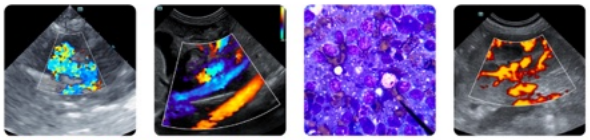


PATIENT

Little Man Ulrick

SPECIES

Feline

BREED

Domestic Longhair

SEX

Neutered male

AGE

3 years

WEIGHT

7.4 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Mark Reser

HOSPITAL NAME

Harvest Hills VH

REFERRING VET

Dr. Sieger

INVOICE

77713

DATE

5/19/26

PRESENTING CLINICAL SIGNS

History: weight loss, vomiting and chronic diarrhea first noted by owners Oct 25, first evaluated in Dec 25 - convenia, profender - no improvement per O
Sent GI panel at eval in Jan 26 - Minimally responsive to metronidazole, B12 supplementation and change to hydrolyzed protein diet starting in Jan 26.
However appetite and frequency of vomiting improved overall with these. Weight did increase while getting b12 injections but pt lost it again over the last 2 months.
Abnormal PE/Chem/CBC/UA Results: cbc/chem in December showed neutrophilic leukocytosis, chem unremarkable gi panel in Jan showed low cobalamin and folate current cbc/chem pending 5/19/26

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: 3.60×1.97 cm, and the thickness of the cortex is 0.34 cm in the sagittal plane. The right kidney is normal in shape and size: 3.84×2.03 cm, and the thickness of the cortex is 0.38 cm in the sagittal plane. The renal cortices are mildly hyperechoic compared to the liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved bilaterally. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

Dorsoventral diameters measured in the sagittal plane: the left adrenal gland measures 0.31 cm at the cranial pole and 0.34 cm at the caudal pole. The right adrenal gland is not confidently visualized.

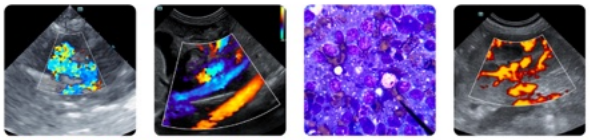
Spleen

Splenic thickness is 0.67 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 hepatic parenchyma is mildly diffusely hypoechoic relative to the falciform fat, with mildly increased conspicuity of the portal venous walls. No focal hepatic lesions are identified. No hepatic lymphadenopathy is observed.

The gallbladder lumen is minimally distended. The gallbladder wall measures 2.08 mm in thickness. The luminal content is scant and predominantly anechoic. No evident dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach is markedly distended with abundant ingesta, with mural thickness measuring 1.27 mm and preserved wall layering. The pylorus measures 3.20 mm in thickness. Duodenum: 2.0 mm. Jejunum: 2.91 mm. Mucosa: 1.94 mm. Submucosa: 0.61 mm. Muscularis propria: 0.20 mm.

The ileum and ileocecocolic junction could not be visualized and adequately evaluated due to the marked amount of intraluminal ingesta throughout the gastrointestinal tract, significantly limiting complete gastrointestinal assessment and accurate mural measurements.

The colon measures 0.72 mm in thickness and contains soft fecal material within the descending segment.

Pancreas

The pancreas measures 6.70 mm in thickness. The pancreatic parenchyma is mildly hypoechoic relative to the adjacent mesenteric fat. The pancreatic duct measures 1.69 mm in diameter. No convincing evidence of active peripancreatic fat inflammation is identified.

Free Abdomen

Small-volume abdominal effusion is present. Cranial mesenteric lymph nodes measure 6.02–7.77 mm, and are mildly hypoechoic and mildly heterogeneous. The ileocecal lymph nodes are not visualized. The region of the iliac trifurcation appears normal.

PRIMARY FINDINGS

- Subtle diffuse hepatic hypoechogenicity with increased conspicuity of portal venous walls.
- Gallbladder wall thickening with minimal luminal distension.
- Mild pancreatic enlargement/hypoechogenicity with pancreatic duct dilation.
- Cranial mesenteric lymphadenopathy/heterogeneity.
- Small-volume abdominal effusion.

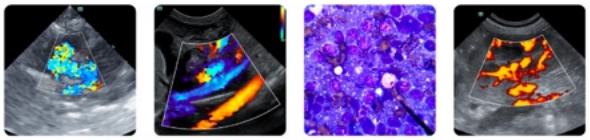
SECONDARY FINDINGS

- Mild bilateral renal cortical hyperechogenicity.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The combination of chronic gastrointestinal clinical signs, previously documented hypocobalaminemia/hypofolatemia, mild cranial mesenteric lymphadenopathy, and subtle pancreatic abnormalities is most compatible with chronic inflammatory enteropathy with concurrent pancreatobiliary involvement (“feline triaditis-type” disease complex).

The jejunal wall measurements obtained during this examination do not demonstrate muscularis propria thickening or loss of mural stratification. The jejunal muscularis-to-mucosa ratio is



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approximately 0.10, which does not support the classic ultrasonographic pattern more commonly associated with feline low-grade alimentary lymphoma. However, the ileum and ileocecocolic junction, which are commonly affected regions in feline small-cell lymphoma and chronic enteropathy, could not be adequately evaluated during this study due to the marked amount of gastrointestinal ingesta. Additionally, there is recognized ultrasonographic overlap between inflammatory enteropathy and early/small-cell lymphoma in cats, and ultrasound alone cannot definitively exclude infiltrative intestinal disease.

The pancreatic changes are mild but could reflect chronic pancreatopathy/chronic pancreatitis, particularly considering the mild pancreatic hypoechogenicity and pancreatic duct dilation. In cats, chronic pancreatic inflammation may occur without marked peripancreatic fat reaction, and mild pancreatic changes may also overlap with chronic or age-related remodeling.

The mild gallbladder wall thickening together with the diffuse hepatic parenchymal changes may represent concurrent hepatobiliary inflammation, such as cholangitis/cholangiohepatitis, with possible mild reactive cholecystitis. Correlation with hepatobiliary enzymes, bilirubin concentration, and current laboratory findings is recommended to further assess the clinical significance of these changes.

The small-volume abdominal effusion and mild cranial mesenteric lymphadenopathy may be seen secondary to chronic inflammatory enteropathy; however, given the chronic clinical signs and the recognized overlap between inflammatory enteropathy and feline low-grade alimentary lymphoma, an infiltrative neoplastic process cannot be completely excluded based on the current examination alone.

The previously documented hypocobalaminemia and hypofolatemia support the presence of chronic diffuse small intestinal disease/malabsorptive enteropathy. Previously reported questionable fPLI elevation also supports the possibility of concurrent chronic pancreatopathy in the context of the current ultrasonographic findings.

Mild renal cortical hyperechogenicity is nonspecific and may represent incidental chronic renal change without evidence of obstructive or advanced structural renal disease.

Recommendations

- Correlation with current CBC, serum biochemistry, and GI panel results is recommended.
- Spec fPL testing may be useful to further assess concurrent pancreatitis/chronic pancreatopathy.
- If clinical concern for infiltrative intestinal disease remains high despite conservative management, intestinal biopsy would ultimately be required for definitive differentiation between chronic inflammatory enteropathy and low-grade alimentary lymphoma.
- In the absence of biopsy, empiric therapeutic management for chronic inflammatory enteropathy, with close clinical and body weight monitoring, may be clinically appropriate given the chronic progressive nature of the disease and the previously documented partial treatment response.
- Follow-up abdominal ultrasound following an adequate fasting period, with improved evaluation of the ileum and ileocecocolic junction, would also be recommended.

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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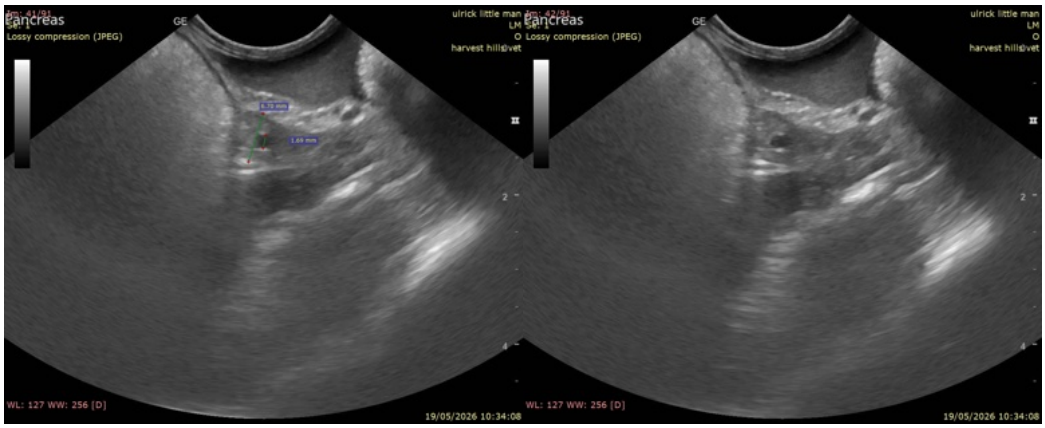

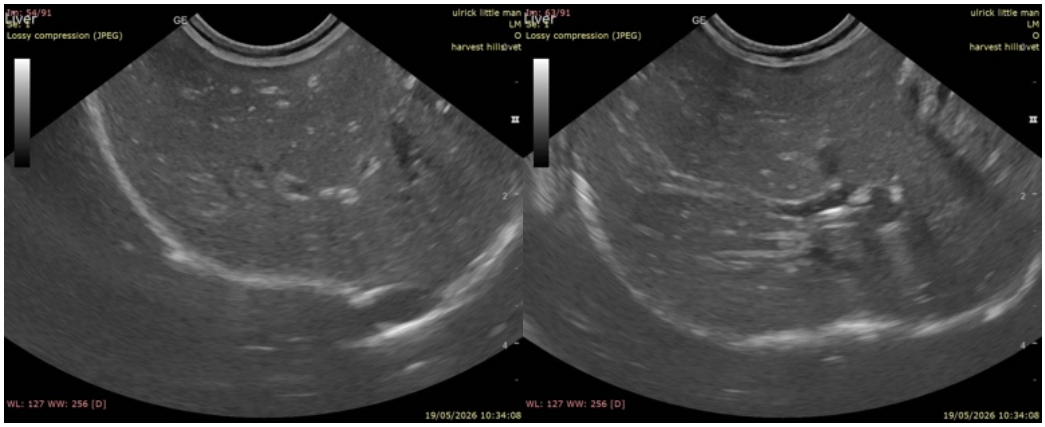

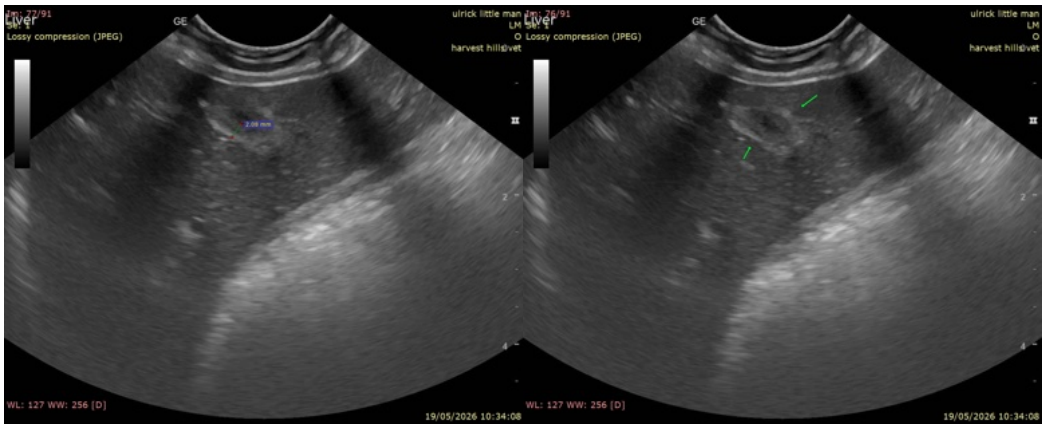

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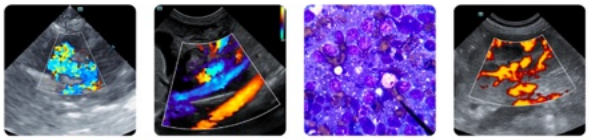

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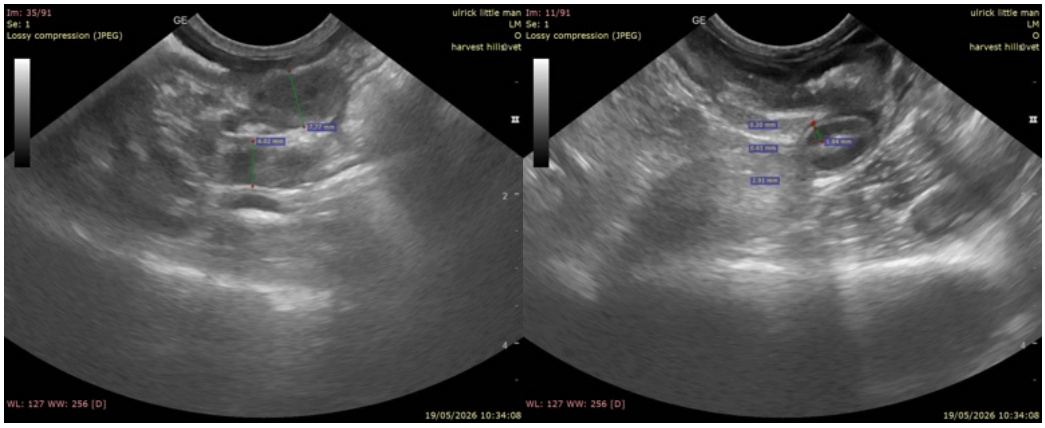

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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