



PATIENT

Pika Goodram

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

5 years

WEIGHT

4.23 kg

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Dr. Corbeil

HOSPITAL NAME

Cochrane AC

REFERRING VET

Dr. Corbeil

INVOICE

75377

DATE

5/12/26

PRESENTING CLINICAL SIGNS

History: On 01/May presented for chronic vomiting (3-4 times per week) and progressive weight loss
Abnormal PE/Chem/CBC/UA Results: 07/May- elevated ALT (150 U/L), GGT (9 U/L), and Potassium (5.9 mmol/L), along with low platelets ($14 \times 10^9/L$)

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 anechoic. 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 3.30×2.27 cm, with a cortical thickness of 0.36 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.56×2.21 cm, with a cortical thickness of 0.32 cm in the sagittal plane. Both kidneys demonstrate mildly increased cortical echogenicity compared 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 0.21 cm at the cranial pole and 0.26 cm at the caudal pole. The right adrenal gland measures 0.26 cm at the cranial pole and 0.22 cm at the caudal pole.

Spleen

Splenic thickness is 0.80 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 measures 0.66 mm in thickness, and the contents are predominantly anechoic. No dilation of the cystic duct or common bile duct is identified.

Gastrointestinal Tract

The stomach is empty and folded, with mural thickness measuring 1.51 mm and preserved wall layering. The pylorus measures 3.57 mm. The duodenum measures 1.63 mm in thickness. The major duodenal



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papilla measures approximately 2.14×2.19 mm. The jejunum measures 1.62 mm in thickness, with preserved wall layering. The mucosa measures 0.89 mm, the submucosa 0.38 mm, and the muscularis propria 0.35 mm. The ileum measures 2.05 mm in thickness, with preserved wall layering. The mucosa measures 0.83 mm, the submucosa 0.70 mm, and the muscularis propria measures 0.37 mm. The muscularis-to-mucosa ratio is approximately 0.45. The ileocecal junction measures 2.87 mm in thickness, with muscularis propria measuring 0.75 mm. The colon measures approximately 0.66-1.03 mm in thickness and contains formed fecal material within the descending segment.

Pancreas

The pancreas measures approximately 3.98 mm in thickness. Pancreatic parenchyma is isoechoic relative to the adjacent omental fat. The pancreatic duct measures 0.34 mm in diameter. No ultrasonographic evidence of active peripancreatic inflammation is identified.

Free Abdomen

No abdominal effusion or peritonitis is identified. Cranial mesenteric lymph nodes are not visualized, although the surrounding mesentery appears unremarkable. The ileocecal lymph nodes measure approximately 1.31-2.27 mm in thickness and maintain normal shape and echogenicity. The pancreaticoduodenal lymph node measures approximately 2.74×4.38 mm and appears normal in shape and echogenicity. The iliac trifurcation region is unremarkable.

PRIMARY FINDINGS

- Mild muscularis prominence at the ileocecal junction.

SECONDARY FINDINGS

- Mild bilateral renal cortical hyperechogenicity

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This abdominal ultrasound examination is largely unremarkable. Mild muscularis prominence is present at the ileocecal junction while preserving normal wall layering. This finding is nonspecific and may reflect mild or early chronic inflammatory enteropathy; however, the remainder of the gastrointestinal tract appears relatively unremarkable sonographically.

No diffuse intestinal thickening, focal intestinal mass lesion, obstruction, mesenteric inflammatory change, or abdominal lymphadenopathy is identified.

Despite the elevated ALT and GGT activities, the hepatobiliary system appears largely unremarkable sonographically. Importantly, mild hepatobiliary inflammatory disease may occur in cats despite minimal or absent ultrasonographic abnormalities, particularly during earlier or milder stages of disease. Differential considerations include mild cholangitis/cholangiohepatitis, early lymphocytic cholangitis, mild neutrophilic cholangitis, or mild forms of feline triaditis.



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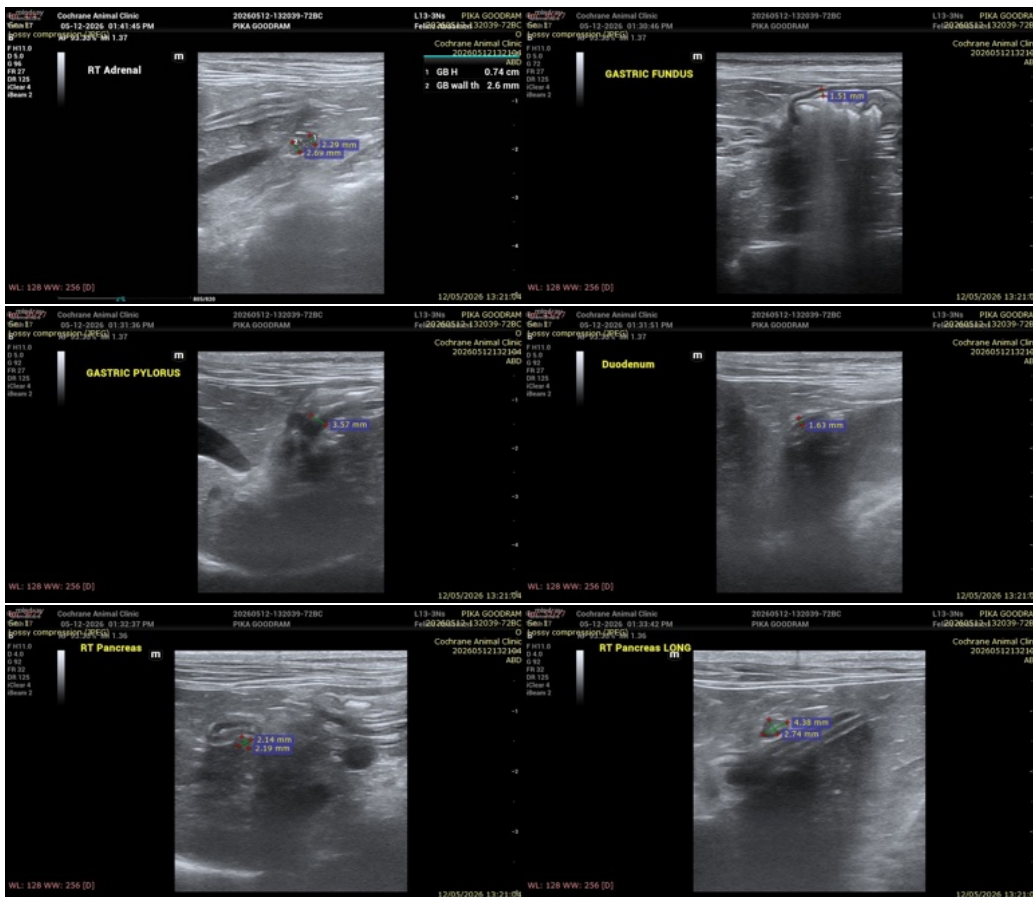
Additionally, subtle pancreaticobiliary inflammatory disease may not always produce overt ultrasonographic changes in cats. No evidence of biliary obstruction, marked gallbladder disease, severe hepatic infiltration, or overt pancreatitis is identified on the current study.

The mild bilateral renal cortical hyperechogenicity is nonspecific and may represent mild chronic or incidental renal change.

Recommendations

- Serum cobalamin/folate and fPLI testing are recommended if not already performed.
- Empirical treatment for hepatobiliary inflammatory disease and hepatobiliary supportive therapy may be considered.
- Dietary management with a highly digestible, novel protein, or hydrolyzed diet trial may be clinically beneficial.
- Gastrointestinal and/or hepatobiliary biopsies may eventually be considered if clinical signs become progressive or poorly responsive to medical management and a definitive diagnosis is clinically required.

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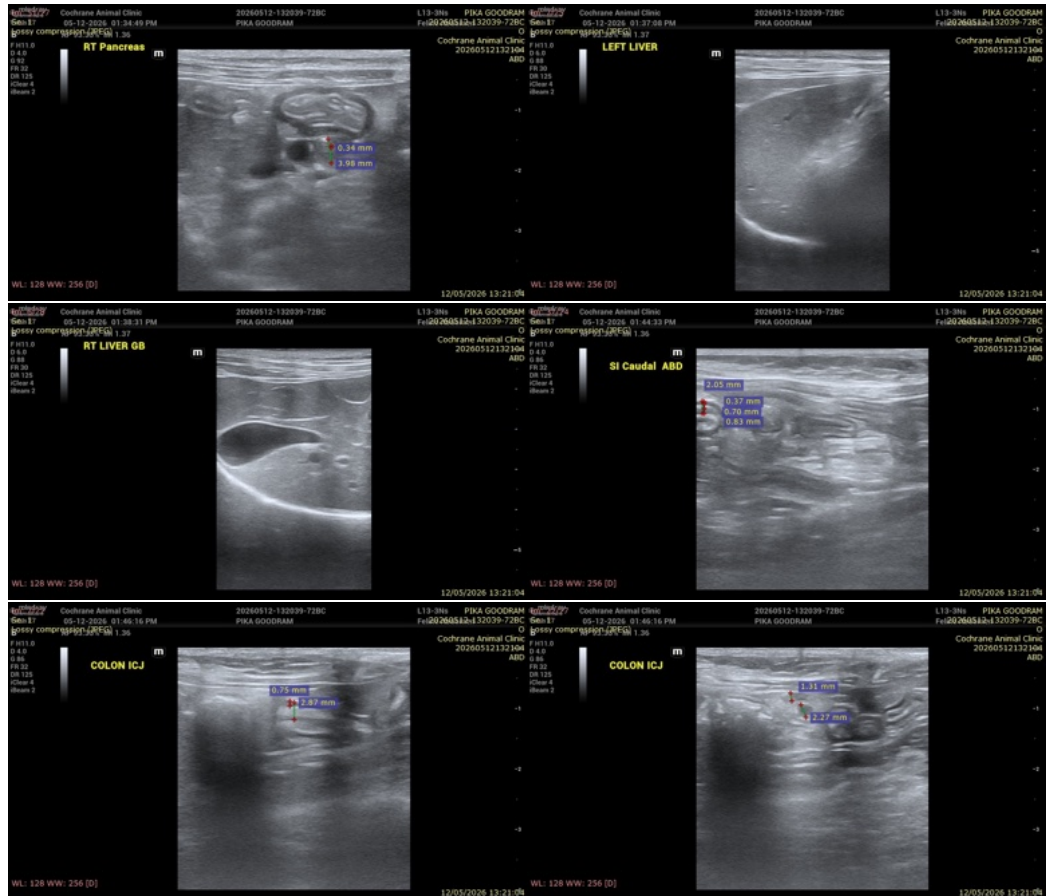
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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