



PATIENT

Ollie Grasse

SPECIES

Feline

BREED

Domestic Longhair

SEX

Neutered male

AGE

6 years

WEIGHT

9 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Joan Kula Gramazio

HOSPITAL NAME

Narrowsburg
Veterinary

REFERRING VET

Joan Kula Gramazio

INVOICE

75481

DATE

5/13/26

PRESENTING CLINICAL SIGNS

History: Losing weight and skinny, vomiting multiple times a day, decreased appetite, sometimes vomits food or bile, becoming more aggressive and angry with other cats in the house hold, pain noted around the stomach area, Has been fasted for >12 hours and didnt eat until the morning before but did vomit, no food given before ultrasound appt, no response to steroids, testing for EPI was negative, no response to cerenia, worried for neoplasia of the stomach. No response to prescription diet such as HA or Z/D O has tried many from another hospital. Previous ultrasound at another hosp in 2024 showed possible IBD or lymphoma

Abnormal PE/Chem/CBC/UA Results: WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The 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. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.42×2.13 cm, and the thickness of the cortex is 0.35 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 shows a normal vascular pattern.

The right kidney is normal in shape and size: 3.49×2.11 cm, and the thickness of the cortex is 0.32 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 shows a normal vascular pattern.

Adrenal Glands

The left adrenal gland measures 0.31 cm. The right adrenal gland is not confidently visualized.

Spleen

Splenic thickness is 0.58 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 Tract

The stomach is moderately distended with luminal ingesta, with mural thickness measuring 1.28 mm and preserved wall layering. The pylorus measures 3.61 mm. The duodenum measures 1.92 mm. The jejunum measures 2.71 mm, with mucosa measuring 1.51 mm, submucosa 0.73 mm, and muscularis propria 0.65 mm. Wall layering is preserved. The muscularis-to-mucosa ratio is approximately 0.43. The ileum measures 2.99 mm, with mucosa measuring 1.13 mm, submucosa 0.60 mm, and muscularis propria 0.83 mm. Wall layering is preserved. The muscularis-to-mucosa ratio is approximately 0.73. The ileocolic junction is not confidently visualized. No evidence of obstructive gastrointestinal pattern, ileus, or foreign material is identified. The colon measures 0.86 mm, with formed fecal material 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

- Mild ileal muscularis prominence with mildly increased ileal muscularis-to-mucosa ratio

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This study is largely unremarkable ultrasonographically. Mild prominence of the ileal muscularis layer with a mildly increased ileal muscularis-to-mucosa ratio may reflect mild chronic inflammatory enteropathy; however, these changes are subtle and nonspecific, and preserved wall layering is maintained throughout the evaluated gastrointestinal tract.

No focal gastric mass, gastric wall thickening, obstructive lesion, transmural intestinal abnormality, regional lymphadenopathy, or other convincing ultrasonographic evidence of aggressive gastrointestinal neoplasia is identified at this time.

Importantly, the stomach remains moderately distended with ingesta despite the reported prolonged fasting period, raising concern for delayed gastric emptying.

Given the severity of the clinical signs relative to the relatively mild ultrasonographic findings, pancreatitis, functional gastric emptying disorders, focal inflammatory disease, or early infiltrative/neoplastic gastrointestinal disease not visible on the current study due to the presence of luminal ingesta cannot be excluded. Chronic corticosteroid therapy may also partially suppress or mask subtle inflammatory or infiltrative intestinal disease.



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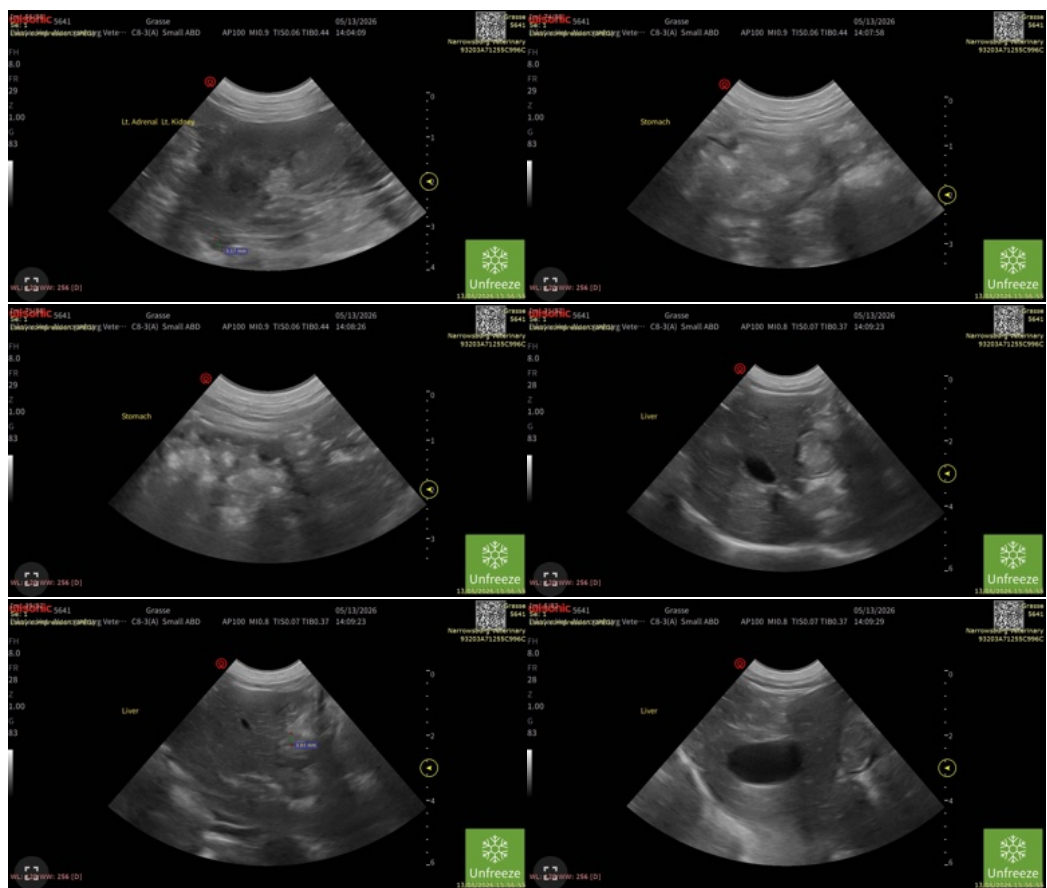
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Recommendations

- Correlation with current GI laboratory testing, including cobalamin/folate and feline pancreatic lipase if not recently performed, is recommended.
- If pancreatic lipase testing is negative and clinical signs persist, gastroscopy with gastric and proximal small intestinal biopsies is strongly recommended if clinically feasible. Careful fasting prior to the procedure is advised to ensure the stomach is completely empty for optimal evaluation of the gastric wall and mucosa.

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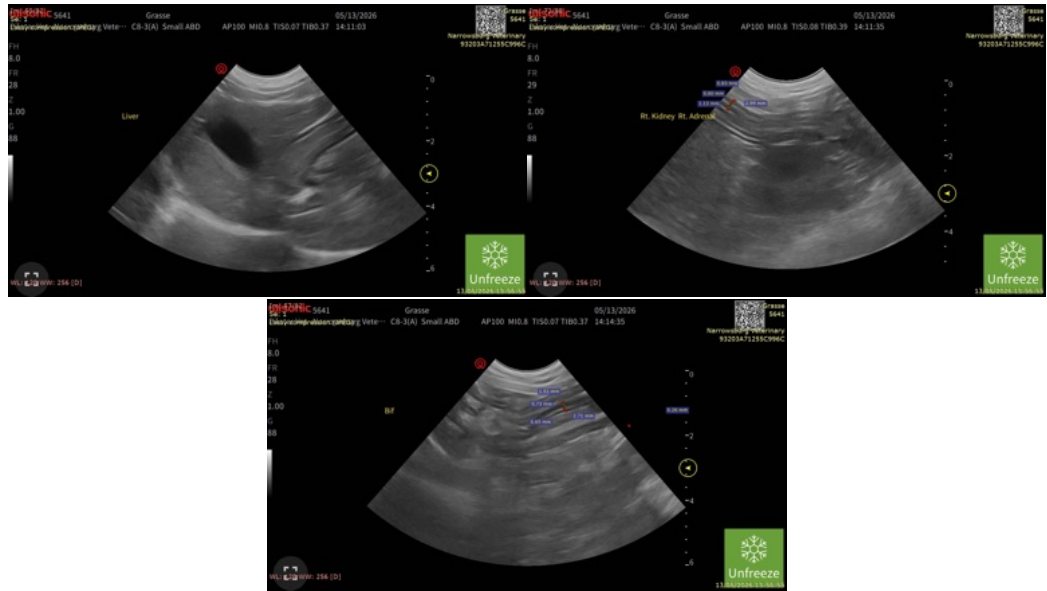
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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