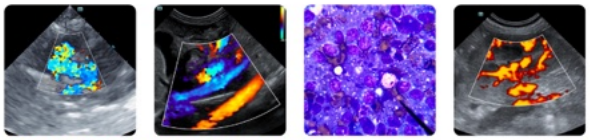




**PATIENT**

Giselle Hack

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Spayed female

**AGE**

11 years

**WEIGHT**

13.08 lbs

**INTERPRETED BY**

Alicia Angosto Guerrero, DMV, PgDip, MSc.

**IMAGING PERFORMED BY**

Kristi Whitten

**HOSPITAL NAME**

North Fork VC

**REFERRING VET**

Dr. Katherine Jordan

**INVOICE**

75506

**DATE**

5/13/26

## PRESENTING CLINICAL SIGNS

History: P presented 2 weeks ago for frank blood with green discoloration and mucus. Since then, BM have solidified and gone back to a normal color with persistent mild hematochezia present. P is acting normal with normal appetite. She has a history of vomiting that O has attributed to rapid food consumption. P was seen in January 2026 for urinary incontinence. A UA was performed which was normal and incontinence improved better without medications. She was seen in Nov 2024 for URI and developed vasculitis on ear tips after steroid/Baytril/b12 injection given which is stable. Indoor only. P currently eating Hill's i/d.
Abnormal PE/Chem/CBC/UA Results: On PE, P BARH. BCS 6.5/9. DS 3-4/4. Numerous FORLs. Missing many teeth, severe gingivitis. Mild NS OU. Mild congestion in nasal cavity, no discharge noted. OU clear. H and L auscult WNL. Non painful. abdomen. Large semi soft, non painful urinary bladder. Amb x 4 with decreased PL muscling. Joints palpate WNL. Senior screen with UPC on 4/30/26: CBC: basophilia 225/ul. CHEM: Mild hyponatremia, rest WNL. UPC: 0.1 UA: WNL, T4 WNL Abdominal radiographs submitted with telemed consultation 4/30/26: Assessment attached

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The bladder lumen is mildly underdistended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. The bladder neck, trigone region, and proximal urethra are unremarkable. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.57×2.18 cm, and the thickness of the cortex is 0.36 cm, in the sagittal plane. The cortex is isoechoic compared to liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Doppler color demonstrates a normal vascular pattern.

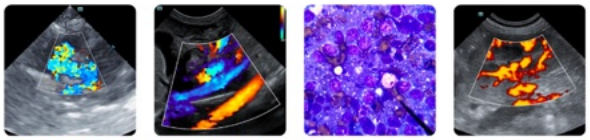
The right kidney is normal in shape and size: 4.08×2.26 cm, and the thickness of the cortex is 0.40 cm, in the sagittal plane. The cortex is isoechoic compared to liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Doppler color 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 0.34 cm. The right adrenal gland measures 0.28 cm.

### *Spleen*

Splenic thickness is 0.90 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.





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### *Liver*

The liver is subjectively normal in size, with sharp edges and a regular contour. The hepatic parenchyma appears uniform and isoechoic relative 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 with a small amount of biliary sludge. 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 1.44 mm and preserved wall layering. The pylorus measures 2.38 mm. The duodenum measures 1.73-2.07 mm. The jejunum measures 2.11 mm, with mucosa measuring 0.46 mm, submucosa 0.39 mm, and muscularis propria 0.95 mm. Wall layering is preserved. The muscularis-to-mucosa ratio is approximately 2.07. The ileum measures 2.42 mm, with mucosa measuring 0.78 mm, submucosa 0.68 mm, and muscularis propria 0.92 mm. Wall layering is preserved. The muscularis-to-mucosa ratio is approximately 1.18. The ileocolic junction is not visualized. The colon measures 0.79 mm, with soft fecal material present within the descending segment.

### *Pancreas*

The evaluated pancreatic regions do not demonstrate evidence of overt pancreatitis or focal pancreatic mass lesion.

### *Free Abdomen*

No abdominal effusion or evidence of peritonitis is observed. The cranial mesenteric lymph nodes are not confidently visualized; however, the surrounding mesentery appears unremarkable. The ileocolic lymph nodes measure 2.93 mm and maintain normal morphology and echogenicity. The pancreaticoduodenal lymph node measures 2.03 mm and appears within normal limits. The iliac trifurcation is normal.

## PRIMARY FINDINGS

- Diffuse muscularis propria thickening involving the jejunum and ileum with preserved wall layering.

## SECONDARY FINDINGS

- Mild biliary sludge.

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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The primary abnormality identified on this study is the diffuse muscularis propria thickening involving both the jejunum and ileum, resulting in markedly increased muscularis-to-mucosa ratios, while overall wall layering remains preserved. In cats, this pattern is most commonly associated with chronic inflammatory enteropathy and/or low-grade alimentary lymphoma, and reliable ultrasonographic differentiation between these entities is not possible.

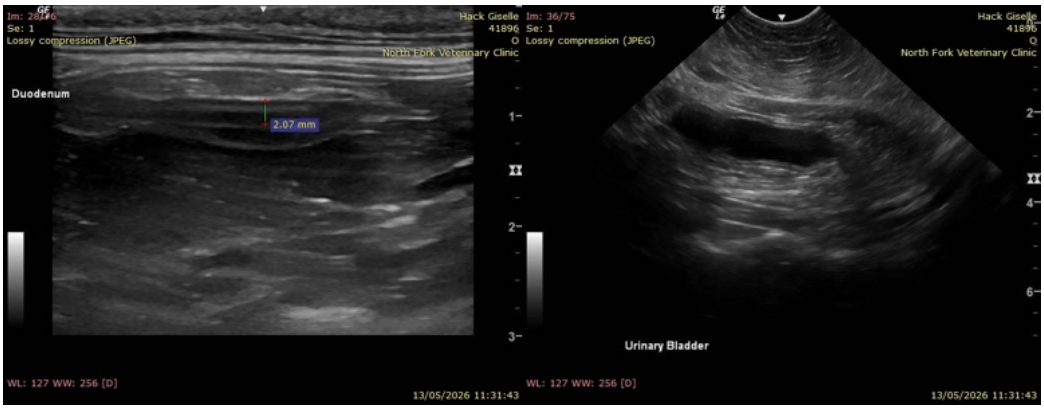
The thickness of the intestinal wall and the lack of significant ileocolic or cranial mesenteric lymph node abnormalities slightly favor a more chronic low-grade inflammatory process; however, low-grade lymphoma cannot be completely excluded based on ultrasound alone.

The reported hematochezia and mucus may reflect mild colonic inflammation despite the relatively unremarkable sonographic appearance of the colon, as mucosal inflammatory disease can be poorly characterized ultrasonographically in cats.

Recommendations

- Correlation with fecal testing, cobalamin/folate, and GI laboratory evaluation is recommended if not already performed.
- Medical management for chronic enteropathy may be reasonable initially depending on clinical progression and owner goals.
- If gastrointestinal signs persist, recur, or progressive weight loss develops, intestinal biopsy should be considered for a definitive diagnosis.
- Follow-up abdominal ultrasound may be beneficial to monitor progression of the intestinal muscularis thickening over time.

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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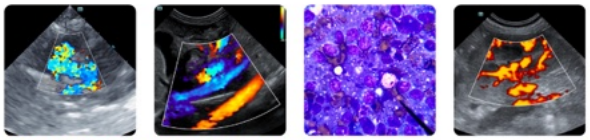

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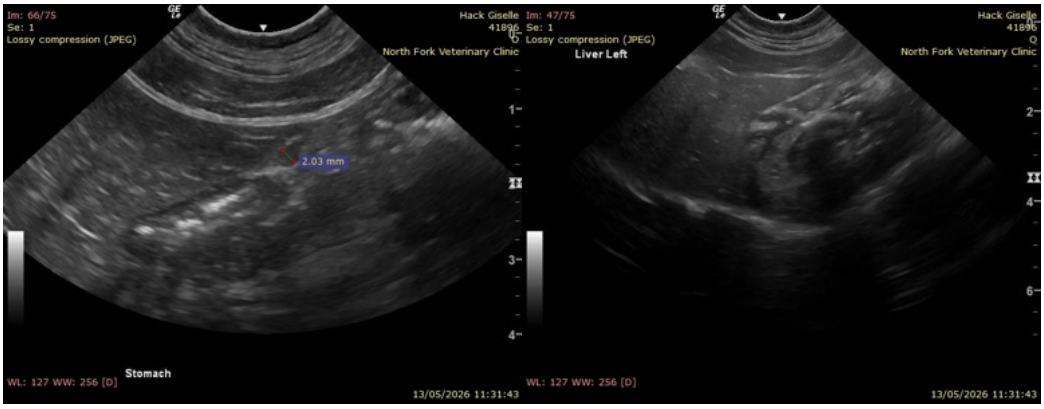


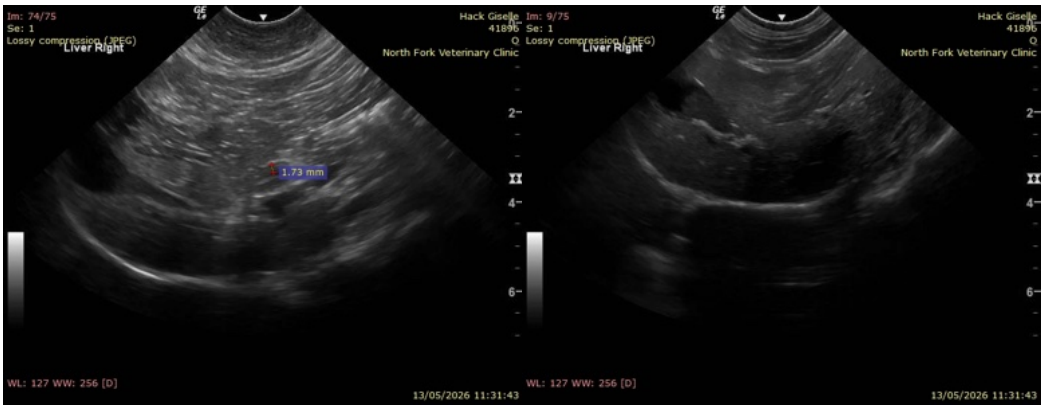


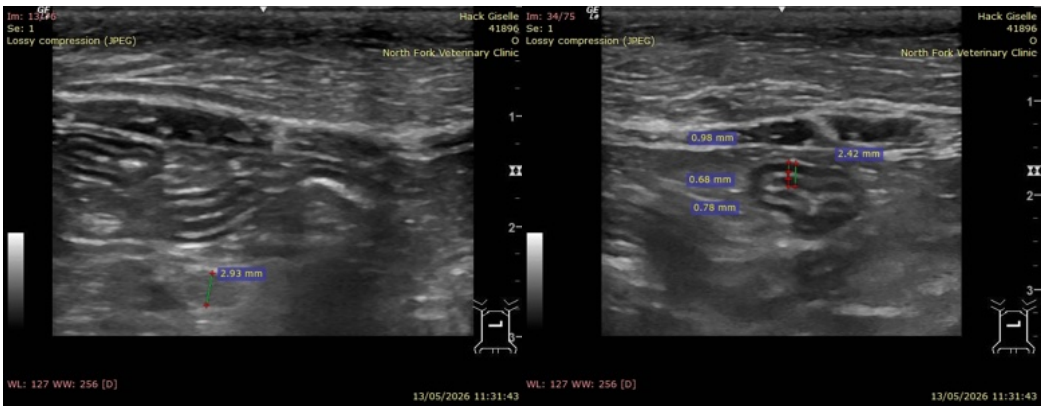

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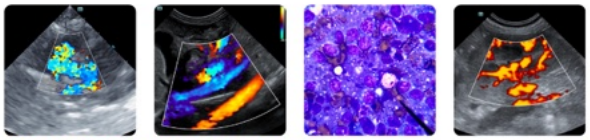

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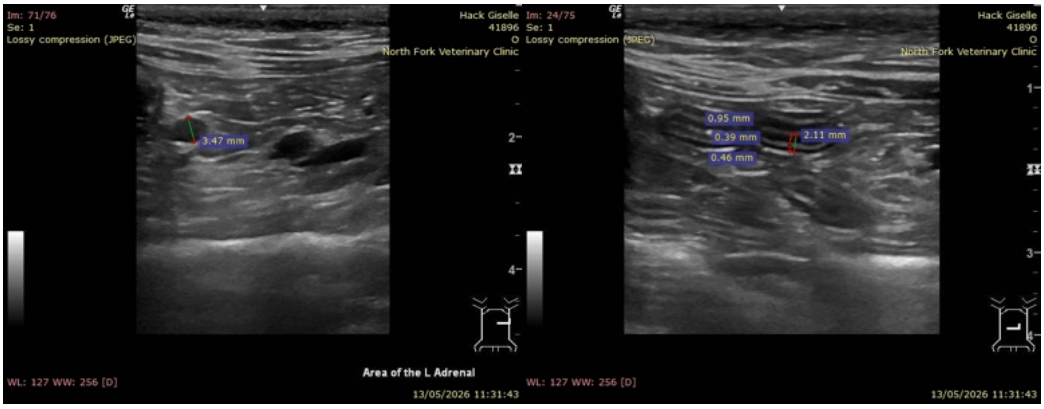


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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