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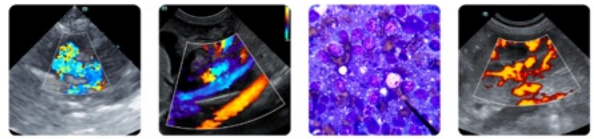


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT
Nemo Lane

SPECIES
Feline

BREED
Domestic Shorthair Siamese Mix

SEX
Neutered male

AGE
6 ½ years

WEIGHT
8.1 lbs

INTERPRETED BY
Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY
Chrissy Krell, DVM

HOSPITAL NAME
Taylor Veterinary Emergency Hospital

REFERRING VET
Dr. Rivers

INVOICE
75566

DATE
5/14/26

PRESENTING CLINICAL SIGNS

History: Vomiting and unable to keep any food down. Off and on symptoms for a couple of weeks. Usually lasts a couple days, but has been every day lately. Diarrhea started about the same time. Drinking well, eating but less/slower than usual. Lost some weight this year. Has been on Royal Canin Sensitive Stomach for about a year, was doing well. Has been on Alprazolam 0.25mg/kg for anxiety, this was discontinued recently (after the diarrhea started as thought could be the cause). He was seen about a month ago for diarrhea, trial of antibiotics but there was no notable improvement.
Presented yesterday on emergency with mild muscle atrophy, mildly dehydrated, noted a murmur, and had moderate dental calculus.
DDX:
- GI disease: enteropathy enteropathy (IBD, lymphoma, other) vs renal vs hyperthyroidism vs hepatic vs other.
- Heart murmur: physiologic vs HCM vs other
Abnormal PE/Chem/CBC/UA Results: PE: BCS 4/9, muscle atrophy/loss, ropey intestines, mild heart murmur (not ausculted this morning on PE). LABS: -CBC: WBC * 23.65 2.87 - 17.02 K/µL H, Neutrophils * 78.8 %, Lymphocytes * 16.9 %, Monocytes * 2.1 %, Neutrophils * 18.63 2.30 - 10.29 K/µL H. -Chem: Phosphorus 2.7 3.1 - 7.5 mg/dL -URINALYSIS - IH: USG >1.050, pH 7, prot 100, blood/Hgb 25, bili 1, urobili 1, WBC 1/hpf, RBC 2/hpf, XR Consult: Mixed opaque granular material within the stomach commonly represents ingesta; a combination with foreign material is also possible. No evidence of intestinal obstruction is identified on the images provided. Alternatively, consider gastroenteritis/enterocolitis (dietary indiscretion, infection, toxin) or pancreatitis for the reported clinical signs Unremarkable thorax.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

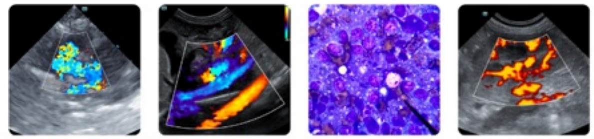
The urinary bladder lumen is moderately distended, and the wall of the urinary bladder appears thin and smooth. The urine is turbid with abundant suspended echoes. The bladder neck and proximal urethra appear normal. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.96×2.22 cm, and the thickness of the cortex is 0.39 cm in the sagittal plane.
The right kidney is normal in shape and size: 4.41×2.31 cm, and the thickness of the cortex is 0.38 cm in the sagittal plane.

Both kidneys demonstrate cortical echogenicity similar to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

The left adrenal gland measures 0.39 cm at the cranial pole and 0.29 cm at the caudal pole. The right adrenal gland is not confidently visualized.



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Spleen

Splenic thickness is 0.55 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. The common bile duct is 1.88-1.41 mm

Gastrointestinal

The stomach is empty and folded, with preserved wall layering and mural thickness measuring 2.28 mm. The pylorus measures 3.77 mm.

The duodenum measures 3.44 mm, with muscularis propria thickness measuring approximately 1.06 mm.

The jejunum measures 3.27 mm, with the following mural layer measurements: Mucosa: 0.70 mm. Submucosa: 0.65 mm. Muscularis propria: 1.85 mm, focally up to 2.37 mm

The ileum measures 3.56 mm, with the following mural layer measurements: Mucosa: 0.65 mm. Submucosa: 0.62 mm. Muscularis propria: 2.11 mm, focally up to 2.69 mm

Wall layering remains preserved throughout the evaluated intestinal tract. The ileocecocolic junction was not confidently visualized.

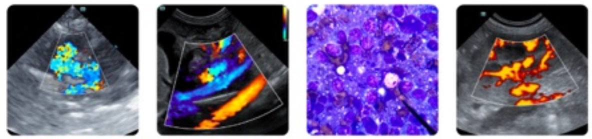
The colon measures approximately 0.75–1.02 mm in thickness and contains formed fecal material within the descending colon.

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.



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ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Marked diffuse muscularis propria thickening affecting the duodenum, jejunum, and ileum with preserved wall layering

SECONDARY FINDINGS

- Urinary sediment/debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The study shows a severe diffuse muscularis propria thickening affecting the small intestinal tract, particularly the jejunum and ileum, while overall mural layering remains preserved. The muscularis-to-mucosa ratios are markedly increased throughout the evaluated bowel. The jejunal muscularis-to-mucosa ratio ranges from approximately 2.6–3.4, and the ileal muscularis-to-mucosa ratio ranges from approximately 3.2–4.1. These values are markedly abnormal for a cat and substantially exceed expected physiologic ratios.

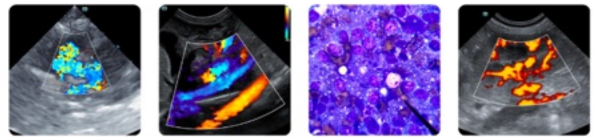
This ultrasonographic pattern is highly supportive of chronic feline enteropathy. Primary differential considerations include severe inflammatory bowel disease/chronic inflammatory enteropathy and low-grade alimentary lymphoma. The degree and diffuse nature of muscularis thickening, combined with the clinical history, raise particularly strong concern for low-grade alimentary lymphoma; however, overlap between severe inflammatory enteropathy and small cell lymphoma remains well recognized ultrasonographically, especially when mural layering is preserved and abdominal lymphadenopathy is absent.

No ultrasonographic evidence of mechanical gastrointestinal obstruction, focal intestinal mass lesion, perforation, diffuse peritonitis, or overt pancreatitis is identified. Mild gastrointestinal dysmotility may still be present functionally despite the absence of obstructive disease.

Recommendations

- If definitive differentiation between severe inflammatory enteropathy and low-grade lymphoma is clinically required, surgical full-thickness intestinal biopsies would likely provide the highest diagnostic yield.
- Correlation with serum cobalamin/folate and feline pancreatic lipase immunoreactivity (fPLI) is recommended if not already performed.
- Empirical therapy for chronic feline enteropathy/alimentary lymphoma spectrum disease may also be clinically reasonable depending on patient stability, owner goals, and response to treatment.
- Repeat abdominal ultrasound may be considered to monitor progression and response to therapy.

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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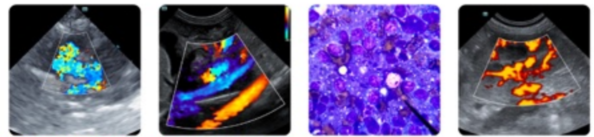

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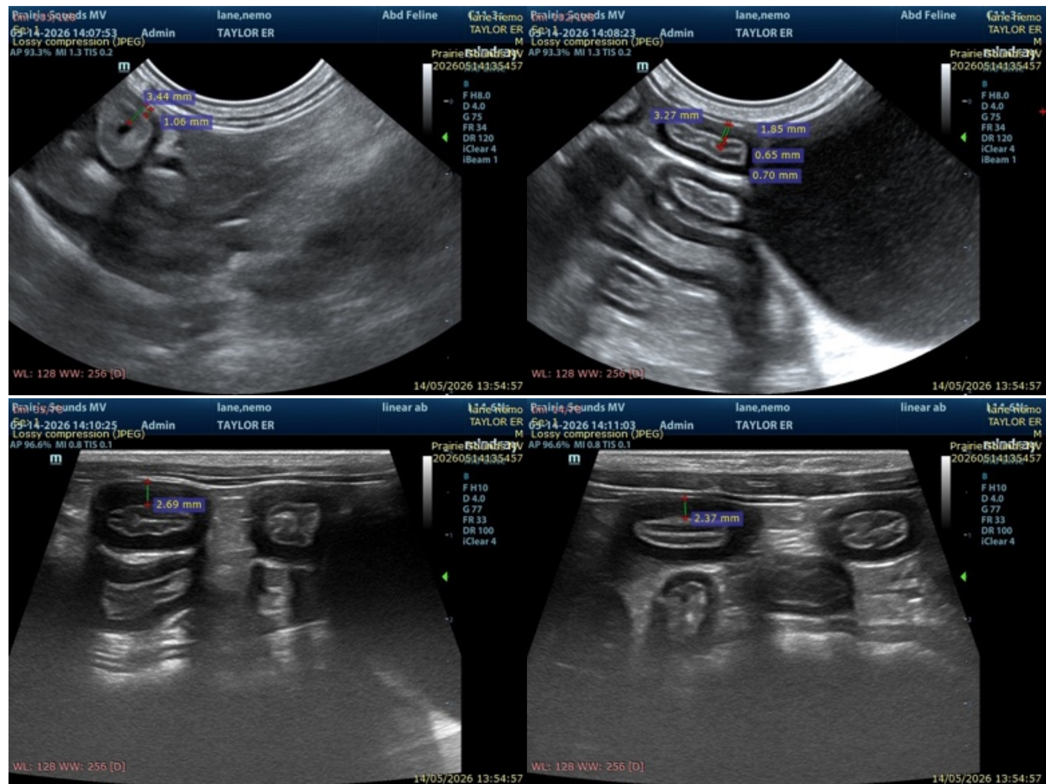

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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