



PATIENT

Sophie Hans Varney

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

16 years

WEIGHT

6 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Alison Cornwall

HOSPITAL NAME

Onion River AH

REFERRING VET

Dr. Amanda Wojtalik
Courter

INVOICE

75593

DATE

5/15/26

PRESENTING CLINICAL SIGNS

History: Vomiting and weight loss, chronic. Slightly elevated BP was treated with amlodipine, cat clinically fared less well on amlodipine so D/C.

Abnormal PE/Chem/CBC/UA Results: Eos elevated 2.774 (0.2-1.2) TP low 5.8 (6.3-8.8) ProBNP NSF, renal values NSF, No anemia. Total t4 3.1, FT4 2.7 (ng/dL) sl elevated (0.7-2.6)

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 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: 3.40×2.22 cm, and the thickness of the cortex is 0.27 cm in the sagittal plane. The cortex is mildly hyperechoic compared to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. Mild pyelectasia measuring approximately 2.94 mm is present. There is no evidence of nephrolithiasis or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

The right kidney is normal in shape and size: 3.40×2.12 cm, and the thickness of the cortex is 0.28 cm in the sagittal plane. The cortex is mildly hyperechoic compared to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. Mild pyelectasia measuring approximately 1.48 mm is present. There is no evidence of nephrolithiasis or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

Not confidently visualized.

Spleen

Splenic thickness is 0.81 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 with a very small amount of biliary sludge. The common bile duct measures approximately 3.25 mm proximally, tapering distally to approximately 1.16 mm.



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Gastrointestinal

The stomach is empty and folded, with preserved wall layering and mural thickness measuring approximately 2.42 mm.

The pylorus measures 3.71 mm. The duodenum measures 2.35 mm.

The jejunum measures 2.53 mm, with the following mural layer measurements:

- Mucosa: 0.94 mm
- Submucosa: 0.65 mm
- Muscularis propria: 1.03 mm

The ileum measures 3.09 mm, with the following mural layer measurements:

- Mucosa: 0.53 mm
- Submucosa: 0.53 mm
- Muscularis propria: 2.08 mm

The ileocecolic junction measures approximately 3.71 mm, with muscularis propria measuring approximately 1.99 mm.

Wall layering remains preserved throughout the evaluated gastrointestinal tract.

The colon measures approximately 0.93 mm in thickness and contains soft fecal material.

Pancreas

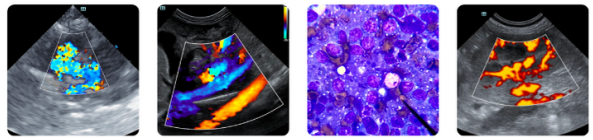
The pancreas measures up to approximately 8.92 mm in thickness. Margins are irregular and the pancreatic parenchyma is mildly hypoechoic relative to the adjacent omental fat. The pancreatic duct measures approximately 2.47 mm in diameter.

Free Abdomen

No abdominal effusion or peritonitis is identified. Cranial mesenteric and ileocecolic lymph nodes measure approximately 3.07–4.28 mm in thickness and maintain normal shape and echogenicity. The iliac trifurcation appears normal.

PRIMARY FINDINGS

- Severe diffuse small intestinal muscularis thickening, particularly affecting the ileum and ileocecolic junction
- Pancreatic enlargement with pancreatic duct dilation



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SECONDARY FINDINGS

- Mild common bile duct prominence
- Mild bilateral renal cortical hyperechogenicity with mild bilateral pyelectasia
- Minimal biliary sludge

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Marked diffuse muscularis propria thickening affects the jejunum, ileum, and ileocecolic junction, with preservation of mural layering. The muscularis-to-mucosa ratios are markedly increased throughout the evaluated intestinal tract, particularly within the ileum and ileocecolic junction. The jejunal muscularis-to-mucosa ratio is approximately 1.1, while the ileal muscularis-to-mucosa ratio approaches approximately 3.9, which is markedly abnormal relative to expected feline reference values. This ultrasonographic pattern is highly supportive of clinically significant chronic feline enteropathy. Differential considerations include severe inflammatory bowel disease/chronic inflammatory enteropathy, eosinophilic enteritis, and low-grade alimentary lymphoma.

The pancreas is enlarged and mildly hypoechoic, with marked pancreatic duct dilation. These findings support chronic pancreatopathy/chronic pancreatitis.

Mild common bile duct prominence may occur secondarily within the spectrum of feline triaditis; no extrahepatic biliary obstruction is not identified at this time.

Mild bilateral renal cortical hyperechogenicity and mild pyelectasia are also present, likely representing mild chronic renal change/chronic kidney disease. No ultrasonographic evidence of obstructive nephropathy is identified.

Overall, the combination of chronic gastrointestinal disease, pancreatic abnormalities, weight loss, vomiting, eosinophilia, and mild biliary changes is considered compatible with chronic feline inflammatory gastrointestinal-pancreatobiliary disease (triaditis spectrum), although low-grade alimentary lymphoma remains an important differential consideration.

Recommendations

- Correlation with serum cobalamin, folate, and feline pancreatic lipase immunoreactivity (fPLI), is recommended.
- Intestinal biopsy would be required for definitive differentiation between inflammatory enteropathy/eosinophilic disease and low-grade alimentary lymphoma if clinically indicated. Given the marked ileal and ileocecolic involvement, full-thickness surgical biopsies would likely provide greater diagnostic yield than upper gastrointestinal endoscopy alone.
- Medical management for chronic enteropathy/chronic pancreatitis may be clinically appropriate while pursuing additional diagnostics, depending on patient stability and owner goals.
- Repeat abdominal ultrasound may be considered to monitor progression and response to therapy.
- Serial monitoring of body weight, appetite, gastrointestinal signs, renal values, and hepatobiliary parameters is recommended.



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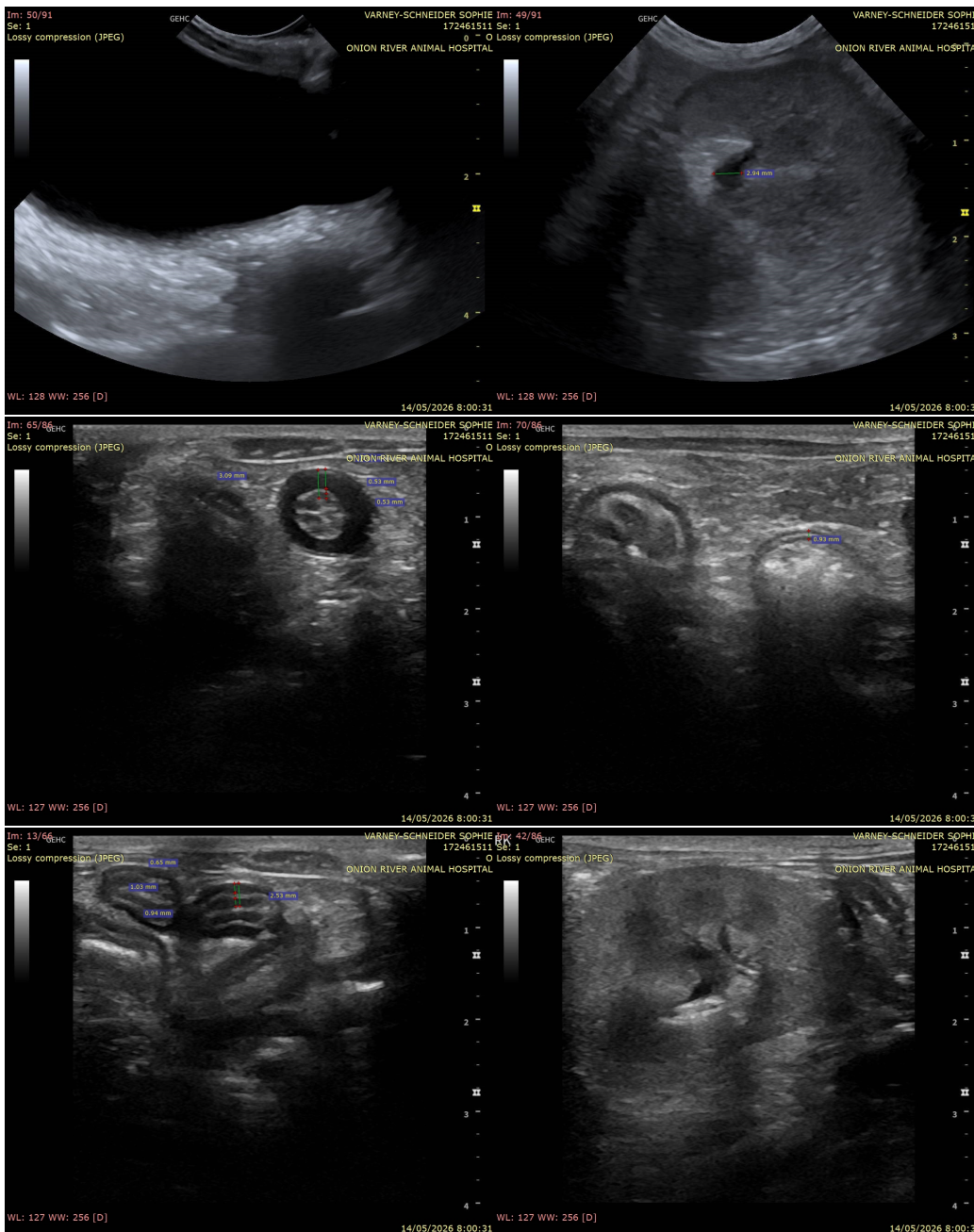
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Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.





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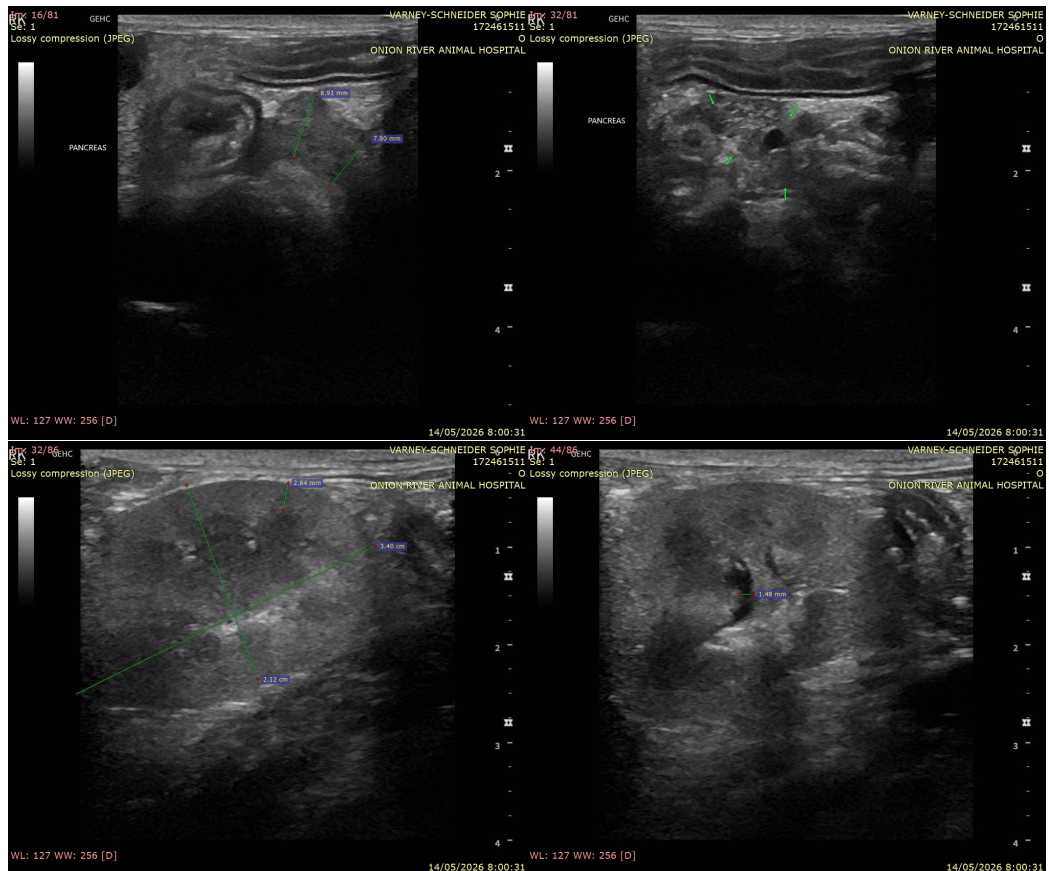
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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