



PATIENT

Millie Smith

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

2 years

WEIGHT

7.28 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Saum Hadi

HOSPITAL NAME

Nimbus PH

REFERRING VET

Dr. Hadi

INVOICE

77885

DATE

5/21/26

PRESENTING CLINICAL SIGNS

- Vomiting since kittenhood; currently every other day, previously daily
- Vomiting includes water, food (mushy kibble, often shortly after eating), and hairballs (trichobezoars)
- Diarrhea: every second or third bowel movement is pure diarrhea; stools generally soft
- Eating and drinking normally; appetite good
- Normal chem 11, CBC, fPL. Negative fecal DX. GI panel pending.

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 moderately turbid with abundant suspended echogenic debris. Normal appearance of the bladder neck and proximal urethra. No cystoliths or convincing ultrasonographic evidence of cystitis or urinary bladder neoplasia are identified.

The left kidney is normal in shape and size, measuring 3.58×1.89 cm, with cortical thickness measuring 0.31 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 4.06×1.81 cm, with cortical thickness measuring 0.40 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. Mild bilateral medullary rim sign is present. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler demonstrates an overall 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 0.29 cm The right adrenal gland measures 0.24 cm at the cranial pole and 0.24 cm at the caudal pole.

Spleen

Splenic thickness is 0.94 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 empty and folded, with wall thickness measuring 1.52 mm and preserved wall layering.

The pylorus measures 4.79 mm. The duodenum measures approximately 1.21–1.66 mm. The jejunum measures 2.43 mm in total thickness, with mucosa measuring 1.02 mm, submucosa 0.55 mm, and muscularis propria 0.62 mm. The ileum measures 2.51 mm, with mucosa measuring 0.88 mm, submucosa 1.10 mm, and muscularis propria 0.56 mm. The ileocecal junction measures approximately 2.03 mm, with mucosa measuring 0.96 mm and muscularis propria 0.57 mm. Intestinal wall layering remains preserved throughout all evaluated intestinal segments.

Mild diffuse muscularis propria prominence is present involving the jejunum, ileum, and ileocecal junction, resulting in mildly increased muscularis-to-mucosa ratios. A few small intestinal segments are mildly fluid distended, without evidence of focal obstructive pattern, plication, foreign material, or severe ileus. The colon measures approximately 1.36–1.78 mm and contains small amounts of formed fecal material.

Pancreas

The pancreas measures approximately 7.12–7.49 mm in thickness. The pancreatic parenchyma is overall isoechoic relative to the adjacent omental fat. The pancreatic duct measures approximately 1.24–1.37 mm in diameter and is mildly prominent for a cat of this age. No convincing hyperechoic peripancreatic mesenteric fat, free fluid, or overt ultrasonographic evidence of active pancreatitis is identified currently.

Free Abdomen

No abdominal effusion or sonographic evidence of peritonitis is identified. Cranial mesenteric lymph nodes are not confidently visualized, although the surrounding mesentery appears unremarkable. Ileocecal lymph nodes measure approximately 4.54 mm in thickness, maintain normal shape, and are mildly hypoechoic without overt features of pathologic lymphadenopathy. The region of the iliac trifurcation appears normal.

PRIMARY FINDINGS

- Mild diffuse muscularis propria prominence involving the jejunum, ileum, and ileocecal junction.
- Subtle pancreatic changes.

SECONDARY FINDINGS

- Turbid urine.
- Mild bilateral renal cortical hyperechogenicity with medullary rim sign.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Subtle diffuse prominence of the muscularis propria is present within portions of the small intestine, resulting in mildly increased muscularis-to-mucosa ratios, particularly within the jejunal and ileocecal regions. In a young cat with longstanding vomiting and intermittent diarrhea beginning early in life, the ultrasonographic appearance is most compatible with chronic inflammatory/functional gastrointestinal disease, including chronic enteropathy or food-responsive enteropathy. The current imaging findings are relatively mild and are not strongly supportive of advanced infiltrative gastrointestinal neoplasia. Mild fluid distension of a few intestinal segments likely reflects functional gastrointestinal dysmotility or enteritis.

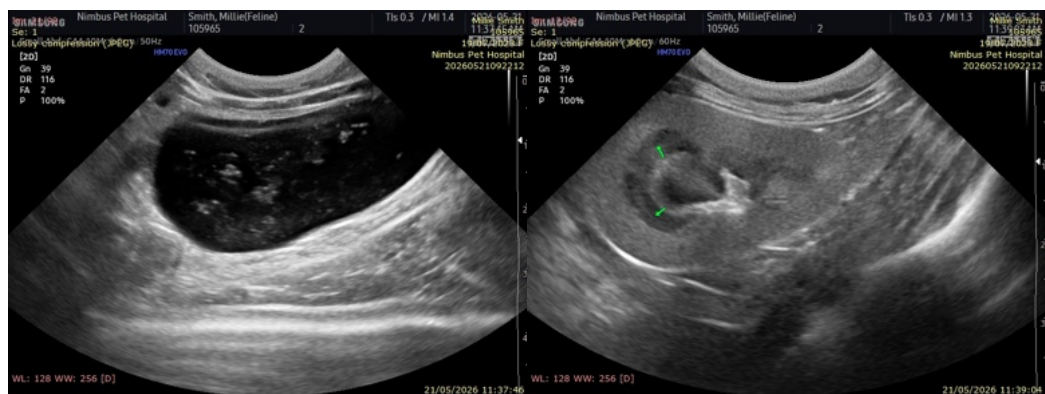
Mild pancreatic enlargement and pancreatic ductal prominence are present, although these findings remain relatively nonspecific in the absence of abnormal pancreatic lipase testing, peripancreatic inflammatory change, or other convincing ultrasonographic evidence of clinically significant pancreatitis.

The renal findings may represent incidental or early chronic renal change.

Recommendations

- Correlation with the pending GI panel/cobalamin status is recommended.
- Correlation with clinical response to antiemetic therapy, dietary modification, probiotics, and/or cobalamin supplementation may be clinically useful. Depending on clinical progression and GI panel results, empiric management directed toward chronic inflammatory enteropathy may be also considered.
- If gastrointestinal signs become progressive or refractory to medical management, endoscopic or surgical intestinal sampling could eventually be considered for definitive characterization of the chronic gastrointestinal process.
- Correlation with urinalysis/urine specific gravity is recommended given the mild nonspecific renal and urinary sediment changes identified ultrasonographically.

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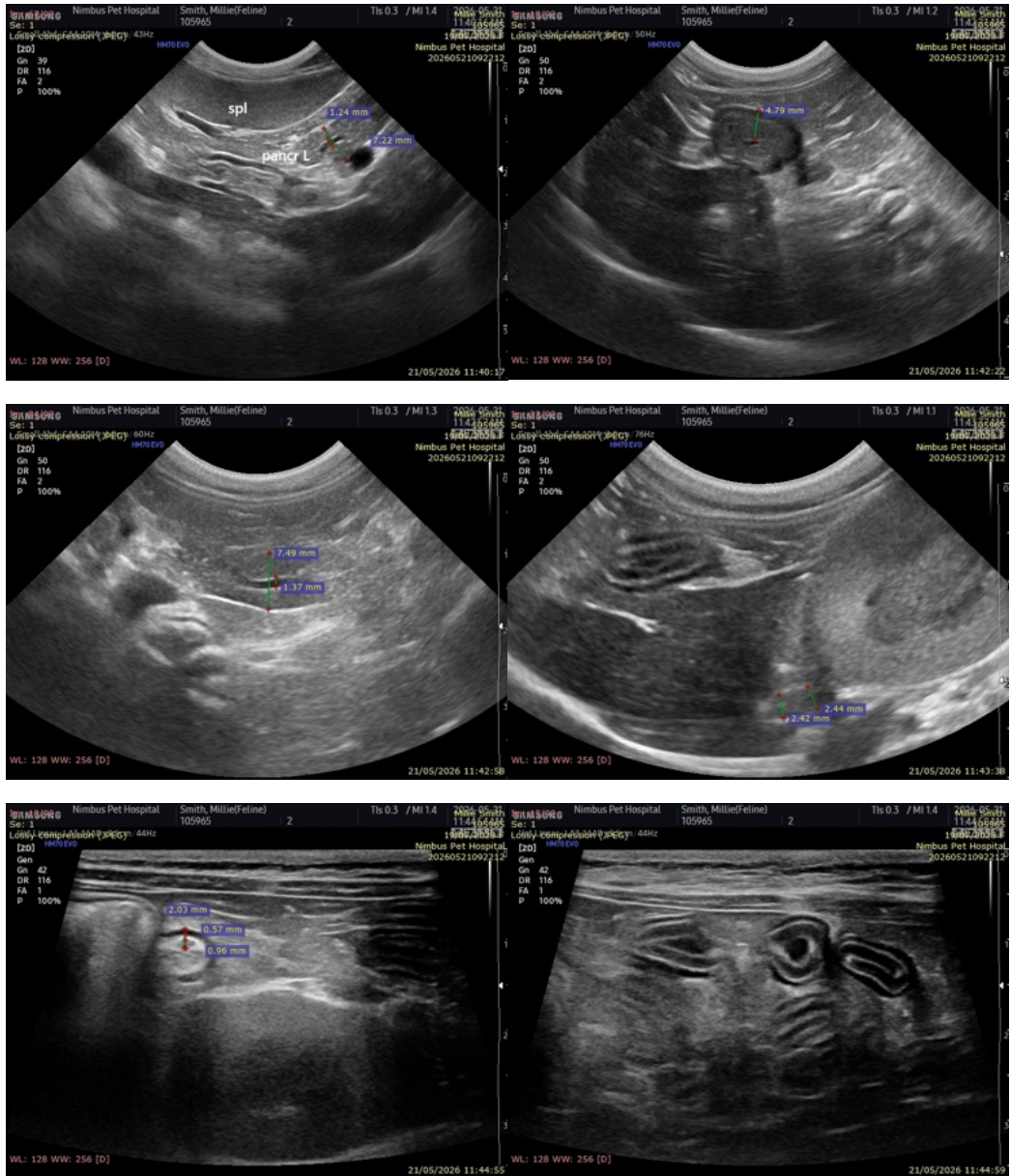
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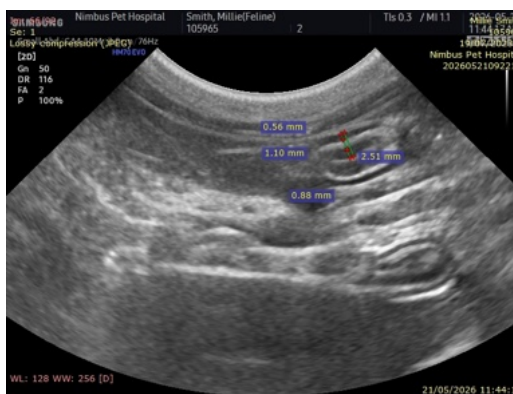
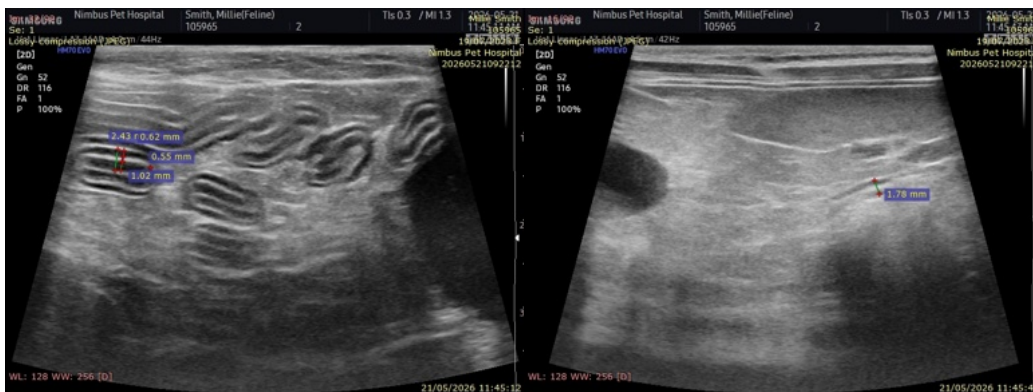
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com