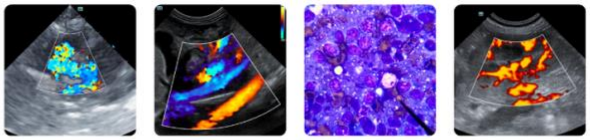

PATIENT

Anise Restifo

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

6 Years

WEIGHT

11.12 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Renee Ziegler-Post

HOSPITAL NAME

For Cats Only Veterinary Clinic

REFERRING VET

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INVOICE

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DATE

05/22/26

PRESENTING CLINICAL SIGNS

Vomiting/diarrhea/lethargy

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended, and the urinary bladder wall appears thin and smooth. The urine is predominantly turbid, with abundant suspended echogenic debris. Normal appearance of the bladder neck and proximal urethra. No calculi or sonographic evidence of inflammatory or neoplastic mural changes are identified.

The left kidney is normal in shape and size, measuring 3.72×2.08 cm, with a cortical thickness of 0.32 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.77×2.11 cm, with a cortical thickness of 0.34 cm in the sagittal plane. In both kidneys, the cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. No evidence of pyelectasia, nephrolithiasis, ureteral dilation, or hydronephrosis is identified. Color Doppler interrogation demonstrates a normal vascular pattern bilaterally.

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 at the cranial pole and 0.22 cm at the caudal pole. The right adrenal gland measures 0.25 cm at the cranial pole and 0.24 cm at the caudal pole.

Spleen

No splenic images or videos were provided for evaluation.

Liver

The liver is subjectively normal in size, with sharp margins and a regular contour. The hepatic parenchyma is homogeneous and isoechoic relative to the surrounding falciform fat, with a normal echotexture. No hepatic lymphadenopathy is identified.

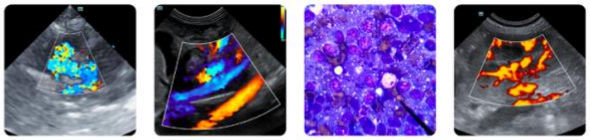
The gallbladder is normally distended. The gallbladder wall is thin, and the luminal contents are predominantly anechoic. The common bile duct measures 3.78 mm proximally, tapering to 2.17 mm at the mid portion and 1.57 mm distally.

Gastrointestinal tract

The stomach is poorly distended and contains a minimal amount of partially digested ingesta. Gastric wall thickness measures 1.59 mm, with preserved wall layering. The pyloric wall measures 3.29 mm.

The duodenal wall measures 1.72 mm. The jejunal wall measures 2.11 mm, with mucosa measuring 1.13 mm, submucosa 0.52 mm, and muscularis propria 0.33 mm. The ileal wall measures 1.92 mm, with mucosa measuring 0.59 mm, submucosa 0.70 mm, and muscularis propria 0.29 mm. The ileocecocolic junction measures 2.03 mm, with mucosa measuring 0.82 mm and muscularis propria 0.78 mm. Normal intestinal wall layering is preserved throughout the evaluated gastrointestinal tract.

No sonographic evidence of gastrointestinal obstruction, focal mural mass lesion, corrugation, mechanical ileus, or foreign material is identified.



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The colon measures 0.81–0.86 mm in wall thickness and contains semiformed fecal material.

Pancreas

The pancreas measures 4.77 mm in thickness. Pancreatic parenchyma is isoechoic relative to the adjacent mesenteric fat. The pancreatic duct measures 0.58 mm in diameter. No surrounding mesenteric fat hyperechogenicity, free fluid, or other sonographic evidence of active peripancreatic inflammation is identified.

Free Abdomen

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

PRIMARY FINDINGS

- Turbid urine with abundant suspended echogenic debris.
- Mild muscularis prominence at the ileocecocolic junction.
- The common bile duct is mildly prominent proximally.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The current abdominal ultrasonographic examination is relatively unremarkable overall and does not demonstrate convincing sonographic evidence of severe inflammatory gastrointestinal disease, obstructive gastrointestinal pathology, focal intestinal mass lesion, pancreatitis, or abdominal neoplasia.
There is mild muscularis prominence at the ileocecocolic junction, although intestinal wall layering remains preserved and the remainder of the small intestinal tract is within normal sonographic limits. This isolated finding is nonspecific and may represent mild chronic inflammatory remodeling or early/chronic enteropathy; however, the overall ultrasonographic appearance is not strongly supportive of advanced feline chronic enteropathy or alimentary lymphoma at this time.

The common bile duct is mildly prominent proximally, although it tapers normally distally and there is no associated gallbladder abnormality, intrahepatic biliary dilation, or extrahepatic biliary obstruction. In some cats, mild common bile duct prominence may be physiologic or associated with chronic low-grade hepatobiliary or pancreatic remodeling. Correlation with liver enzymes, bilirubin concentration, pancreatic lipase testing, and clinical progression is recommended.

The mildly prominent urinary sediment/debris is nonspecific and may reflect concentrated urine, crystalluria, inflammatory sediment, or incidental particulate material. Correlation with urinalysis is recommended if clinically indicated.

Recommendations

- Correlation with CBC, serum biochemistry, urinalysis, urine specific gravity, and urine sediment examination is recommended.
- Correlation with feline pancreatic lipase immunoreactivity (Spec fPL) may be clinically reasonable, particularly given the gastrointestinal signs and mild proximal biliary prominence.
- If gastrointestinal signs persist or progress despite empiric therapy, additional investigation for chronic enteropathy may be considered, including GI panel/cobalamin assessment, dietary trial, and potentially intestinal sampling depending on long-term clinical evolution.

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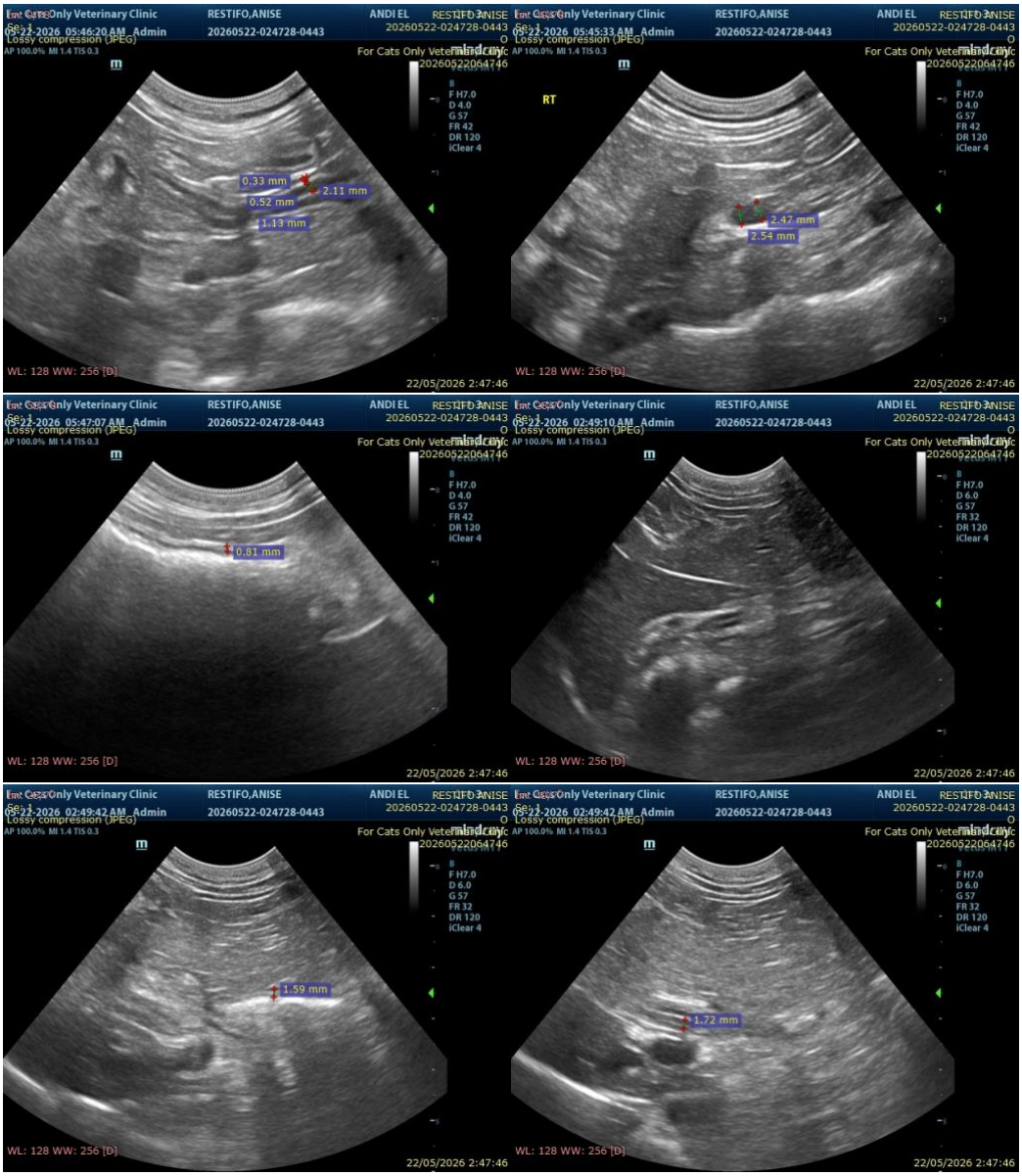
Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.



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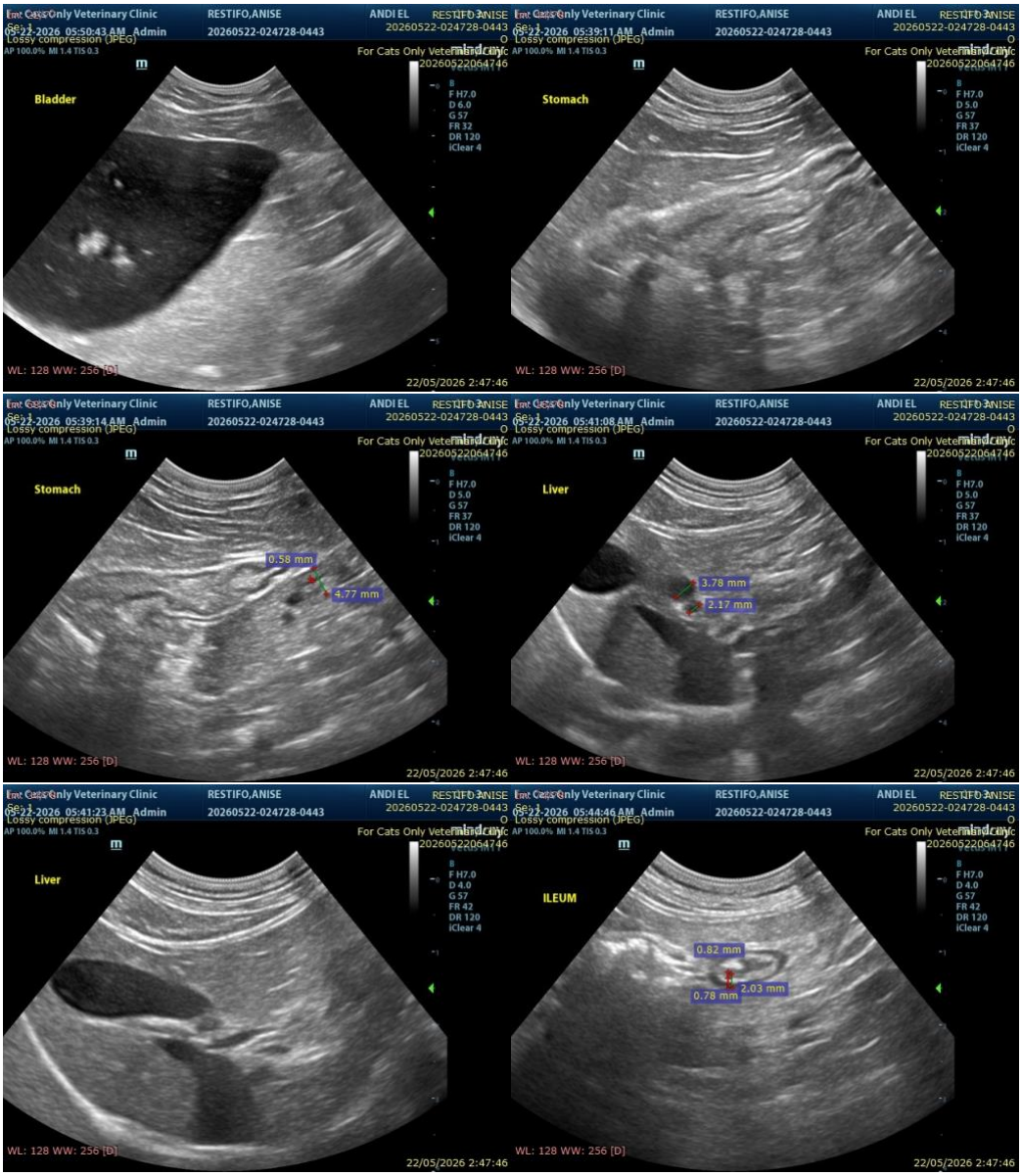

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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