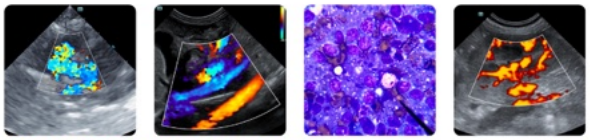


PATIENT

Lilah Mechlin

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

1 year

WEIGHT

6.5 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Ryan Moreno

HOSPITAL NAME

Seven Fields VH

REFERRING VET

Dr. Griffin

INVOICE

77988

DATE

5/26/26

PRESENTING CLINICAL SIGNS

History: History of vomiting more than usual, doing well at home otherwise with no concerns.

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 anechoic with scant 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 3.36×1.78 cm, with a cortical thickness of 0.24 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.69×1.71 cm. Both kidneys: Renal cortical echogenicity is within normal limits relative to the hepatic parenchyma bilaterally. The corticomedullary ratio and corticomedullary definition are preserved. Mild bilateral medullary rim sign change is present. No evidence of pyelectasia, nephrolithiasis, ureteral dilation, or hydronephrosis is identified. Color Doppler interrogation demonstrates a 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 0.21 cm at the cranial pole and 0.20 cm at the caudal pole. The right adrenal gland measures cm at the cranial pole and cm at the caudal pole.

Spleen

Splenic thickness is 0.56 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

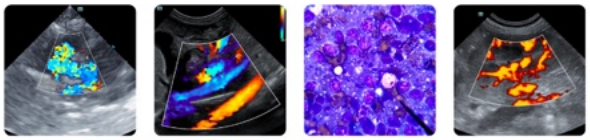
Liver

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.

Gastrointestinal tract

The stomach is empty and folded, with a small amount of fluid present within the gastric fundus. Gastric wall thickness measures approximately 1.26 mm, with preserved wall layering.



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The duodenal wall measures 1.44 mm in thickness. The jejunal wall measures 1.84 mm, with mucosa measuring 1.22 mm, submucosa 0.48 mm, and muscularis propria 0.21 mm. The ileal wall measures 2.06 mm, with mucosa measuring 0.71 mm, submucosa 0.76 mm, and muscularis propria 0.19 mm. Wall layering remains preserved throughout the evaluated intestinal tract.

The ileocecocolic junction measures approximately 2.59 mm, with mucosa measuring 0.83 mm and muscularis propria 0.53 mm. The cecal wall measures approximately 2.06–2.13 mm in thickness.

The colon measures approximately 0.80–0.89 mm in wall thickness and is largely empty/collapsed.

No sonographic evidence of gastrointestinal obstruction, foreign material, focal mass lesion, or severe inflammatory bowel disease is identified.

Pancreas

The pancreas measures approximately 3.80–4.37 mm in thickness. The pancreatic parenchyma is isoechoic relative to the adjacent mesenteric fat. The pancreatic duct is not dilated. No surrounding mesenteric fat hyperechogenicity or sonographic evidence of active pancreatitis is identified.

Free Abdomen

No sonographic evidence of abdominal effusion or peritonitis is identified. Cranial mesenteric lymph nodes measure approximately 2.68–3.33 mm in thickness, and ileocecocolic lymph nodes measure approximately 2.47–3.62 mm in thickness. The evaluated lymph nodes maintain overall normal morphology and echogenicity. The iliac trifurcation region appears normal.

PRIMARY FINDINGS

- Mild diffuse cecal and ileocecocolic junction wall prominence with preserved layering.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The current abdominal ultrasonographic examination is overall relatively unremarkable and does not demonstrate convincing sonographic evidence of gastrointestinal obstruction, infiltrative intestinal neoplasia, severe inflammatory bowel disease, pancreatitis, or clinically significant hepatobiliary disease.

Mild prominence of the cecal and ileocecocolic junction wall is present; however, mural layering remains preserved and there is no associated regional inflammatory change, obstructive pattern, or significant lymphadenopathy. In a young cat with otherwise minimal ultrasonographic abnormalities, these findings are considered nonspecific and may reflect mild reactive lymphoid tissue prominence or low-grade inflammatory change.

A small amount of fluid within the gastric fundus may reflect mild gastritis, transient reflux, or recent gastric secretions and is considered nonspecific in isolation.

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The pancreas appears within normal ultrasonographic limits, without convincing evidence of active pancreatitis at the time of examination.

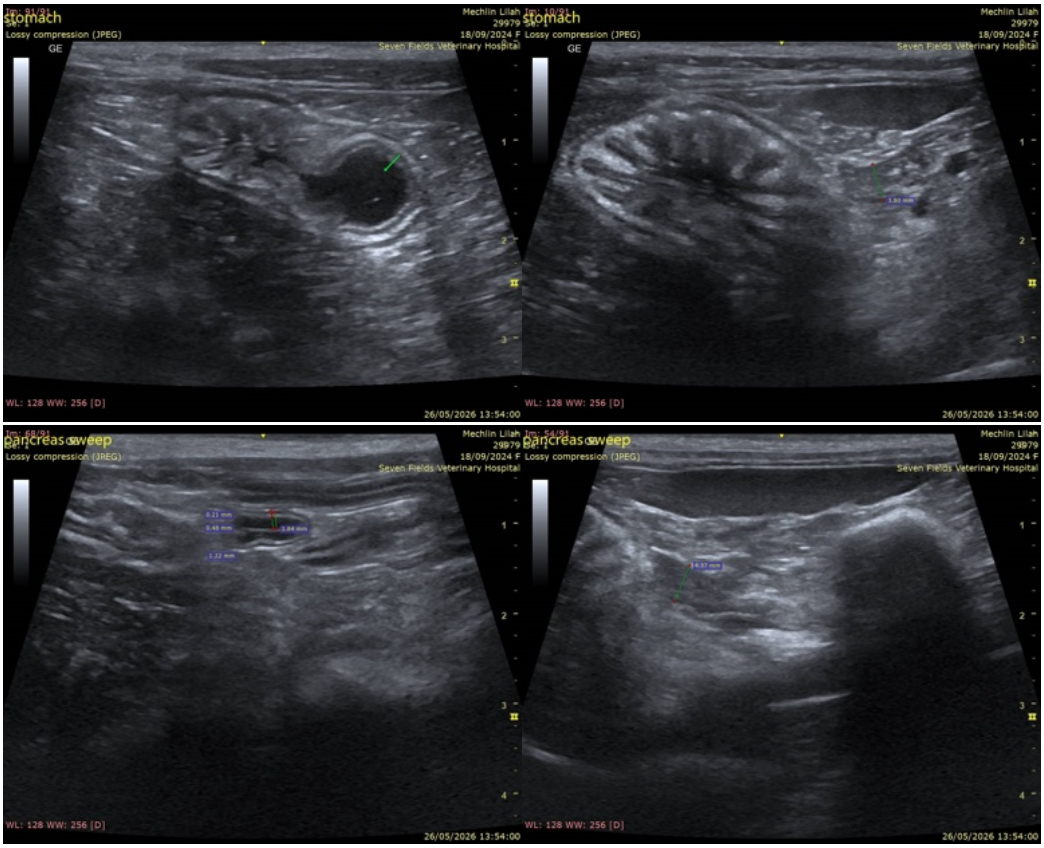
Mild bilateral medullary rim sign change is present within the kidneys. This is a common nonspecific/incidental finding in cats and does not currently suggest clinically significant renal disease.

Overall, the examination does not identify a definitive structural cause for the reported intermittent vomiting. Functional gastrointestinal disease, dietary sensitivity, mild chronic gastritis, early inflammatory enteropathy, hairball-associated vomiting, or subtle pancreatobiliary disease not detectable ultrasonographically remain possible differential considerations.

Recommendations

- Correlation with CBC, serum biochemistry, urinalysis, fecal testing, and parasite prevention history is recommended if not already performed.
- Dietary trial with a highly digestible or novel protein diet may be clinically reasonable if vomiting persists.
- Repeat abdominal ultrasound and/or additional gastrointestinal diagnostics (GI panel, fecal panel) may be considered if clinical signs worsen or become chronic/progressive.

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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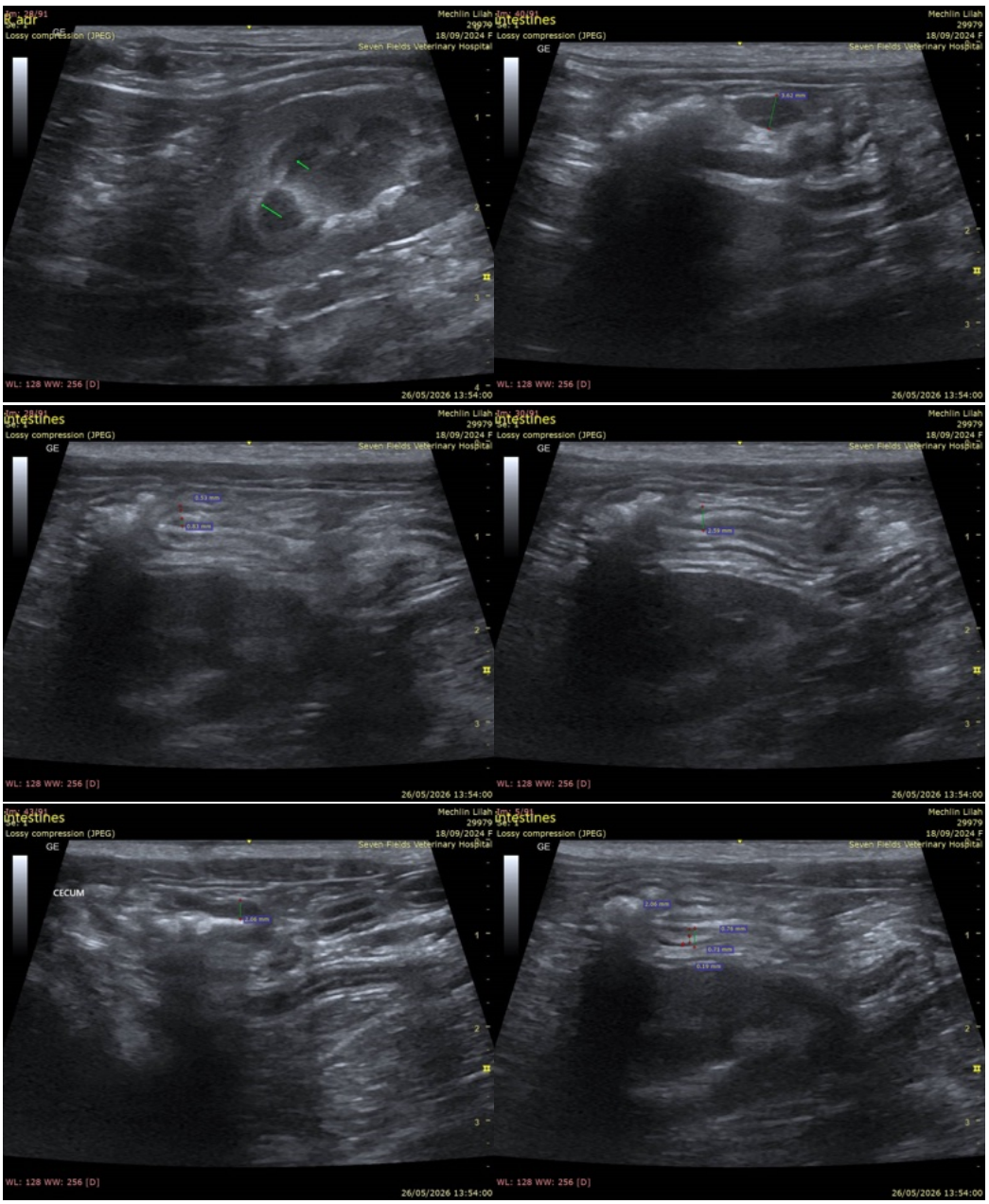

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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