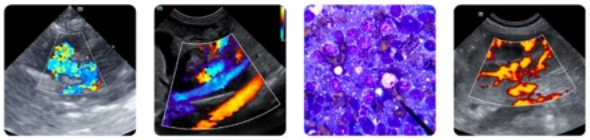


PATIENT

Jessica Freeman

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

6 years

WEIGHT

7.4 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Cameron Johnson

HOSPITAL NAME

Craig Road AH

REFERRING VET

Cameron Johnaon

INVOICE

77880

DATE

5/21/26

PRESENTING CLINICAL SIGNS

History: P is a 6yr 2mo old FS DSH presenting for more consistent flair-ups (defecating small amounts more frequently and vomiting 2-3 days a week per O) of P's historical/suspected chronic enteropathy. O noted an increase in these flair ups over the past couple of weeks and would like P to get seen.
Eating, drinking, and urinating within normal limits. No coughing or sneezing noted by owner. No known allergies to vaccines/ medication. P has no recent travel history.
Current medications: Hills Z/D diet, Gabapentin

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, measuring 3.44×2.03 cm, with cortical thickness measuring 0.30 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.66×2.24 cm, with cortical thickness measuring 0.33 cm in the sagittal plane. In both kidneys, the renal cortex is mildly hyperechoic compared to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. Mild diffuse renal cortical hyperechogenicity may reflect early chronic renal change/remodeling.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.25 cm The right adrenal gland measures 0.24 cm at the cranial pole and 0.26 cm at the caudal pole.

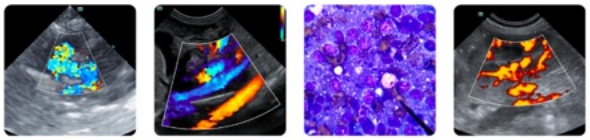
Spleen

Splenic thickness is 0.59 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 is moderately distended. The gallbladder wall measures approximately 1.04 mm in thickness. The contents are predominantly anechoic. No convincing dilation of the cystic duct or common bile duct is identified.



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Gastrointestinal

The stomach is empty and folded, with wall thickness measuring 1.23 mm and preserved wall layering.

The pylorus measures 2.67 mm. The duodenum measures 1.83 mm. The major duodenal papilla measures approximately 2.29×3.95 mm. The jejunum measures 1.46 mm in total thickness, with mucosa measuring 0.95 mm, submucosa 0.32 mm, and muscularis propria 0.29 mm. The ileum measures 1.87 mm, with mucosa measuring 0.83 mm, submucosa 0.54 mm, and muscularis propria 0.29 mm. The ileocecal junction measures approximately 2.13 mm, with mucosa measuring 0.85 mm and muscularis propria 0.58 mm. Intestinal wall layering remains preserved throughout the evaluated small intestinal tract. Mild muscularis prominence is present at the ileocecal junction, although the remainder of the small intestine remains overall within acceptable thickness limits.

The colon contains scant luminal contents throughout its course. Mild diffuse colonic wall thickening is present, most pronounced within the descending colon. The ascending colon measures approximately 1.80 mm, the transverse colon 2.24 mm, and the descending colon 2.84 mm, with mucosal thickness measuring approximately 1.65 mm. Wall layering remains preserved.

Pancreas

The pancreas measures approximately 5.27–5.62 mm in thickness and demonstrates mildly irregular margins. The pancreatic parenchyma is mildly hypoechoic relative to the adjacent omental fat. The pancreatic duct measures approximately 0.88–1.26 mm in diameter and is mildly prominent. No convincing hyperechoic peripancreatic mesenteric fat or free fluid is identified to strongly support active severe pancreatitis at this time.

Free Abdomen

No abdominal effusion or sonographic evidence of peritonitis is identified. Cranial mesenteric and ileocecal lymph nodes measure approximately 2.25–2.32 mm in thickness and maintain normal shape and echogenicity. The region of the iliac trifurcation appears normal.

PRIMARY FINDINGS

- Diffuse colonic wall thickening, most pronounced within the descending colon.
- Mild prominence of the muscularis propria at the ileocecal junction.

SECONDARY FINDINGS

- Apparent chronic pancreatic remodeling characterized by irregular margins and pancreatic ductal prominence.
- Subtle diffuse renal cortical hyperechogenicity.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Subtle diffuse colonic wall thickening, predominantly affecting the mucosal layer and most pronounced within the descending colon, is present with preserved wall layering and scant luminal content. The ultrasonographic appearance is most compatible with chronic inflammatory colonic disease/chronic colitis and correlates well with the reported history of recurrent small-volume frequent defecation episodes.

Small intestinal changes are comparatively minor and limited to slight prominence of the muscularis propria at the ileocecal junction, without convincing ultrasonographic evidence of significant diffuse small intestinal infiltrative disease.

Mild pancreatic remodeling changes are nonspecific and may reflect low-grade chronic pancreatopathy. No convincing ultrasonographic evidence of active pancreatitis is identified currently.

Recommendations

- Continued dietary management and empiric therapy directed toward chronic inflammatory colonic disease/chronic colitis.
- Correlation with fecal testing, dysbiosis/GI panel, cobalamin status, and clinical response to therapy may be clinically useful.
- If clinical signs become progressive or refractory to medical management, colonic and/or intestinal sampling could eventually be considered for definitive characterization of the chronic inflammatory process.

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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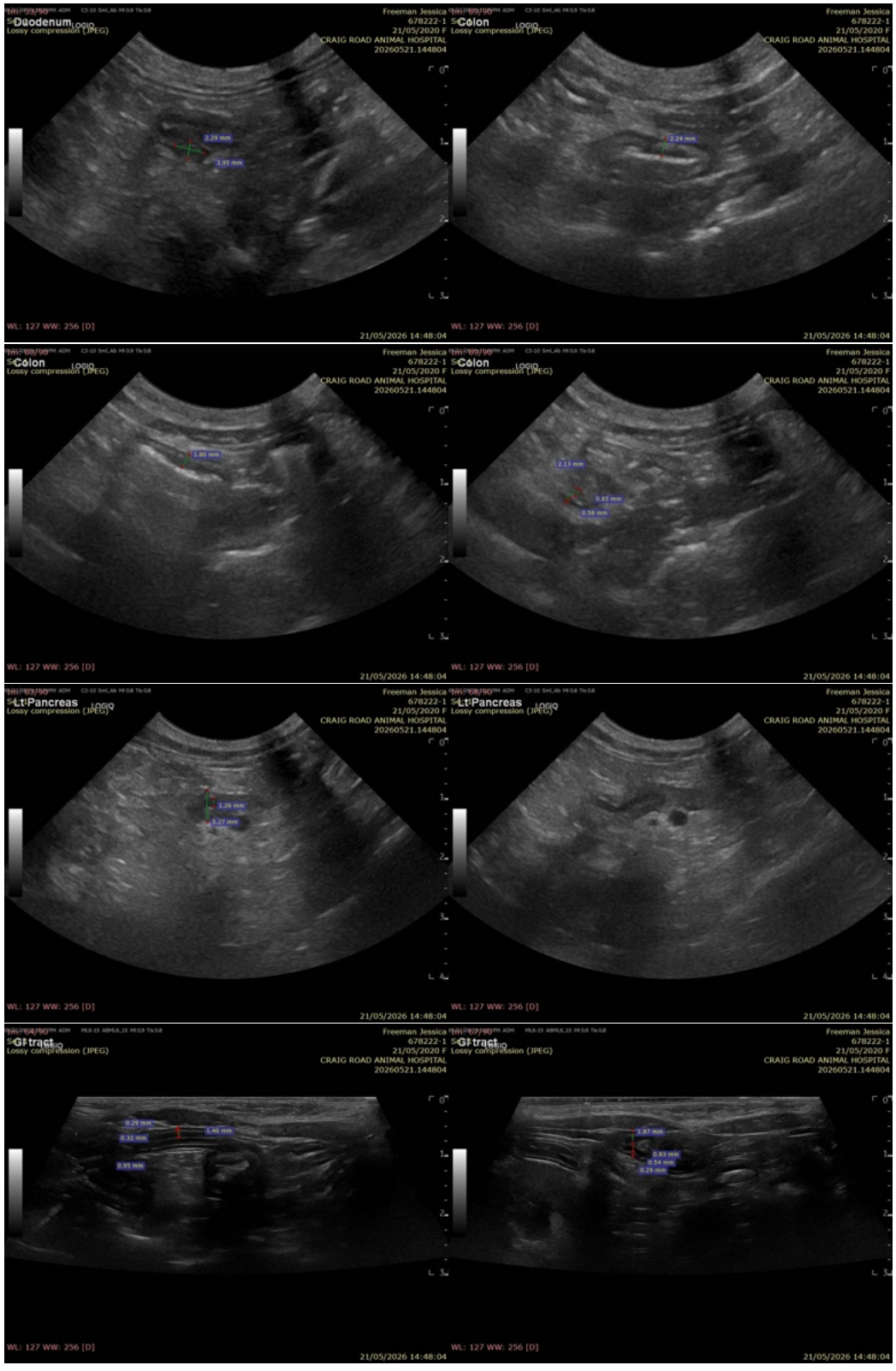

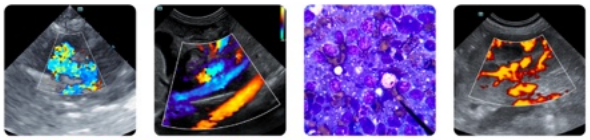

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com