



## PATIENT

Baby Gillingham

## SPECIES

Feline

## BREED

Domestic Shorthair

## SEX

Spayed female

## AGE

10 years

## WEIGHT

11.6 lbs

## INTERPRETED BY

Alicia Angosto  
Guerrero, DMV,  
PgDip, MSc.

## IMAGING PERFORMED BY

Melissa Rosen

## HOSPITAL NAME

South Bellmore  
Veterinary Group

## REFERRING VET

Dr. Franko

## INVOICE

78028

## DATE

5/27/26

## PRESENTING CLINICAL SIGNS

History: low albumin on recent annual bloodwork. Clinically doing well. Nervous, on fluoxetine  
Abnormal PE/Chem/CBC/UA Results: alb 2.2 glob 7.6 TP 9.8 alb/glob ratio 0.3 blood pressures normal  
(with sedation) systolics ~ 140's

## 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 predominantly anechoic with scant suspended echoes. 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 3.87×2.25 cm, with cortical thickness measuring 0.31 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified.

The right kidney is normal in shape and size, measuring 4.03×2.28 cm, with cortical thickness measuring 0.27 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified.

### Adrenal Glands

The left adrenal gland measures 0.30 cm. The right adrenal gland is not confidently visualized.

### Spleen

Splenic thickness is 0.70-0.79 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 poorly 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 tract***

The stomach is moderately distended with food material. Gastric wall thickness measures approximately 2.18 mm with preserved wall layering. The pylorus measures 2.60 mm in wall thickness. The duodenum measures 1.84 mm in wall thickness. The jejunum measures 2.31 mm in total wall thickness. The mucosa measures 1.25 mm, submucosa 0.58 mm, and muscularis propria 0.22 mm. Wall layering remains preserved. The ileum measures approximately 2.80 mm in total wall thickness. The mucosa measures 0.77 mm, submucosa 0.88 mm, and muscularis propria 0.93 mm, resulting in a markedly increased muscularis-to-mucosa ratio. Wall layering remains preserved. The ileocecal junction measures approximately 2.82 mm in total wall thickness. The mucosa measures 1.24 mm and the muscularis propria measures 1.54 mm, indicating marked muscularis-predominant mural thickening. The colon measures approximately 0.61 mm in wall thickness with scant luminal contents.

## ***Pancreas***

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

## ***Free Abdomen***

No abdominal effusion or peritonitis is identified. Cranial mesenteric lymph nodes measure approximately 3.79-4.80 mm in thickness, and ileocecal lymph nodes measure approximately 1.94-2.09 mm in thickness. These lymph nodes maintain normal shape and echogenicity. No abdominal lymphadenopathy is identified. The iliac trifurcation lymph nodes are within normal limits.

## **PRIMARY FINDINGS**

- Marked muscularis-predominant mural thickening involving the ileum and ileocecal junction with preserved wall layering

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

This examination demonstrates marked muscularis-predominant mural thickening involving the ileum and ileocecal junction with preservation of normal wall layering and without associated abdominal lymphadenopathy, obstructive gastrointestinal disease, mesenteric inflammatory change, or abdominal effusion.

In the context of the reported marked hyperglobulinemia and low albumin-to-globulin ratio, these findings are concerning for chronic infiltrative gastrointestinal disease. Differential considerations include chronic inflammatory enteropathy/plasmacytic enteritis and early or low-grade alimentary lymphoma. The preserved wall layering and lack of associated aggressive abdominal changes are somewhat reassuring; however, the degree and distribution of muscularis thickening, particularly centered at the ileocecal region, remain abnormal and clinically significant.

The combination of hyperglobulinemia, hypoalbuminemia, proteinuria (UPC 1.3), and chronic infiltrative-appearing intestinal change also raises concern for a broader chronic inflammatory, immune-mediated, or lymphoplasmacytic process rather than renal disease alone.



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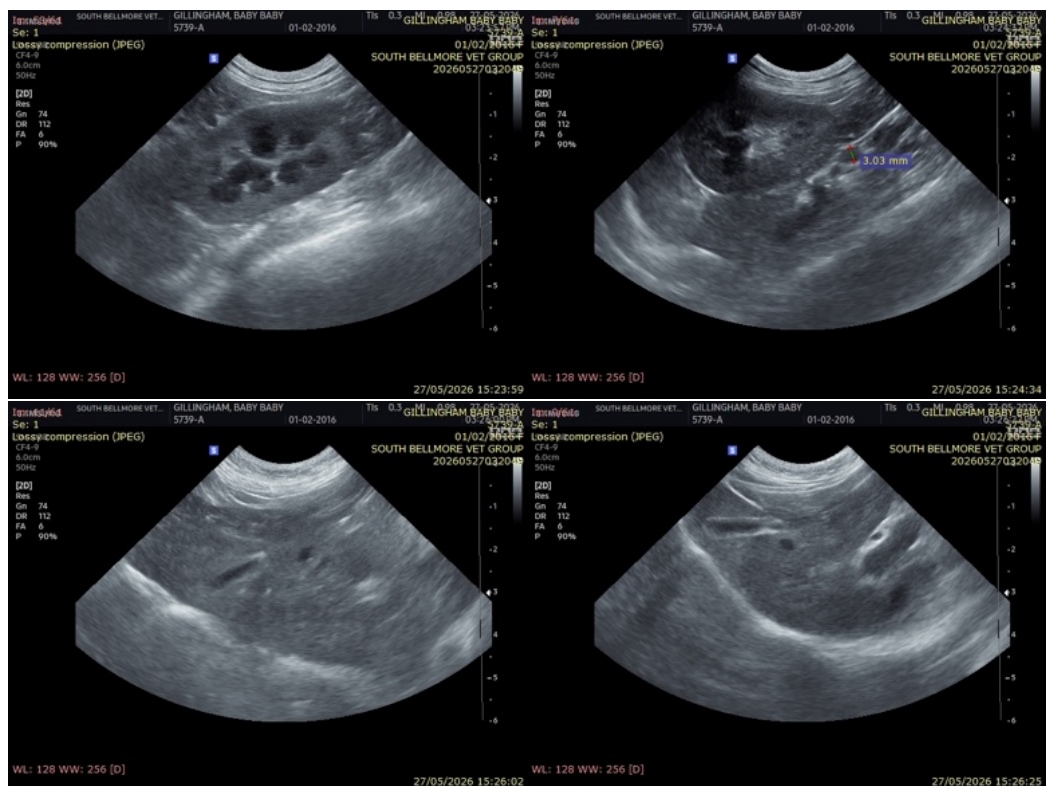
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## Recommendations

- Correlation with serum protein electrophoresis and potentially urine protein electrophoresis is recommended to further characterize the marked hyperglobulinemia and determine whether the gammopathy is polyclonal or monoclonal.
- Correlation with infectious disease testing (including FeLV/FIV status and other regionally appropriate infectious disease screening) should be considered if not already performed.
- Gastrointestinal biopsy (endoscopic versus full-thickness depending on clinician preference and lesion accessibility) may ultimately be required for definitive differentiation between chronic inflammatory enteropathy and low-grade alimentary lymphoma if clinically indicated.
- Continued monitoring of renal parameters, UPC, and serum albumin/globulin trends.

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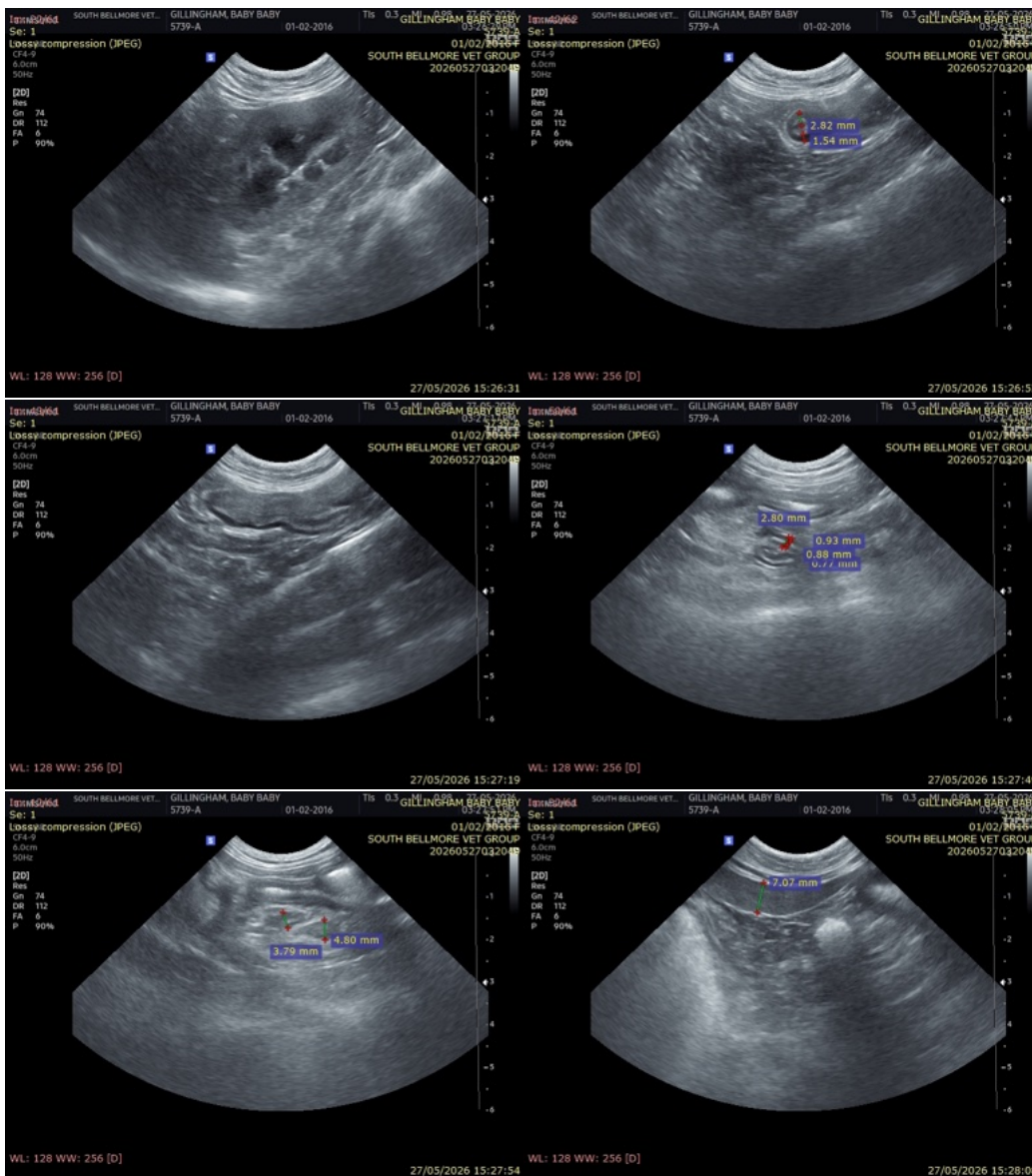
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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