



PATIENT

Oatmeal Van Hala

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

4 years 11 months

WEIGHT

9.9 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Anshu Gupta

HOSPITAL NAME

Liverpool Village
Animal Hospital

REFERRING VET

Dr. Cynthia Huff

INVOICE

12002

DATE

5/26/2026

PRESENTING CLINICAL SIGNS

3yr hx of IBD, occ gets methylpred inj (~1-2x/year, last in Sept 2025). V approx once a month. Recent constipation, responded to miralax. 0.75lb weight loss in the last 3 months.

Abnormal PE/Chem/CBC/UA Results: NSF PE. CBC/Chem April 2026 - mild neutropenia, mild hypophosphatemia, decr amylase. hyperglycemia with 2+ glucosuria, fructosamine WNL.

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 ultrasonographic evidence of inflammatory or neoplastic change.

The left kidney is normal in shape and size, measuring 3.06×2.33 cm, with cortical thickness measuring 0.36 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 4.13×2.38 cm, with cortical thickness measuring 0.32 cm in the sagittal plane.

Both renal cortices are isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is within normal limits and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a subjectively normal vascular pattern.

Adrenal Glands

Not confidently visualized.

Spleen

Splenic thickness is 0.79 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 mildly distended with a small amount of residual ingesta. Gastric wall thickness measures 1.66 mm with preserved wall layering.

The duodenum measures 1.62 mm in total wall thickness.

The jejunum measures 2.12 mm in total wall thickness. The mucosa measures 1.24 mm, submucosa 0.41 mm, and muscularis propria 0.21 mm. Wall layering is preserved.



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The ileum measures 1.76 mm in total wall thickness. The mucosa measures 0.52 mm, submucosa 1.02 mm, and muscularis propria 0.39 mm. Normal wall layering is preserved.

The ileocecal junction was not confidently visualized in the submitted study.

The colon measures 0.74 mm in wall thickness and contains a small amount of formed fecal material within the descending colon.

Pancreas

The evaluated pancreatic regions do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

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

PRIMARY FINDINGS

- Mild gastric distension with residual ingesta.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This abdominal ultrasonographic examination is largely unremarkable and does not demonstrate convincing sonographic evidence of clinically significant infiltrative gastrointestinal disease, intestinal mass lesion, obstructive process, or abdominal lymphadenopathy.

Importantly, the previously reported history of chronic inflammatory bowel disease is not currently associated with significant diffuse intestinal wall thickening, muscularis propria hypertrophy, loss of mural layering, mesenteric lymphadenopathy, or reactive mesenteric change in the evaluated intestinal segments. The muscularis-to-mucosa ratios remain within normal limits throughout the evaluated small intestinal segments and do not support active moderate-to-severe chronic infiltrative enteropathy on this examination.

Mild intermittent gastrointestinal dysfunction, food-responsive enteropathy, low-grade chronic inflammatory enteropathy, dysmotility, or episodic gastritis remain possible despite the relatively unremarkable ultrasonographic appearance, particularly given the chronic clinical history. The mild gastric residual ingesta/distension is nonspecific and may reflect recent feeding or mild delayed gastric emptying.

Recommendations

- Continued clinical and laboratory monitoring is reasonable given the chronic history of gastrointestinal disease and recent mild weight loss.
- Correlation with serum cobalamin/folate testing and GI panel may be considered if not recently performed. If hypcobalaminemia is identified, cobalamin supplementation is recommended.
- Dietary management and ongoing medical management for chronic enteropathy may continue based on clinical response and attending clinician preference. Empiric anti-inflammatory enteropathy-directed therapy may also be considered if clinically indicated by the attending veterinarian.

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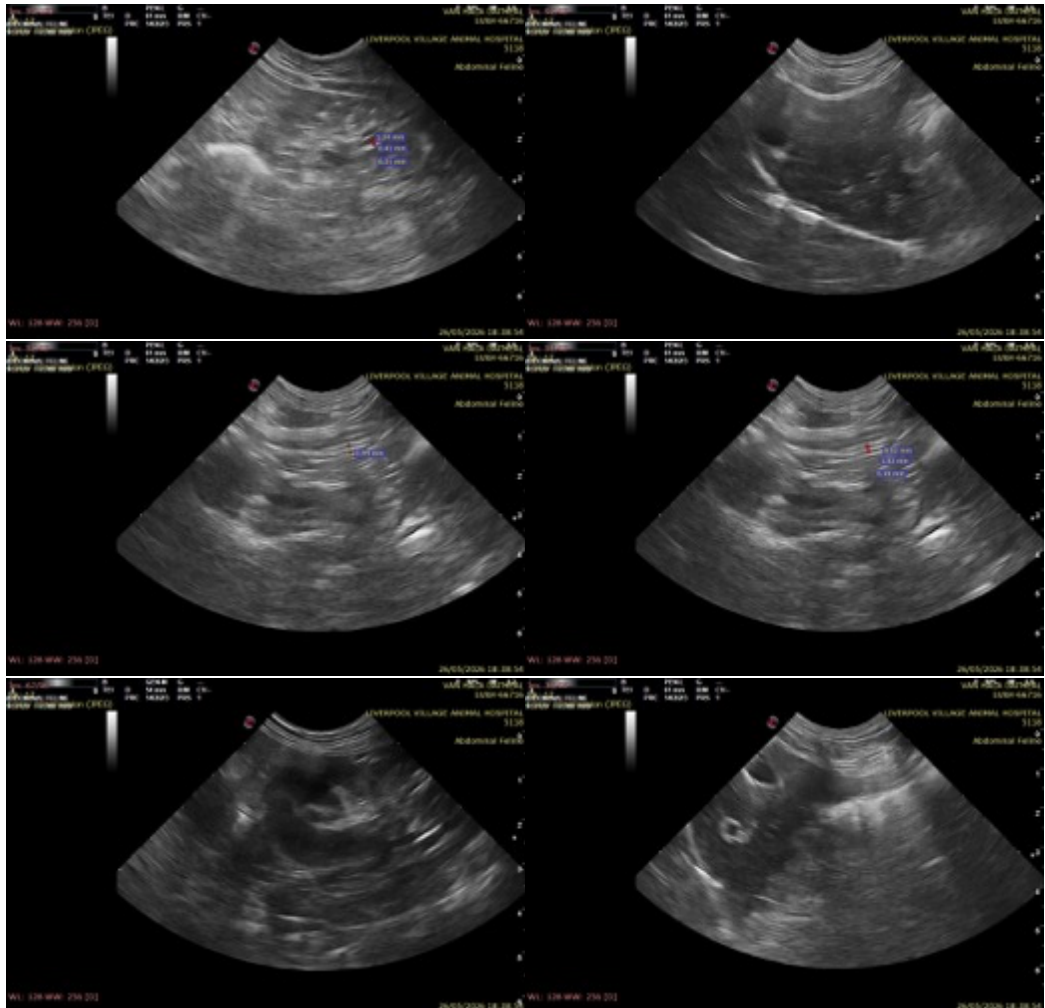
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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