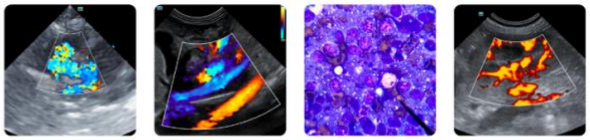


PATIENT

Face Witt

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years

WEIGHT

13 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Brandon

HOSPITAL NAME

Dillsburg Veterinary Center

REFERRING VET

Dr. Amber

INVOICE

16460

DATE

05/22/26

PRESENTING CLINICAL SIGNS

Face has had a history of vomiting about every other day for the past 5 years. The past 3 weeks, he has been having diarrhea with blood in it and is having inappropriate defecation. The owner is unsure if due to the urgency to go or the avoidance of the litterbox. He eats a variety of foods, including Hill's i/d, GI Biome, and Royal Canin Gastrointestinal. He has had noted weight loss (was 15.4 lb in 9/2025). Labwork showed positive renal tech, but the rest of the labs were WNL. His owner has been giving him SQ fluids at home a few times a week, which seems to help with bowels but only for a day or so.

Abnormal PE/Chem/CBC/UA Results: BUN 35, CREA 2.2, AMYL 1215, PSL 74, CPK 772, NEUT 86%, LYMPH 10%, EOS 1%, ABS NEUT 11524, T4 1.5, RENAL TECH POSITIVE

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. No cystoliths or convincing ultrasonographic evidence of inflammatory or neoplastic urinary bladder disease are identified.

The left kidney measures 3.40×2.12 cm, with cortical thickness measuring approximately 0.57 cm in the sagittal plane. The right kidney measures 3.48×1.93 cm, with cortical thickness measuring approximately 0.60 cm. In both kidneys, the renal cortex is mildly hyperechoic relative to the liver parenchyma and appears mildly thickened, resulting in a mildly decreased corticomedullary ratio. Corticomedullary definition remains preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler demonstrates an overall preserved vascular pattern. The renal appearance is most compatible with chronic renal cortical remodeling/chronic nephropathy-type change.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.31 cm at the cranial pole and 0.31 cm at the caudal pole. The right adrenal gland measures 0.29 cm at the cranial pole and 0.30 cm at the caudal pole.

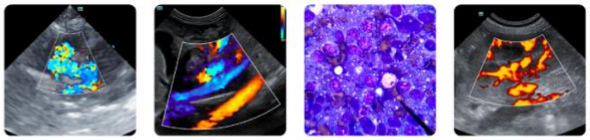
Spleen

Splenic thickness is 0.87 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 margins and regular contour. The hepatic parenchyma is homogeneous and isoechoic relative to the falciform fat, with overall normal echotexture. No focal hepatic lesions or hepatic lymphadenopathy are identified.

The gallbladder lumen is normally distended. The wall is thin and smooth, and the contents are predominantly anechoic. No convincing dilation of the cystic duct or common bile duct is identified. Mild subjective prominence of portions of the intrahepatic biliary tree may be present, although definite clinically significant biliary obstruction is not confirmed ultrasonographically at this time.



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Gastrointestinal tract

The stomach is empty and folded, with wall thickness measuring 1.44 mm and preserved wall layering.

The duodenum measures 2.12 mm. The jejunum measures 3.18 mm in total thickness, with mucosa measuring 1.71 mm, submucosa 0.65 mm, and muscularis propria 0.57 mm. The ileum measures 2.83 mm, with mucosa measuring 0.89 mm, submucosa 0.69 mm, and muscularis propria 0.86 mm. The ileocecal junction measures approximately 3.32 mm, with muscularis propria measuring 1.03 mm. Intestinal wall layering remains preserved throughout all evaluated segments.

Moderate-to-marked muscularis propria thickening is present involving the ileum and ileocecal junction, with lesser involvement of portions of the jejunum, resulting in increased muscularis-to-mucosa ratios. No focal obstructive lesion, plication, or foreign material is identified ultrasonographically. Formed fecal material is present within the descending colon. Normal wall.

Pancreas

The pancreas measures approximately 0.98–1.15 cm in thickness and demonstrates markedly irregular margins. Pancreatic parenchyma is mildly hypoechoic relative to the adjacent omental fat. The pancreatic duct measures approximately 2.05 mm in diameter and is markedly prominent. Multifocal nodular/remodeling-type pancreatic changes may also be present. No convincing hyperechoic peripancreatic mesenteric fat or abdominal effusion is identified to strongly support active severe pancreatitis at this time.

Free Abdomen

No abdominal effusion or sonographic evidence of peritonitis is identified. Marked ileocecal lymphadenopathy is present. Two ileocecal lymph nodes measure approximately 1.80×2.37 cm and 1.13×1.27 cm, respectively. These lymph nodes are markedly rounded and markedly hypoechoic to near anechoic in appearance. The region of the iliac trifurcation appears normal.

PRIMARY FINDINGS

- Moderate-to-marked muscularis propria thickening involving the ileum and ileocecal junction.
- Severe ileocecal lymphadenopathy with markedly rounded hypoechoic lymph nodes.
- Marked pancreatic ductal dilation/prominence with irregular pancreatic remodeling.

SECONDARY FINDINGS

- Mild subjective intrahepatic biliary prominence.
- Bilateral chronic renal cortical remodeling/chronic nephropathy-type change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The combination of marked ileal and ileocecal muscularis propria thickening, severe rounded ileocecal lymphadenopathy, chronic weight loss, chronic vomiting, diarrhea with hematochezia, and chronic gastrointestinal signs raises strong concern for infiltrative gastrointestinal disease. Low-grade alimentary lymphoma remains a primary consideration, although severe chronic inflammatory enteropathy with secondary reactive lymphadenopathy cannot be completely excluded ultrasonographically. The degree of ileocecal involvement and marked lymph node abnormalities are considered more severe than typically expected with mild uncomplicated enteropathy alone.

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Marked pancreatic ductal dilation and irregular pancreatic remodeling are also present and may reflect chronic pancreatopathy/chronic pancreatitis-type remodeling and/or concurrent pancreatic nodular hyperplasia.
Mild associated biliary remodeling may also be present.

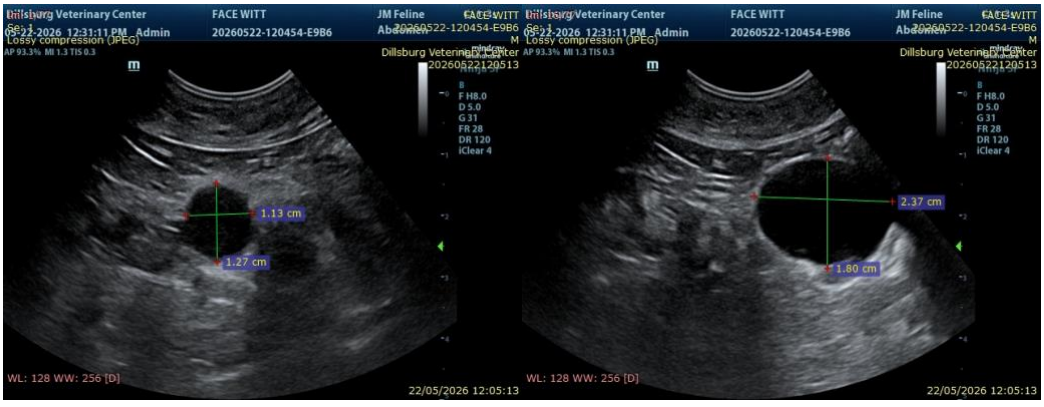
The bilateral renal cortical changes are most compatible with chronic renal disease/remodeling and correlate with the reported azotemia and positive renal biomarker status.

No mechanical gastrointestinal obstruction or abdominal effusion is identified ultrasonographically at this time.

Recommendations

- Correlation with the pending GI panel/cobalamin status is strongly recommended.
- Given the degree of ileocecal and lymph node abnormalities, intestinal and/or lymph node sampling (fine-needle aspiration and/or biopsy) should be strongly considered if clinically appropriate to further differentiate severe inflammatory enteropathy from alimentary lymphoma.
- Correlation with Spec fPL, serial pancreatic monitoring, and clinical pancreatic signs may be clinically useful given the marked pancreatic ductal abnormalities identified ultrasonographically.
- Continued renal monitoring, including serial renal values, urine specific gravity, blood pressure, and hydration support, 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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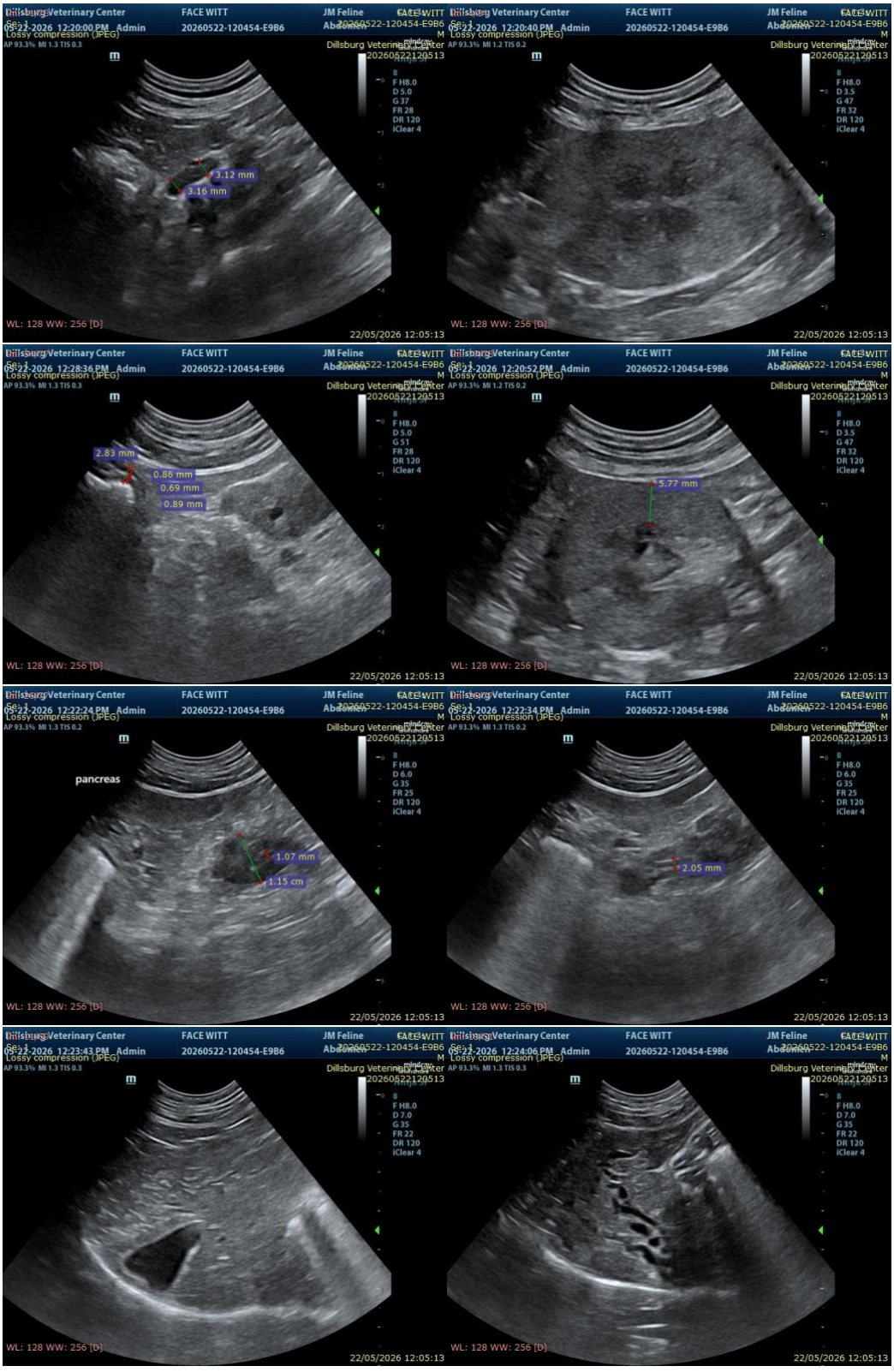

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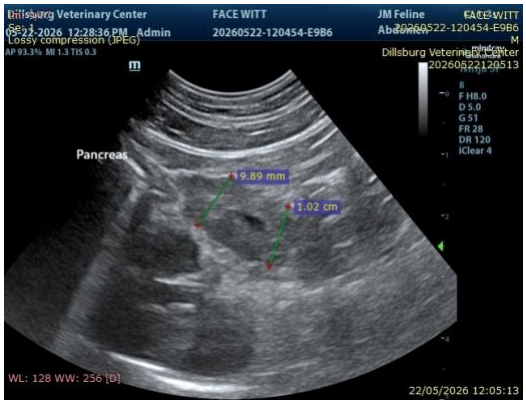

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com