



PATIENT

Nova Haglind

SPECIES

Feline

BREED

Domestic Longhair

SEX

Neutered male

AGE

14 years

WEIGHT

11 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Laura Tarr CVT

HOSPITAL NAME

Ark AH

REFERRING VET

Dr. Cronin

INVOICE

77787

DATE

5/20/26

PRESENTING CLINICAL SIGNS

History: Chronic vomiting for months with some flares of more frequent vomiting. Intermittent diarrhea. Weight loss. Voracious appetite.

Abnormal PE/Chem/CBC/UA Results: Elevated pancreatic lipase (8.5) in January. Labs drawn today are pending. Exam not performed today.

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 3.36×2.48 cm, with cortical thickness measuring 0.39 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 4.02×2.22 cm, with cortical thickness measuring 0.40 cm in the sagittal plane. The renal cortices are mildly hyperechoic relative to the liver parenchyma bilaterally. The corticomedullary ratio is normal and corticomedullary definition is preserved. Mild medullary rim sign is present bilaterally. 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 0.21 cm at the cranial pole and 0.22 cm at the caudal pole. The right adrenal gland is not confidently visualized.

Spleen

Splenic thickness is 0.95 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 small amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach is empty and folded and contains a small amount of fluid. Gastric mural thickness measures approximately 1.39 mm with preserved wall layering. The pylorus measures approximately 3.22 mm in thickness. Duodenum: 2.25 mm. Jejunum: 1.80 mm. Mucosa: 1.12 mm. Submucosa: 0.49 mm. Muscularis propria: 0.38 mm. Ileum: 1.84 mm. Mucosa: 0.63 mm. Submucosa: 0.89 mm. Muscularis propria: 0.22 mm. Wall layering remains preserved. The ileoceocolic junction was not confidently visualized. No evidence of gastrointestinal obstruction, ileus, focal inflammatory mural thickening, or foreign material is identified. The descending colon contains formed fecal material.

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.

PRIMARY FINDINGS

- Mild bilateral renal cortical hyperechogenicity with mild medullary rim sign.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The current abdominal ultrasonographic examination is overall relatively unremarkable and does not demonstrate convincing evidence of clinically significant infiltrative gastrointestinal disease, marked chronic enteropathy, or overt abdominal neoplasia. Intestinal wall layering is preserved throughout the evaluated gastrointestinal tract, and no significant muscularis propria thickening or abdominal lymphadenopathy is identified.

Mild bilateral chronic renal changes are present, including cortical hyperechogenicity and mild medullary rim sign, most compatible with mild chronic degenerative renal remodeling/early chronic kidney disease change.

Overall, the current examination does not provide strong ultrasonographic support for advanced inflammatory bowel disease or feline low-grade alimentary lymphoma at this time. However, chronic gastrointestinal disease cannot be completely excluded given the longstanding clinical history of chronic vomiting, intermittent diarrhea, weight loss, and previously elevated pancreatic lipase concentration. In cats, chronic relapsing pancreatopathy/chronic pancreatitis, early chronic enteropathy, food-responsive enteropathy, or functional gastrointestinal disease may occasionally demonstrate minimal or fluctuating ultrasonographic abnormalities, particularly during periods of lower clinical activity.

Hyperthyroidism should also remain an important clinical differential consideration given the history of weight loss, polyphagia/voracious appetite, and chronic gastrointestinal signs, as early or fluctuating



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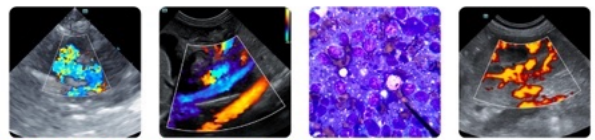
feline hyperthyroidism may occasionally coexist with relatively unremarkable abdominal ultrasonographic findings.

Recommendations

- Correlation with pending CBC, serum biochemistry, and current pancreatic lipase testing is recommended.
- Correlation with current thyroid testing (including repeat total T4 and/or free T4 if clinically indicated) is recommended given the patient's chronic weight loss and voracious appetite.
- If thyroid testing remains within normal limits, correlation with a complete feline GI panel (including cobalamin/folate assessment) may be clinically useful if not recently performed.
- Empiric dietary management and medical management for chronic relapsing gastrointestinal/pancreatobiliary disease may still be clinically reasonable despite the relatively mild ultrasonographic findings.
- Clinical monitoring of body weight, appetite, vomiting frequency, stool quality, and overall clinical 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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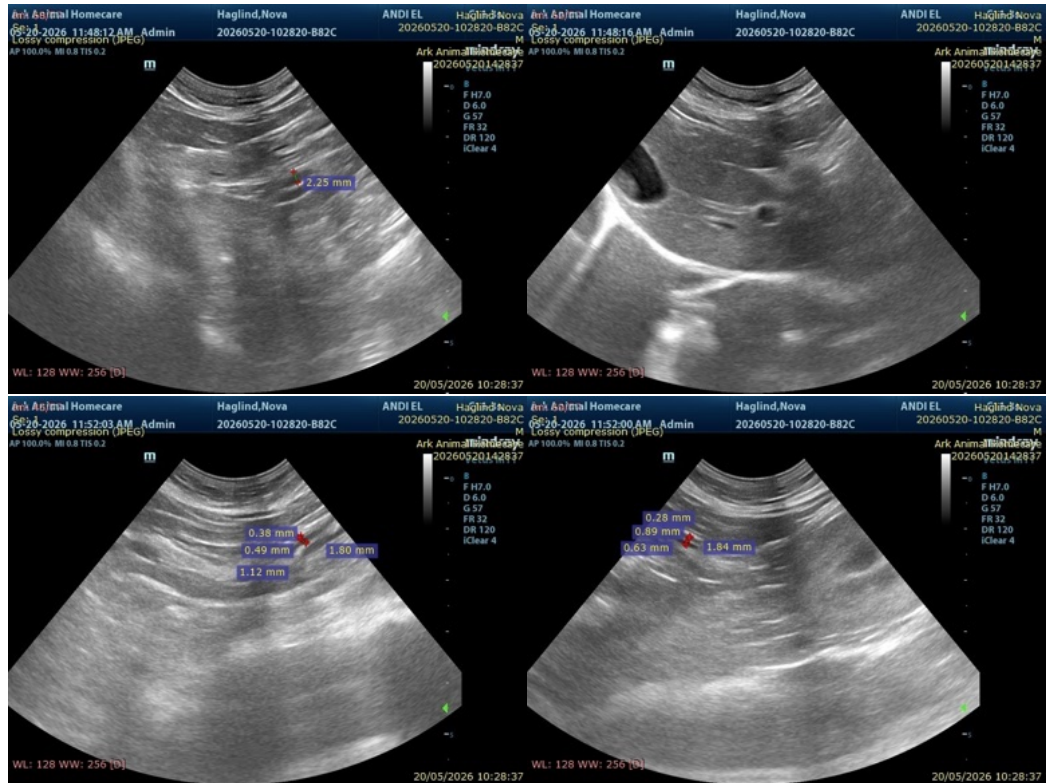
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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