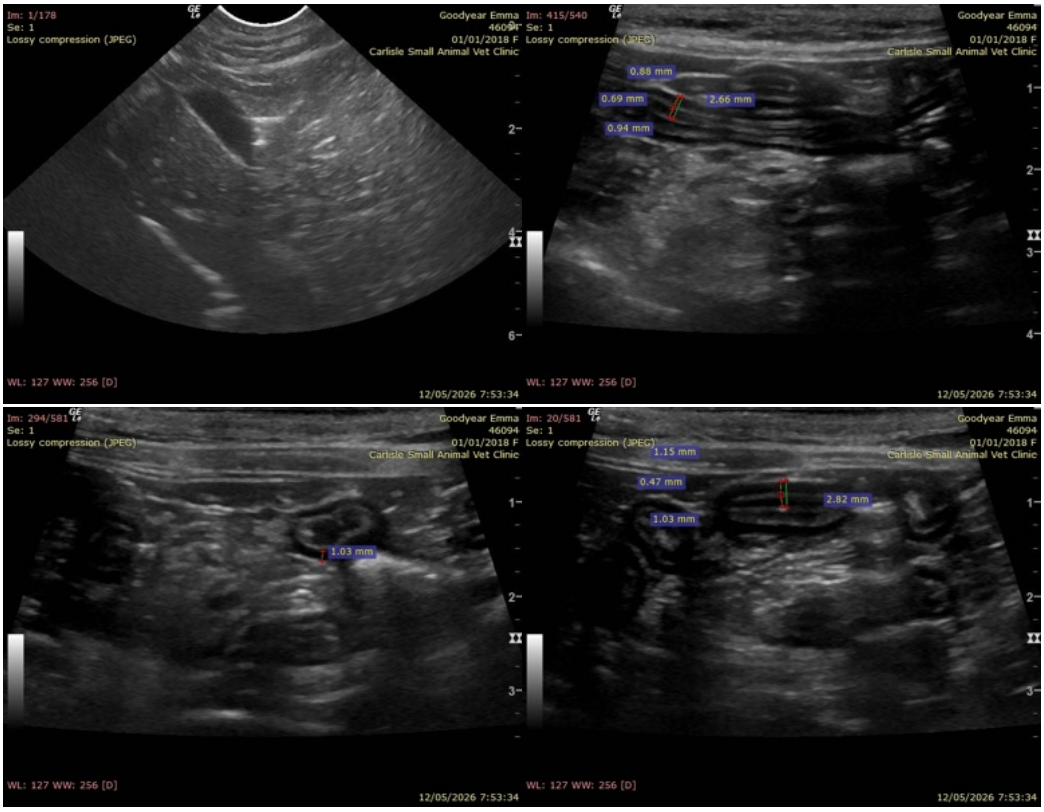


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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