



PATIENT

Ethel Bly

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

14 ½ years

WEIGHT

12.8 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Melinda Persson

HOSPITAL NAME

At Home Veterinary

REFERRING VET

Dr. Persson

INVOICE

77879

DATE

5/21/26

PRESENTING CLINICAL SIGNS

History: *Weight loss
*Controlled hyperthyroid
*Stage 1 renal disease

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 demonstrates mildly irregular contour and measures 3.47×2.55 cm, with cortical thickness measuring 0.37 cm in the sagittal plane. The right kidney measures 4.10×2.37 cm, with cortical thickness measuring 0.42 cm in the sagittal plane. In both kidneys, the renal cortex is isoechoic compared to the liver parenchyma. Both kidneys: The corticomedullary ratio and corticomedullary definition are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler demonstrates an overall normal vascular pattern. Mild chronic cortical remodeling of the left kidney is present.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.36 cm at the cranial pole and 0.36 cm at the caudal pole. The right adrenal gland measures 0.33 cm at the cranial pole and 0.31 cm at the caudal pole.

Spleen

Splenic thickness is 0.73 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 gallbladder wall measures approximately 1.2 mm in thickness. Moderate multifocal hyperechoic mineralized biliary sediment/concretions are present within the gallbladder lumen. Similar small mineralized hyperechoic foci are also identified within a few intrahepatic bile ducts, most compatible with early cholelithiasis/mineralized biliary concretions. No convincing dilation of the cystic duct or common bile duct is identified.



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Gastrointestinal

The stomach is empty and folded, containing only a very small amount of fluid. Gastric wall thickness measures 1.49 mm with preserved wall layering.

The pylorus measures 4.51 mm. The duodenum measures 2.58 mm. The jejunum measures 2.77 mm in total thickness, with mucosa measuring 0.87 mm, submucosa 0.69 mm, and muscularis propria 1.20 mm. The ileum measures 2.21 mm, with mucosa measuring 0.82 mm, submucosa 0.53 mm, and muscularis propria 0.82 mm. The ileocecal junction measures approximately 3.22 mm, with mucosa measuring 0.59 mm and muscularis propria 0.77 mm. Intestinal wall layering remains preserved throughout all evaluated segments.

Diffuse muscularis propria thickening is present involving the jejunum, ileum, and ileocecal junction, resulting in increased muscularis-to-mucosa ratios. No focal obstructive pattern, ileus, foreign material, or severe focal inflammatory change is identified ultrasonographically.

The colon measures approximately 1 cm and contains formed fecal material within the descending colon.

Pancreas

The pancreas measures approximately 8.01–9.78 mm in thickness and appears mildly hypoechoic relative to the adjacent omental fat. The pancreatic duct measures approximately 1.66–1.78 mm in diameter and is diffusely prominent. No convincing hyperechoic peripancreatic mesenteric fat, free fluid, or overt evidence of active necrotizing pancreatitis is identified at this time.

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Diffuse muscularis propria thickening involving the jejunum, ileum, and ileocecal junction.
- Diffuse pancreatic enlargement with pancreatic ductal dilation/prominence. Mild hypoechoogenicity of the pancreatic parenchyma.
- Moderate mineralized biliary sediment with mild intrahepatic cholelithiasis/mineralized biliary debris.

SECONDARY FINDINGS

- Mild chronic left renal cortical remodeling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Diffuse intestinal muscularis propria thickening involving the small intestine and ileocecal region is present, with preserved wall layering and without severe focal mass effect or loss of mural architecture.



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In a geriatric cat with chronic weight loss, this ultrasonographic pattern raises concern for chronic feline enteropathy, with low-grade alimentary lymphoma and chronic inflammatory enteropathy both considered important differential diagnoses. The degree and distribution of muscularis thickening, particularly involving the ileum and ileocecal region, are more significant than would be expected from incidental age-related change alone. However, preserved layering and absence of marked lymphadenopathy indicate substantial biologic overlap between inflammatory and infiltrative disease processes on ultrasound alone.

Concurrent pancreatic enlargement, mild pancreatic hypoechogenicity, and marked pancreatic ductal prominence support associated chronic pancreatopathy/chronic pancreatitis-type remodeling.

Moderate mineralized biliary sediment with suspected early cholelithiasis and mild intrahepatic biliary mineralization are present, supporting chronic biliary remodeling/change. In combination with the concurrent pancreatic and intestinal abnormalities, a chronic pancreatobiliary-enteric inflammatory process (triaditis-type syndrome) is considered a biologically reasonable consideration, although the biliary mineralization itself remains nonspecific ultrasonographically.

Recommendations

- Correlation with cobalamin/folate testing, GI panel, Spec fPL, and ongoing thyroid monitoring is recommended.
- Empiric management for chronic feline enteropathy/chronic pancreatobiliary disease may be reasonable depending on clinical severity and response to therapy.
- If weight loss and gastrointestinal signs continue to progress despite medical management, intestinal sampling may ultimately become necessary to obtain a definitive diagnosis and further differentiate chronic inflammatory enteropathy from low-grade alimentary lymphoma.

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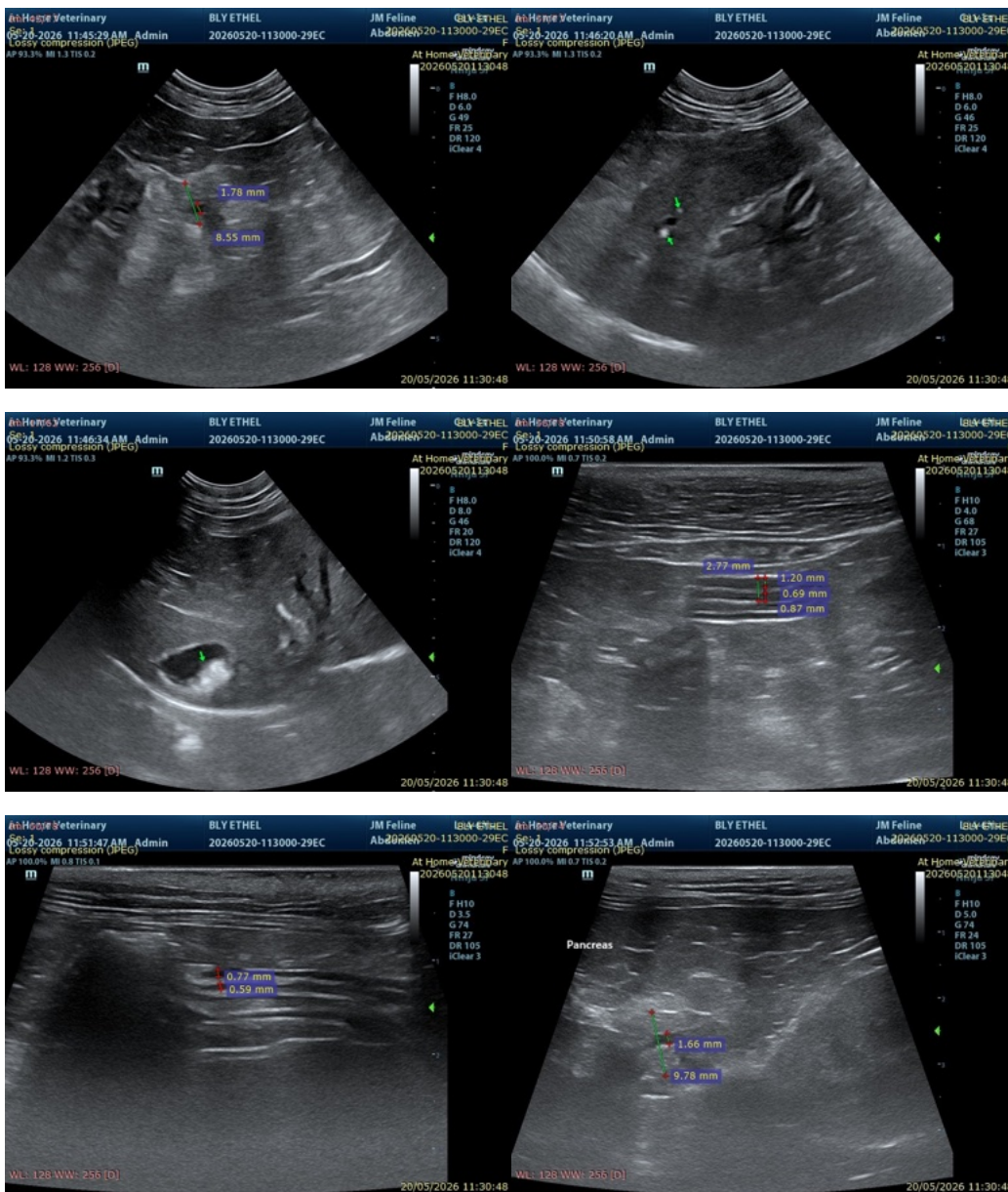
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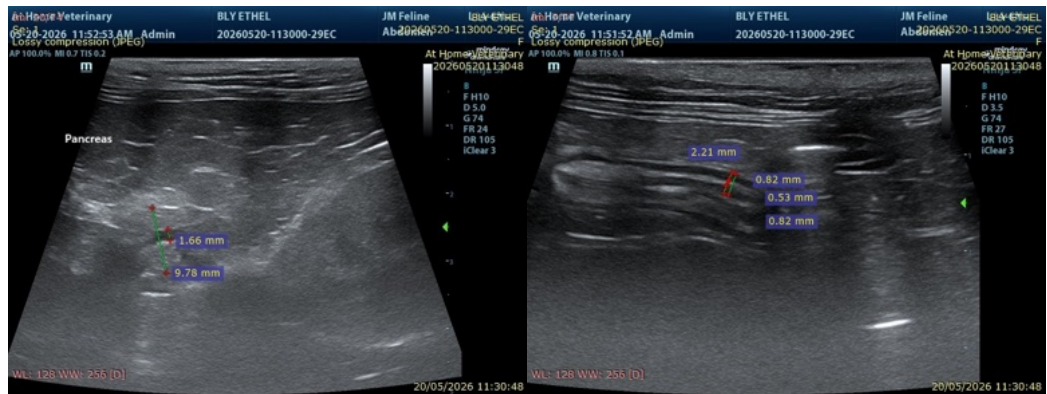
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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