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FOSTERING THE ART OF VETERINARY MEDICINE™

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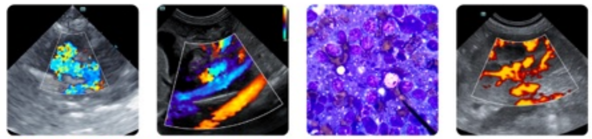


Clinical Sonography & Telecytology

Educational Teleconsultation Services™

PATIENT

Coral C2220 AID

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed Female

AGE

10 years

WEIGHT

6 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Pamela Bay

HOSPITAL NAME

For Cats Only VC

REFERRING VET

Dr. Pamela Bay

INVOICE

75538

DATE

5/14/26

PRESENTING CLINICAL SIGNS

History: * Weight loss, Low USG

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. 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: 2.97×1.95 cm, and the thickness of the cortex is 0.26 cm in the sagittal plane. The right kidney is normal in shape and size: 3.25×1.82 cm, and the thickness of the cortex is 0.30 cm in the sagittal plane. Both kidneys demonstrate cortical echogenicity similar to the hepatic parenchyma, with multiple small hyperechoic mineral foci scattered throughout the renal parenchyma. The corticomedullary ratio is preserved, although corticomedullary definition is mildly decreased. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

Not confidently visualized.

Spleen

Splenic thickness is 0.69 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

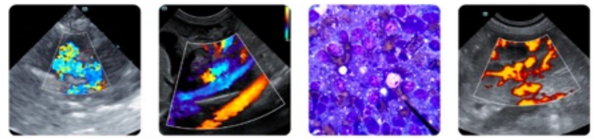
Liver

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 0.75 mm and the contents are primarily anechoic No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal Tract

The is distended with ingesta and demonstrates preserved wall layering with normal mural thickness (1.23 mm). The duodenum measures 1.92 mm. he jejunum measures 2.63 mm (mucosa 1.41 mm, submucosa 0.68 mm, muscularis propria 0.40 mm). The ileum measures 2.13 mm (mucosa 0.42 mm, submucosa 0.71 mm, muscularis propria 0.65 mm). The ileocecocolic junction measures 2.91 mm, with muscularis thickness measuring 0.91 mm. Wall layering is preserved throughout the evaluated



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intestinal tract. No ultrasonographic evidence of focal gastrointestinal inflammation, mechanical ileus, or foreign material is identified. The colon measures 0.89–0.97 mm in thickness and contains mildly soft fecal material.

Pancreas

The pancreas measures 6.18 mm in thickness. The pancreatic parenchyma is isoechoic relative to the adjacent mesenteric fat. The pancreatic duct measures 1.25 mm in diameter.

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Mild diffuse muscularis thickening of the ileum and ileocecocolic junction
- Subtle pancreatic enlargement with mildly dilated pancreatic duct

SECONDARY FINDINGS

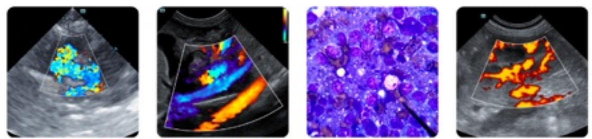
- Mild diffuse reduction in corticomedullary definition with multifocal renal mineralization

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The kidneys demonstrate mild chronic degenerative changes, including mildly reduced corticomedullary definition and multifocal parenchymal mineralization. In the context of low urine specific gravity, these findings are compatible with early chronic kidney disease or chronic tubulointerstitial renal change, although no advanced chronic renal architectural distortion is identified.

Mild diffuse muscularis thickening is present within the ileum and ileocecocolic junction while preserving normal wall layering. The ileal muscularis-to-mucosa ratio is mildly increased (approximately 1.5), and the ileocecocolic junction muscularis is also mildly thickened relative to expected reference proportions. This pattern is nonspecific but compatible with chronic enteropathy. In cats, mild muscularis thickening with preserved layering may be seen with inflammatory bowel disease/chronic enteropathy as well as low-grade intestinal lymphoma. However, given the relatively mild changes, preserved mural architecture, absence of regional lymphadenopathy, and lack of more overt infiltrative features, the current ultrasonographic appearance is considered more supportive of mild or early inflammatory enteropathy, although ultrasound alone cannot completely exclude early low-grade lymphoma.

The pancreas is mildly enlarged, and the pancreatic duct is mildly dilated. Mild chronic pancreatitis and/or age-related pancreatic change are considered most likely. It should be noted that feline pancreatitis may occur without marked peripancreatic fat inflammation or dramatic ultrasonographic abnormalities.



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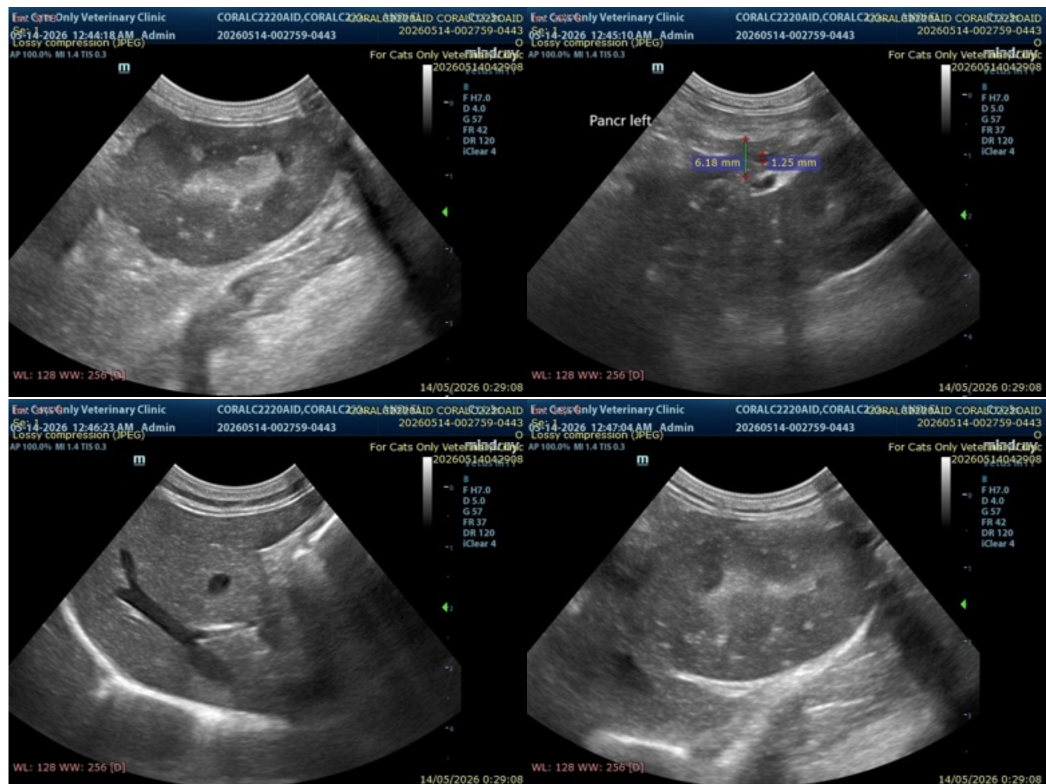
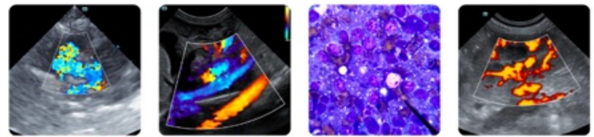
Taken together, the mild intestinal and pancreatic findings could fit within a chronic feline enteropathy/pancreatitis spectrum (“triaditis-type” overlap), although the current changes remain relatively mild and nonspecific.

Recommendations

- Correlation with renal values, SDMA (if available), blood pressure, UPC ratio, and serial urine specific gravity measurements is recommended given the mild chronic renal changes and history of low USG.
- Correlation with serum T4 (if not already performed recently) is recommended in the context of weight loss and low urine concentrating ability.
- If gastrointestinal signs, weight loss, or appetite abnormalities persist or progress, further evaluation for chronic enteropathy should be considered. This may include GI laboratory testing (cobalamin/folate if not already performed) and eventual intestinal biopsy if clinically warranted.
- Clinical monitoring and conservative management for possible chronic low-grade pancreatitis may be considered as clinically indicated.
- Follow-up abdominal ultrasound may be useful if clinical signs progress or if there is worsening weight loss.

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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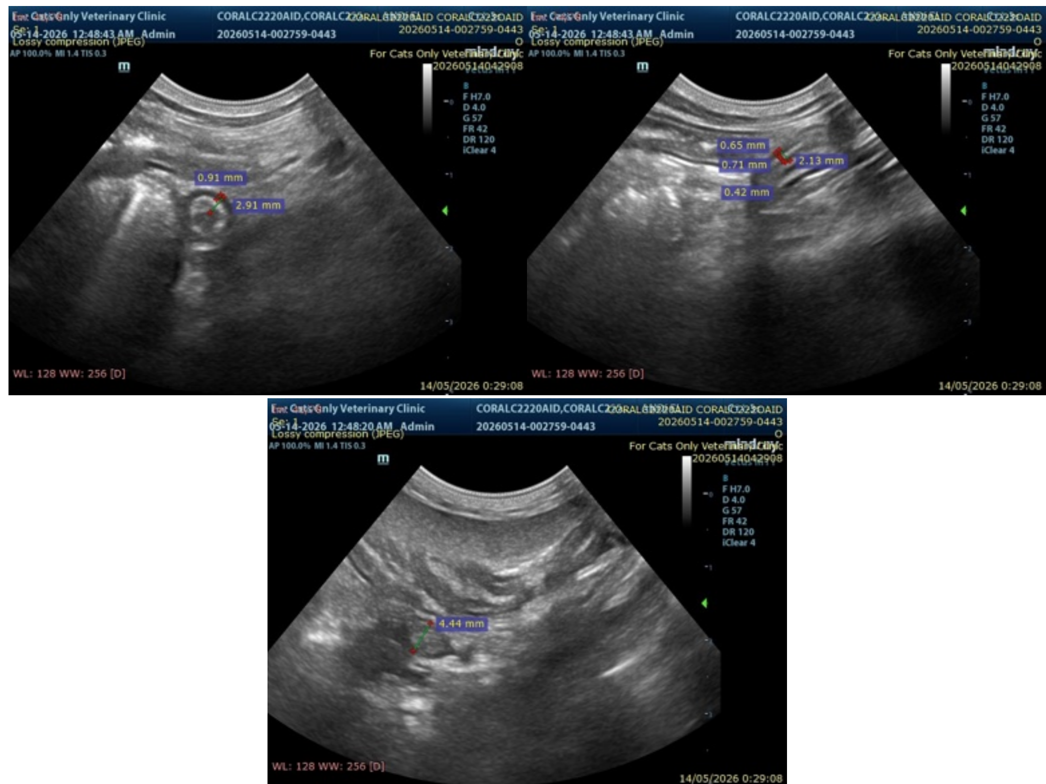

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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