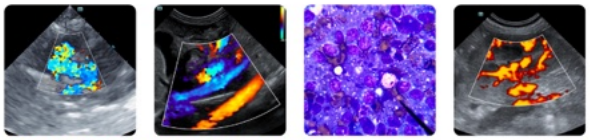


PATIENT

Tinker Bartruff

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

14 years

WEIGHT

7.24 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Jocelyn Smith, CVT

HOSPITAL NAME

Annville Cleona Veterinary Associates

REFERRING VET

Alexandra Pinamonti

INVOICE

75480

DATE

5/13/26

PRESENTING CLINICAL SIGNS

History of IBD- no current vomiting, diarrhea, weight loss. Heaving/retching a few times a month but not producing anything? Weight has been stable since 3/2024 but this weight is down from 3/2023 where at that time she was 10.5 pounds. Currently she is 7.24 pounds. BCS is 3.5-4/9. On prednisolone 5mg -1/2 tablet EOD. Also on ursodiol 1-2 times monthly- cholangitis suspect in 3/2024. This was prompted by an internal medicine consult with the lab- results were High: Glob 5.8, ALT 122, Low: alb 2.4, Na 138, lymphocytes 756 (have been lower in the past), Rest: 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: 3.34×2.20 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 shows a normal vascular pattern.

The right kidney is normal in shape and size: 3.71×2.13 cm, and the thickness of the cortex is 0.34 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

Not confidently visualized.

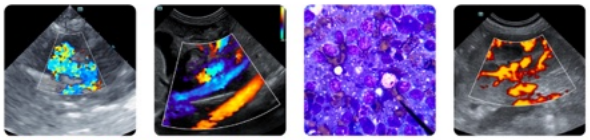
Spleen

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 to mildly decreased in size, with mildly irregular margins. The hepatic parenchyma appears coarse and mildly heterogeneous, although overall isoechoic relative to the falciform fat. No focal hepatic lesions are identified. No hepatic lymphadenopathy is observed.

The gallbladder lumen is moderately distended. The wall is thin and smooth, and the contents are primarily anechoic. No convincing dilation of the cystic duct or common bile duct is identified. The common bile duct measures 5.31-4.91-2.86 mm.



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Gastrointestinal Tract

The stomach is empty and folded, with mural thickness measuring 2.50 mm and preserved wall layering. The pylorus measures 3.11 mm. The duodenum measures 2.50 mm. The major duodenal papilla measures 2.17×3.26 mm. Jejunal wall thickness measures 2.90-3.07 mm, with mucosa measuring 1.23 mm, submucosa 0.75 mm, and muscularis propria 0.71 mm. Wall layering is preserved. The muscularis-to-mucosa ratio is approximately 0.58. The ileum measures 2.26 mm, with mucosa measuring 0.62 mm, submucosa 0.81 mm, and muscularis propria 0.50 mm. Wall layering is preserved. The muscularis-to-mucosa ratio is approximately 0.81. The ileocolic junction measures 2.48 mm, with focal muscularis propria thickening measuring 1.03 mm. Wall layering remains preserved. No evidence of mechanical ileus or gastrointestinal foreign material is identified. The ascending colon measures 1.69 mm. A segment of the transverse colon measures up to 4.67 mm. The descending colon measures 1.25 mm. Colonic contents are scant and semiliquid.

Pancreas

The pancreas measures 8.51-9.50 mm in thickness and demonstrates an irregular contour. Pancreatic parenchyma is diffusely hypoechoic relative to the adjacent mesenteric fat. The pancreatic duct is diffusely dilated, measuring 2.33-2.93 mm, with echogenic intraluminal sediment/mineralized debris present within the duct lumen. No convincing hyperechogenicity of the surrounding peripancreatic fat is identified.

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 3.63-4.84 mm and are mildly rounded, with mild hyperechogenicity of the surrounding perinodal fat. The iliac trifurcation region appears normal.

PRIMARY FINDINGS

- Subjectively mildly small liver with coarse heterogeneous echotexture and mildly irregular margins
- Mild diffuse pancreatic enlargement with irregular contour and marked pancreatic duct dilation containing echogenic intraluminal debris.
- Mild muscularis propria prominence at the ileocolic junction
- Mildly rounded ileocolic lymph nodes with subtle surrounding hyperechoic perinodal fat
- Focal segmental transverse colonic wall thickening.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The predominant abnormality in this study is chronic pancreatic disease, characterized by diffuse pancreatic enlargement, irregular contour, marked pancreatic duct dilation, and multifocal echogenic intraductal mineralized debris/suspected small pancreatoliths. In a cat of this age, this appearance is most consistent with chronic pancreatitis and chronic pancreatic ductal remodeling/fibrosing change. The diffuse ductal dilation and intraductal mineralized material likely reflect longstanding inflammatory

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disease with partial obstructive change.

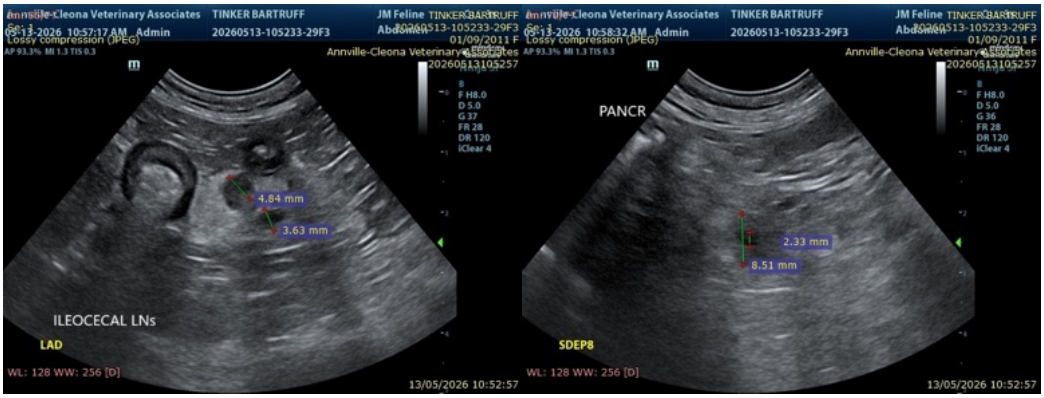
Mild-to-moderate extrahepatic biliary ductal dilation is also present and likely reflects chronic pancreatobiliary inflammatory disease with possible partial or intermittent biliary outflow obstruction secondary to the marked pancreatic and ductal abnormalities. No convincing choledocholiths are clearly identified ultrasonographically, although small non-shadowing calculi or partially obstructive mineralized material cannot be completely excluded. No ultrasonographic evidence of complete extrahepatic biliary obstruction is identified at this time. The hepatic changes are nonspecific but compatible with chronic hepatopathy/cholangitis-related remodeling.

The gastrointestinal abnormalities are comparatively mild overall and include subtle muscularis prominence involving the ileocolic region, mildly increased muscularis-to-mucosa ratios, focal transverse colonic wall thickening, mildly reactive ileocolic lymph nodes, and mild regional perinodal fat hyperechogenicity. In the appropriate clinical context, these findings may support chronic inflammatory enteropathy/triaditis-spectrum disease. There is no convincing ultrasonographic evidence of aggressive infiltrative intestinal neoplasia at this time. However, ultrasound alone cannot reliably differentiate chronic inflammatory enteropathy from low-grade alimentary lymphoma in cats, particularly when wall layering is preserved and changes are subtle. Chronic corticosteroid therapy may also partially suppress or mask the ultrasonographic manifestations of low-grade lymphoma.

Recommendations

- Correlation with current CBC, chemistry profile, bilirubin, cobalamin, and feline pancreatic lipase testing is recommended if not recently performed.
- Given the persistent chronic inflammatory ultrasonographic changes involving the pancreas, hepatobiliary system, and gastrointestinal tract despite current low-dose alternate-day prednisolone therapy, reassessment of anti-inflammatory management may be reasonable based on clinical signs, body weight trends, and laboratory monitoring.
- Continued ursodiol therapy may be beneficial given the chronic pancreatobiliary/hepatobiliary changes and mild extrahepatic biliary dilation.
- Intestinal biopsy should be considered to further differentiate chronic inflammatory enteropathy from low-grade alimentary lymphoma.
- Follow-up abdominal ultrasound.

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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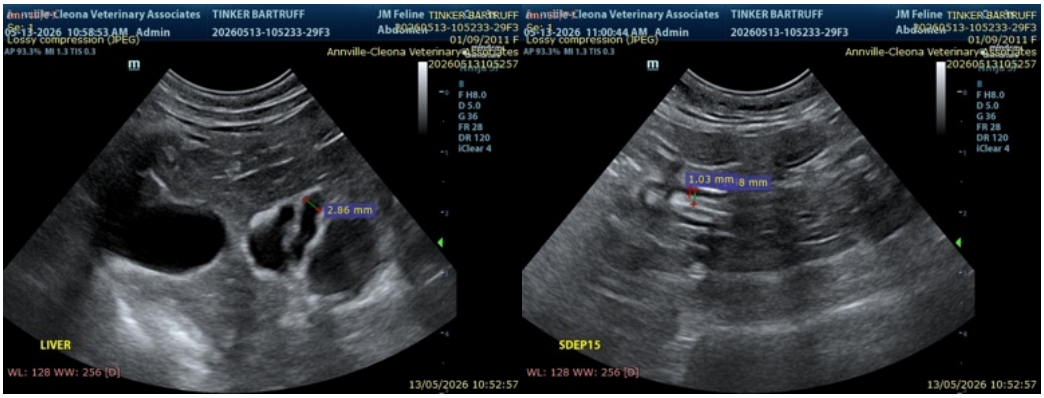

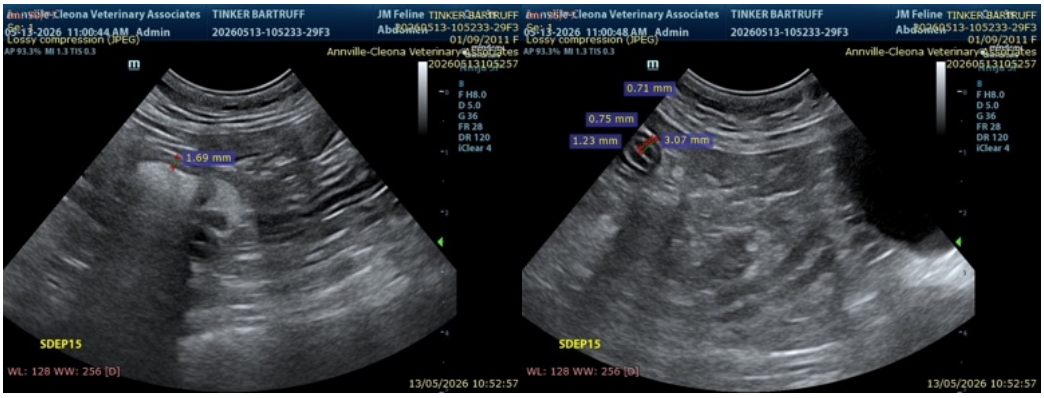

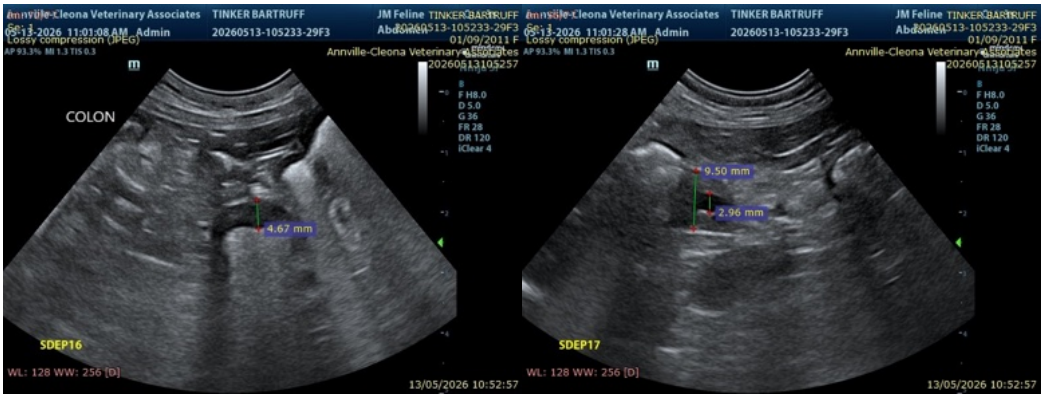

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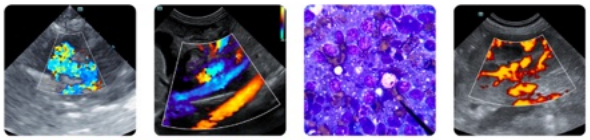

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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