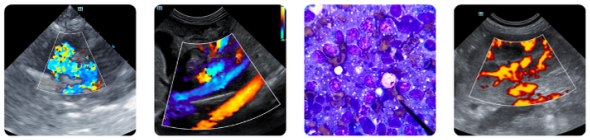


SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

Winnie Ivashin

SPECIES

Feline

BREED

Domestic Longhair

SEX

Spayed female

AGE

17 years

WEIGHT

9 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Melinda Persson

HOSPITAL NAME

At Home Veterinary

REFERRING VET

Dr. Persson

INVOICE

77731

DATE

5/19/26

PRESENTING CLINICAL SIGNS

History: *New mild azotemia
*Weight loss - normal T4
*Inappropriate urination/defecation chronically
*Subtotal colectomy in June 2021 for eosinophilic sclerosing fibroplasia/liver biopsy at the time revealed moderate lymphocytic and eosinophilic cholangiohepatitis with bile duct hyperplasia and hepatocellular vacuolation

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: 3.76×2.01 cm, and the thickness of the cortex is 0.34 cm in the sagittal plane. The right kidney is normal in shape and size: 3.50×1.82 cm, and the thickness of the cortex is 0.29 cm in the sagittal plane. The renal cortices are mildly hyperechoic compared to the liver parenchyma bilaterally. The corticomedullary ratio is normal and corticomedullary definition is preserved. A very mild medullary rim sign is present bilaterally. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Doppler color interrogation demonstrates a normal vascular pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.32 cm at the cranial pole and 0.30 cm at the caudal pole. The right adrenal gland measures 0.35 cm at the cranial pole and 0.31 cm at the caudal pole.

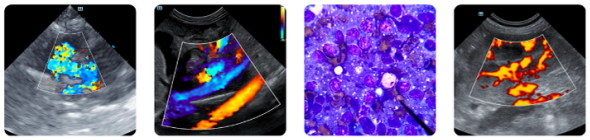
Spleen

Splenic thickness is 0.99 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 appears homogeneous and isoechoic relative to the falciform fat, with normal echotexture. Two mixed hyperechoic multicystic hepatic lesions are identified, measuring approximately 1.38×1.43 cm and 1.20×1.13 cm. No associated biliary obstruction, hepatic contour distortion, or hepatic lymphadenopathy is identified.

The gallbladder lumen is normally distended. The wall is thin and smooth and the contents are predominantly anechoic. No dilation of the cystic duct or common bile duct is identified.



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Gastrointestinal

The stomach is empty and folded, with mural thickness measuring approximately 1.50–1.79 mm and preserved wall layering. The pylorus measures 3.10 mm in thickness. Duodenum: 1.92 mm. Jejunum: 2.53 mm. Mucosa: 0.89 mm. Submucosa: 0.45 mm. Muscularis propria: 1.22 mm. Ileum: 2.13 mm. Mucosa: 0.84 mm. Submucosa: 0.55 mm. Muscularis propria: 0.96 mm. Wall layering remains preserved. The ileocecocolic junction measures 3.58 mm in thickness, with mucosa measuring 1.03 mm and muscularis propria measuring 1.20 mm. No evidence of gastrointestinal obstruction, ileus, or foreign material is identified. The ascending colon measures 0.92 mm and the distal colon measures 1.08 mm in thickness, with a small amount of semiformed fecal material present within the descending segment.

Pancreas

The pancreas measures approximately 5.94 mm in thickness. The pancreatic parenchyma is isoechoic relative to the adjacent mesenteric fat. The pancreatic duct measures 1.45 mm in diameter. No convincing evidence of active peripancreatic fat inflammation is identified.

Free Abdomen

No abdominal effusion or evidence of peritonitis is identified. Cranial mesenteric lymph nodes are not confidently visualized; however, the surrounding mesentery appears unremarkable. Ileocecocolic lymph nodes measure approximately 2.60–3.02 mm, maintain normal shape, and are mildly hypoechoic. The region of the iliac trifurcation appears normal.

PRIMARY FINDINGS

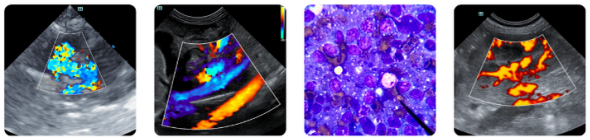
- Marked diffuse muscularis propria thickening involving the jejunum, ileum, and ileocecocolic junction, with preserved wall layering.
- Two mixed hyperechoic multicystic hepatic lesions.

SECONDARY FINDINGS

- Mild pancreatic enlargement with pancreatic duct dilation.
- Mild bilateral renal cortical hyperechogenicity with a very mild medullary rim sign.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Marked diffuse muscularis propria thickening involving the jejunum, ileum, and ileocecocolic junction is present with preserved intestinal wall layering. Given the patient's previously documented eosinophilic sclerosing fibroplasia, the current ultrasonographic findings are considered most compatible with chronic progressive inflammatory gastrointestinal disease with longstanding intestinal remodeling/fibrosis. The degree of muscularis propria thickening is markedly abnormal for a cat and reflects severe chronic infiltrative intestinal change.



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As recognized in many geriatric cats with longstanding inflammatory enteropathy, ultrasonographic overlap with low-grade alimentary lymphoma remains possible and cannot be completely excluded based on ultrasound alone. However, the absence of obstructive gastrointestinal disease, marked abdominal lymphadenopathy, abdominal effusion, or overt neoplastic abdominal disease makes aggressive abdominal neoplasia less supported during the current examination.

Mild pancreatic enlargement and pancreatic duct dilation may reflect chronic pancreatopathy/chronic pancreatitis or age-related pancreatic remodeling.

Although the patient has a documented history of cholangiohepatitis, no convincing ultrasonographic evidence of active hepatobiliary inflammation or biliary obstruction is identified during the current examination. However, chronic feline hepatobiliary inflammatory disease may be poorly expressed ultrasonographically, and correlation with current liver enzymes, bilirubin concentration, and Spec fPL testing is recommended.

The small multicystic hepatic lesions are favored to represent benign chronic cystic/nodular hepatobiliary change, such as cystic nodular hyperplasia or small cystadenoma-like lesions.

Mild bilateral chronic renal changes are also present and may correlate with the reported mild azotemia and advanced age.

Recommendations
- Continued medical management and clinical monitoring are recommended.
- Correlation with current renal values, SDMA, body weight trends, appetite, vomiting/diarrhea frequency, overall quality of life, liver enzymes, bilirubin concentration, and Spec fPL testing is recommended.
- Repeat intestinal biopsy could be considered to assess for interval progression/change in the previously documented inflammatory intestinal disease and to determine whether superimposed low-grade alimentary lymphoma is present, particularly if definitive differentiation would significantly alter therapeutic planning.
- However, given the patient's advanced age and the presence of previously documented histopathologic inflammatory gastrointestinal disease, empiric adjustment/escalation of therapy for chronic inflammatory enteropathy/alimentary small-cell lymphoma spectrum disease may also be clinically reasonable.

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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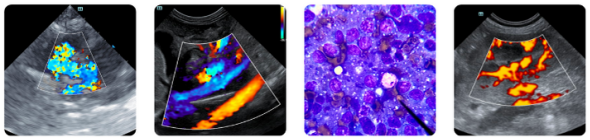

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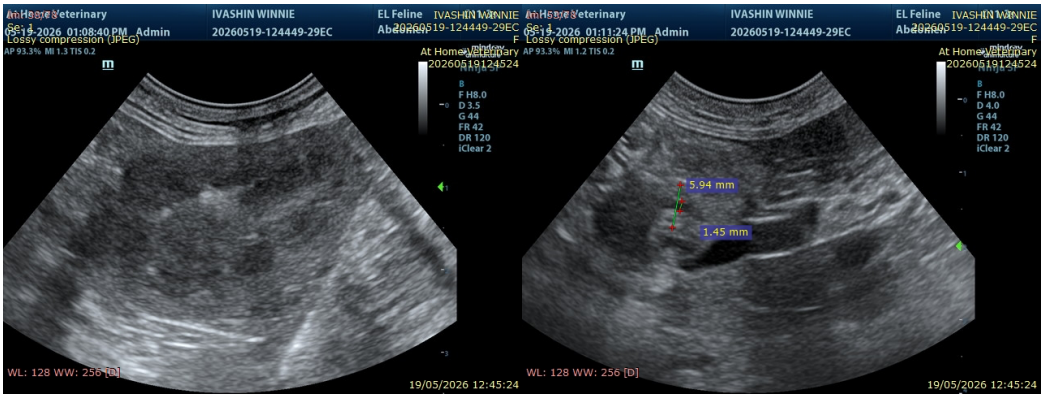

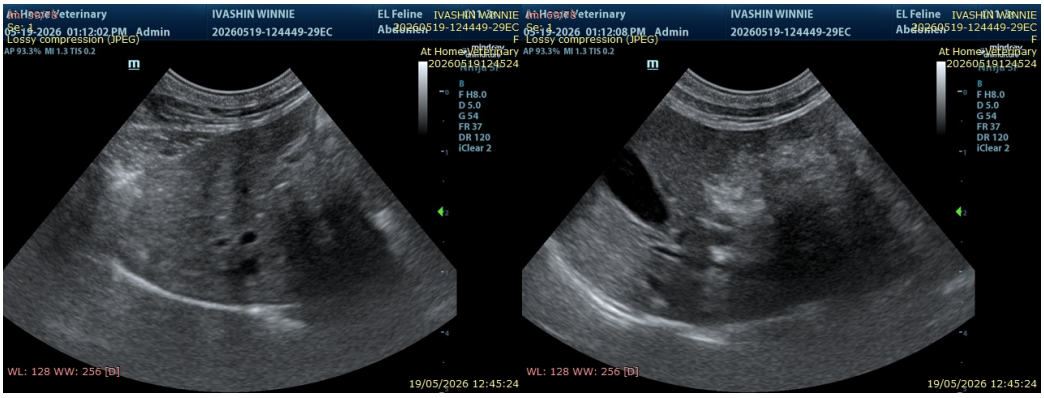

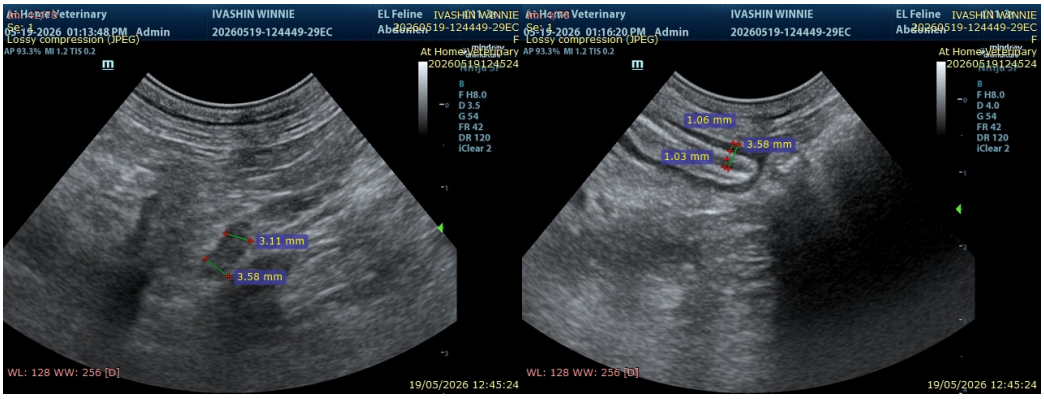

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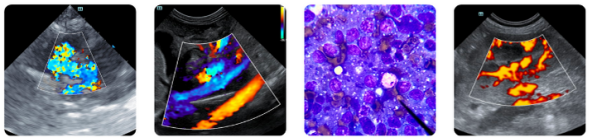

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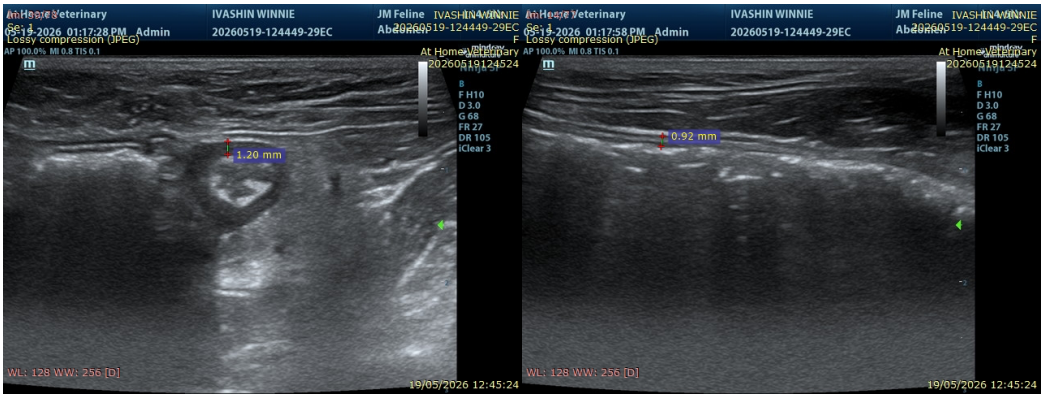

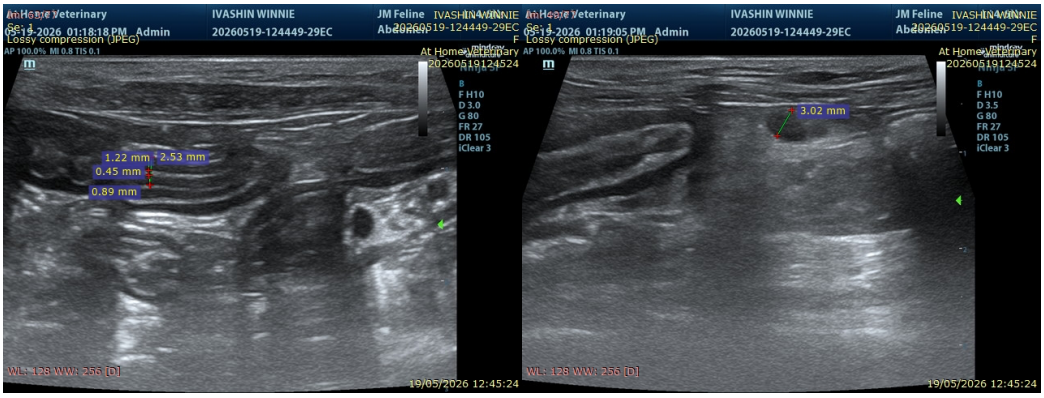

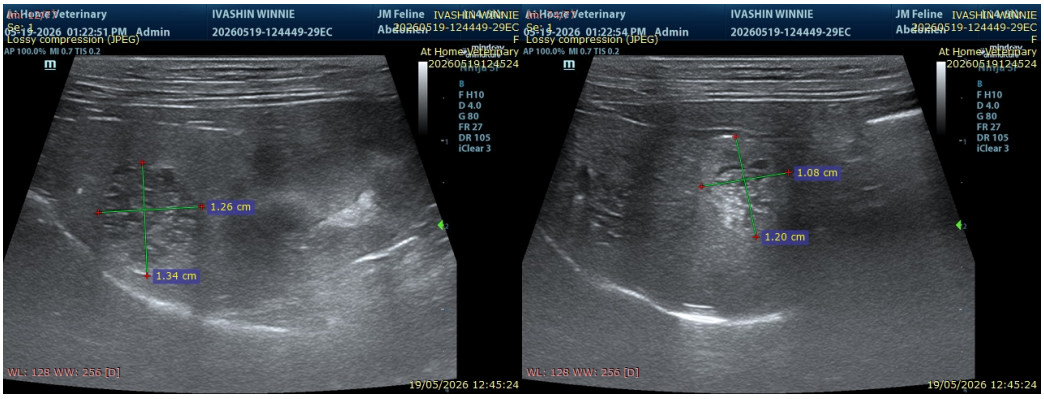

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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