

## PATIENT

Lulu McCoy

## SPECIES

Feline

## BREED

Domestic Shorthair

## SEX

Spayed female

## AGE

7 years

## WEIGHT

9.13 lbs

## INTERPRETED BY

Alicia Angosto  
Guerrero, DMV,  
PgDip, MSc.

## IMAGING PERFORMED BY

Amanda Hockenbrock

## HOSPITAL NAME

Lewisburg VH

## REFERRING VET

Dr. Huepenbecker

## INVOICE

77792

## DATE

5/20/26

## PRESENTING CLINICAL SIGNS

History: -Per O appetite has been varying at home but doesn't seem to be eating as much.  
-Hx V issue that has continued - mostly undigested food.  
-O has tried multiple different foods w/ same result.  
Abnormal PE/Chem/CBC/UA Results: Bloodwork, UA, Fecal are all pending

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder lumen is normally distended, and the urinary bladder wall 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, measuring 3.38×2.02 cm, with cortical thickness measuring 0.33 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.84×2.07 cm, with cortical thickness measuring 0.32 cm in the sagittal plane. The renal cortices are isoechoic relative to the liver parenchyma bilaterally. The corticomedullary ratio is normal and corticomedullary definition is preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified. 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 0.24 cm at the cranial pole and 0.25 cm at the caudal pole. The right adrenal gland measures 0.28 cm at the cranial pole and 0.31 cm at the caudal pole.

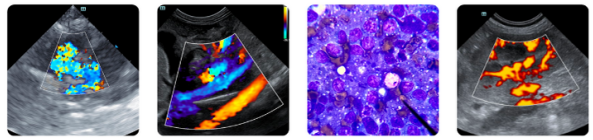
### *Spleen*

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



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## *Gastrointestinal*

The stomach is mildly distended and contains a small amount of residual ingesta. Gastric mural thickness measures approximately 1.68 mm with preserved wall layering. The pylorus measures approximately 3.24 mm in thickness. Duodenum: 1.38 mm. Jejunum: 2.27 mm. Mucosa: 1.21 mm. Submucosa: 0.69 mm. Muscularis propria: 0.67 mm. Ileum: 3.03 mm. Mucosa: 0.61 mm. Submucosa: 0.68 mm. Muscularis propria: 1.80 mm. Wall layering is predominantly preserved. The ileocecolic junction measures approximately 2.90 mm in thickness, with muscularis propria measuring approximately 1.33 mm. Mild diffuse muscularis propria thickening is present within the jejunum, with marked muscularis propria thickening involving the ileum and ileocecolic region. In a few intestinal segments measuring approximately 3–3.5 mm in total thickness, mural layering appears mildly less distinct; however, this may be partially accentuated by image optimization/settings and technical imaging factors during the examination. The colon measures approximately 0.60–0.77 mm in thickness and contains formed fecal material within the descending segment.

## *Pancreas*

The evaluated pancreatic regions do not show evidence of overt inflammation or neoplastic disease.

## *Free Abdomen*

No abdominal effusion or peritonitis is observed. Cranial mesenteric lymph nodes measure approximately 7.86 mm in thickness. Ileocecolic lymph nodes were not confidently visualized. The region of the iliac trifurcation appears normal.

## PRIMARY FINDINGS

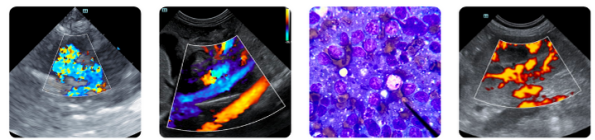
- Diffuse jejunal muscularis propria thickening.
- Marked ileal and ileocecolic muscularis propria thickening.
- Cranial mesenteric lymphadenopathy/reactive change.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mild diffuse jejunal muscularis propria thickening and marked muscularis propria thickening involving the ileum and ileocecolic region are present. The jejunal muscularis-to-mucosa ratio is approximately 0.55, while the ileal muscularis-to-mucosa ratio is approximately 2.95, both exceeding expected normal feline reference values, particularly within the ileum and ileocecolic region. The overall ultrasonographic appearance supports chronic infiltrative intestinal disease.

Differential considerations include chronic inflammatory enteropathy and feline low-grade alimentary lymphoma. Given the marked ileal/ileocecolic muscularis thickening and chronic history of vomiting, low-grade alimentary lymphoma becomes an important clinical consideration in this patient.

Some residual gastric ingesta is present despite reported fasting. While insufficient fasting time cannot be completely excluded, the findings raise concern for possible delayed gastric emptying/chronic gastric



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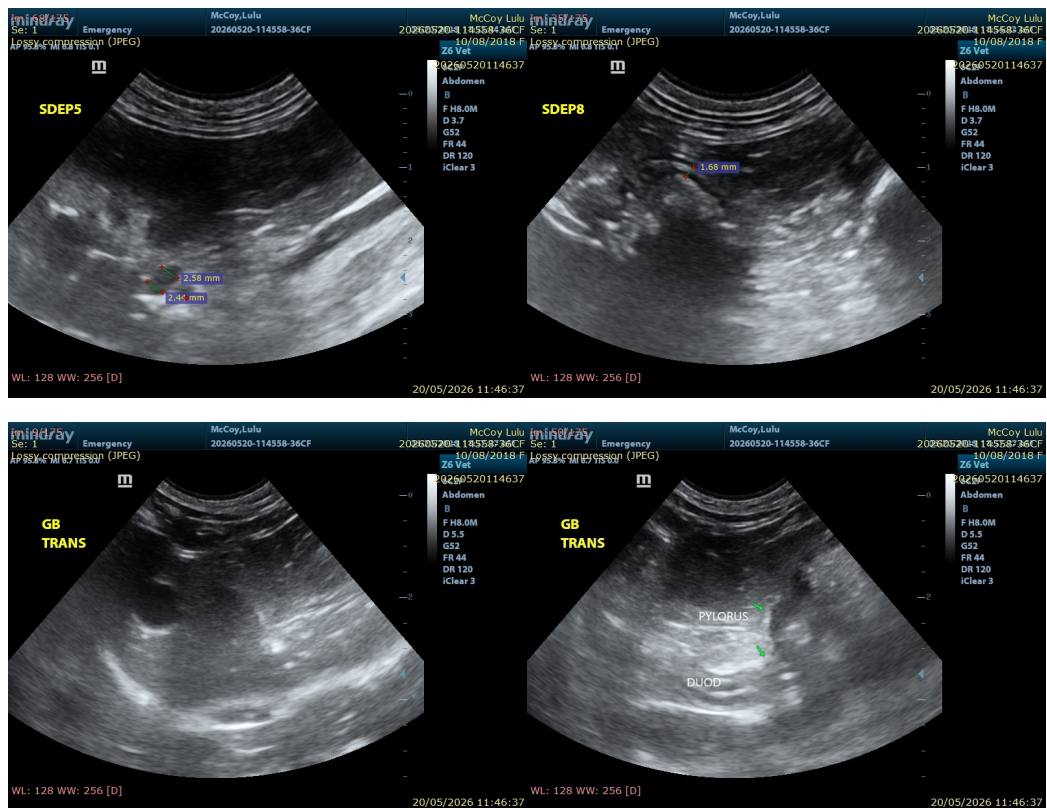
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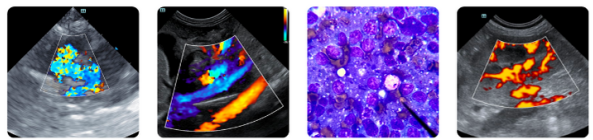
dysmotility in this patient, particularly given the clinical history of recurrent vomiting of partially undigested food.

**Recommendations**

- Correlation with pending CBC, serum biochemistry, urinalysis, fecal testing, GI panel, and cobalamin/folate status is recommended.
- Intestinal biopsy would provide the most definitive differentiation between severe chronic inflammatory enteropathy and feline low-grade alimentary lymphoma if clinically pursued.
- If intestinal biopsy is not pursued, empiric therapeutic management for chronic inflammatory enteropathy/alimentary small-cell lymphoma spectrum disease may still be clinically reasonable depending on clinician and owner goals.
- Clinical monitoring of appetite, body weight, vomiting frequency, and overall gastrointestinal progression is 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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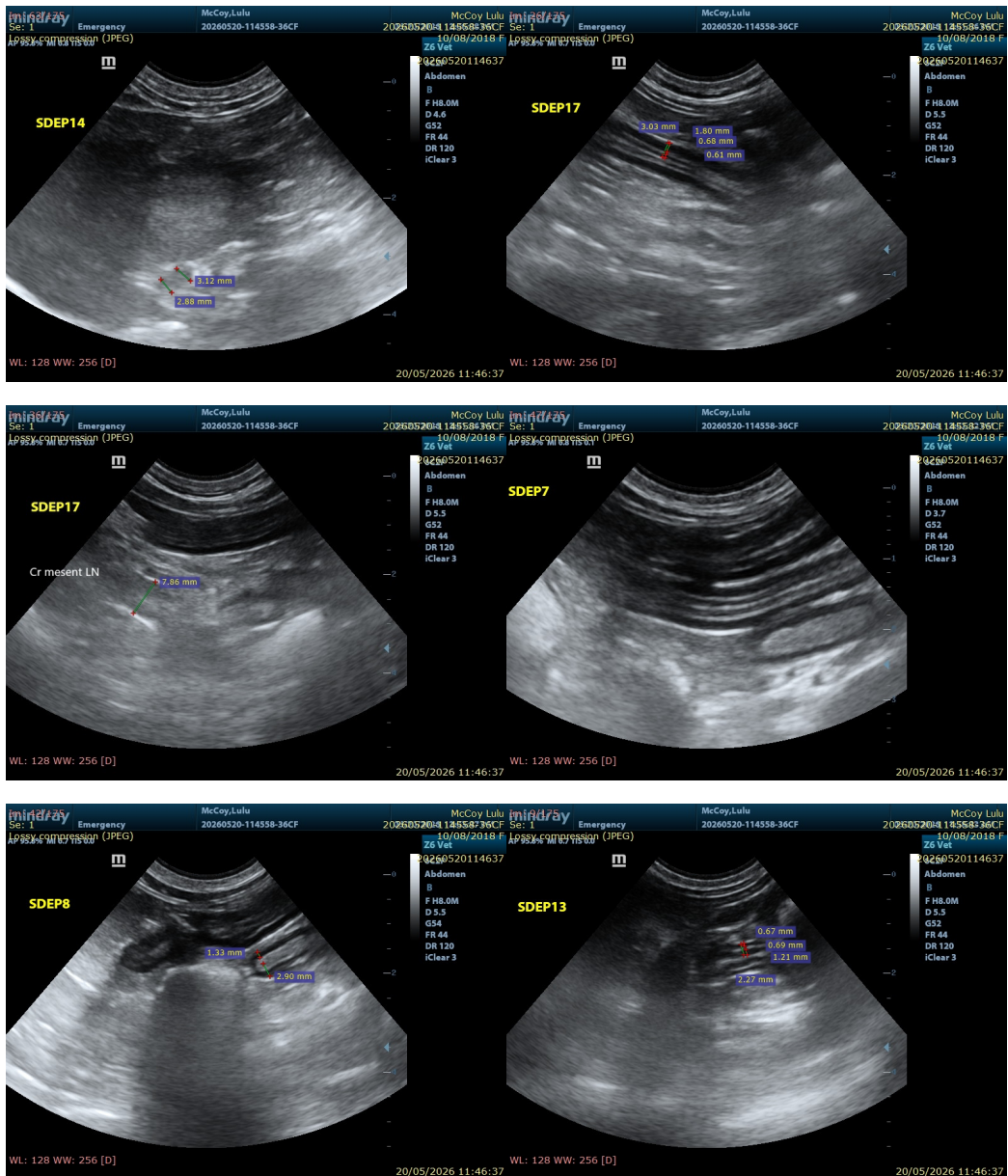
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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