



## PATIENT

Elmo Chen

## SPECIES

Feline

## BREED

Domestic Longhair

## SEX

Neutered male

## AGE

14 ½ years

## WEIGHT

9.46 lbs

## INTERPRETED BY

Alicia Angosto  
Guerrero, DMV,  
PgDip, MSc.

## IMAGING PERFORMED BY

Melinda Persson

## HOSPITAL NAME

At Home Veterinary

## REFERRING VET

Dr. Persson

## INVOICE

78054

## DATE

5/27/26

## PRESENTING CLINICAL SIGNS

History: \*Chronic weight loss - suspected IBD or LSA for years - not imaged before

\*Not eating well, lethargic, vomiting

\*Recent constipation and enema - treated 4 days ago

\*Distended belly

\*Well-managed hyperthyroidism and hypertension

\*Free abdominal fluid a creamy white color but relatively thin - analysis and culture pending

Abnormal PE/Chem/CBC/UA Results: BUN 44 CR 1.7 SMDA 35 (<15) Neutrophils 21,620 Platelets 950,000

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder is incompletely distended. The urinary bladder wall measures approximately 2.69 mm in thickness and appears smooth; however, mild overestimation of wall thickness is possible due to underdistension. 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 3.79 × 2.77 cm, with cortical thickness measuring 0.32 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. Mild pyelectasia is present, measuring approximately 1.3 mm. No nephrolithiasis or hydronephrosis is identified. Mild left renal capsular thickening with a thin adjacent hypoechoic subcapsular interface is also identified, which may represent trace subcapsular fluid accumulation versus infiltrative/reactive subcapsular change.

The right kidney is normal in shape and size, measuring 3.98 × 2.30 cm, with cortical thickness measuring 0.42 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. Color Doppler demonstrates a subjectively normal vascular pattern.

### Adrenal Glands

The adrenal glands are not confidently visualized.

### 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.



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## 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 is normally distended. The wall remains thin and smooth. A moderate amount of non-shadowing biliary sludge is present within the lumen. No cystic duct or common bile duct dilation is identified.

## Gastrointestinal tract

The stomach is empty and folded, with wall thickness measuring approximately 1.23 mm and preserved wall layering.

The duodenum measures approximately 2.18 mm in wall thickness.

The jejunum measures approximately 2.81 mm in total wall thickness. The mucosa measures 1.17 mm, submucosa 0.54 mm, and muscularis propria 0.77 mm, resulting in muscularis prominence.

The ileum measures approximately 3.78 mm in total wall thickness. The mucosa measures 0.98 mm, submucosa 1.04 mm, and muscularis propria 1.69 mm, resulting in marked muscularis-predominant mural thickening. Wall layering remains preserved.

An additional segment of small intestine demonstrates muscularis propria thickening measuring approximately 1.78 mm.

The colon measures approximately 0.89 mm in wall thickness and contains formed fecal material within the descending colon.

## Pancreas

The pancreas measures approximately 8.06 mm in thickness. The pancreatic parenchyma is hypoechoic relative to the adjacent mesenteric fat. The pancreatic duct measures approximately 0.72 mm in diameter.

## Free Abdomen

Abundant markedly turbid abdominal effusion is present. The peritoneum appears diffusely and markedly thickened, consistent with generalized peritonitis/peritoneal inflammation.

Cranial mesenteric lymph nodes measure approximately 5.43-7.14 mm in thickness. Ileocecal lymph nodes measure approximately 5.15 mm in thickness and are mildly heterogeneous.

Mild pleural effusion is also suspected, although thoracic imaging would be required for confirmation and further characterization.

The iliac trifurcation lymph nodes are within normal limits.



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## PRIMARY FINDINGS

- Marked muscularis-predominant mural thickening involving the ileum and additional segments of small intestine.
- Severe diffuse peritoneal thickening/peritonitis with abundant turbid abdominal effusion
- Moderate mesenteric and ileocecal lymphadenopathy
- Mild left renal pyelectasia and subcapsular renal change/fluid

## SECONDARY FINDINGS

- Moderate biliary sludge accumulation
- Pancreas enlarged and hypoechoic.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This examination demonstrates marked muscularis-predominant mural thickening involving the ileum and additional segments of small intestine, together with severe diffuse peritoneal thickening/peritonitis, abundant markedly turbid abdominal effusion, and mild-to-moderate mesenteric/ileocecal lymphadenopathy.

The overall ultrasonographic appearance is highly concerning for advanced infiltrative gastrointestinal disease with secondary diffuse peritoneal involvement. Alimentary lymphoma with associated peritoneal/lymphatic infiltration is highly suspected.

Concurrent pancreatopathy/pancreatitis is also present and may represent either a secondary reactive process or part of a more diffuse feline gastrointestinal-pancreatobiliary inflammatory/neoplastic syndrome.

Mild left renal capsular thickening with an adjacent hypoechoic subcapsular band/interface is additionally identified. Although trace subcapsular fluid cannot be completely excluded, infiltrative/reactive subcapsular change is considered more likely in the context of the overall abdominal abnormalities. Possible lymphomatous infiltration is considered a strong differential consideration.

Mild pleural effusion is also suspected, although dedicated thoracic imaging would be required for confirmation and further characterization.

Concurrent neutrophilia and marked reactive thrombocytosis further support the presence of significant active inflammatory and/or infiltrative disease. The markedly turbid/creamy abdominal effusion, severe diffuse peritoneal thickening, and inflammatory leukogram substantially increase concern for clinically significant infiltrative/neoplastic disease with secondary peritoneal inflammatory involvement rather than isolated uncomplicated inflammatory bowel disease.

### Recommendations

- Full cytologic evaluation of the abdominal effusion is strongly recommended.
- Ultrasound-guided fine needle aspiration of abnormal mesenteric/ileocecal lymph nodes could be considered if clinically feasible and safe.
- Gastrointestinal biopsy (endoscopic versus surgical full-thickness) will likely ultimately be required for definitive diagnosis if clinically appropriate.
- Thoracic imaging is recommended to further evaluate for pleural effusion and assess for concurrent



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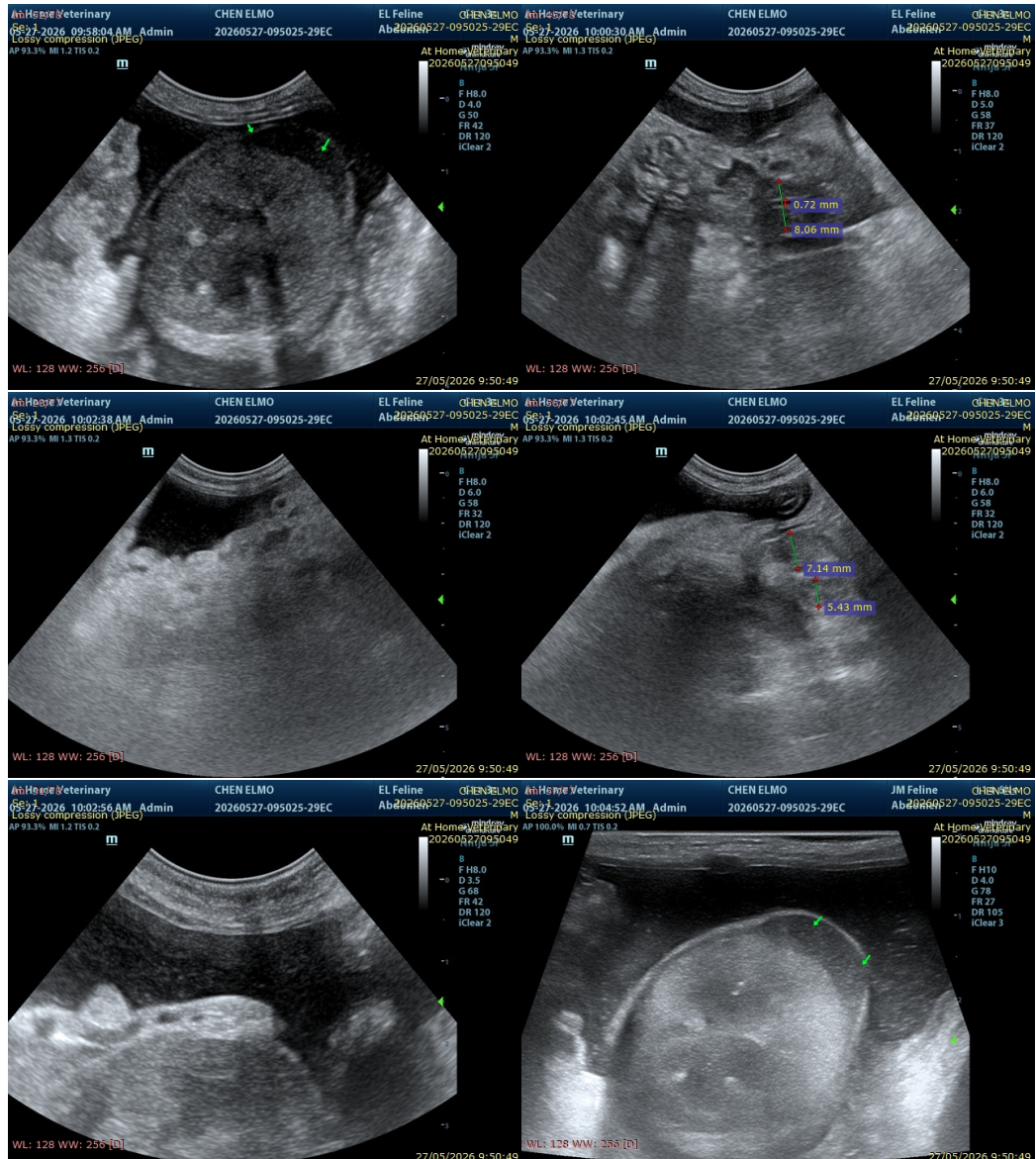
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thoracic involvement.

- Correlation with Spec fPL, cobalamin/folate testing, and ongoing renal monitoring 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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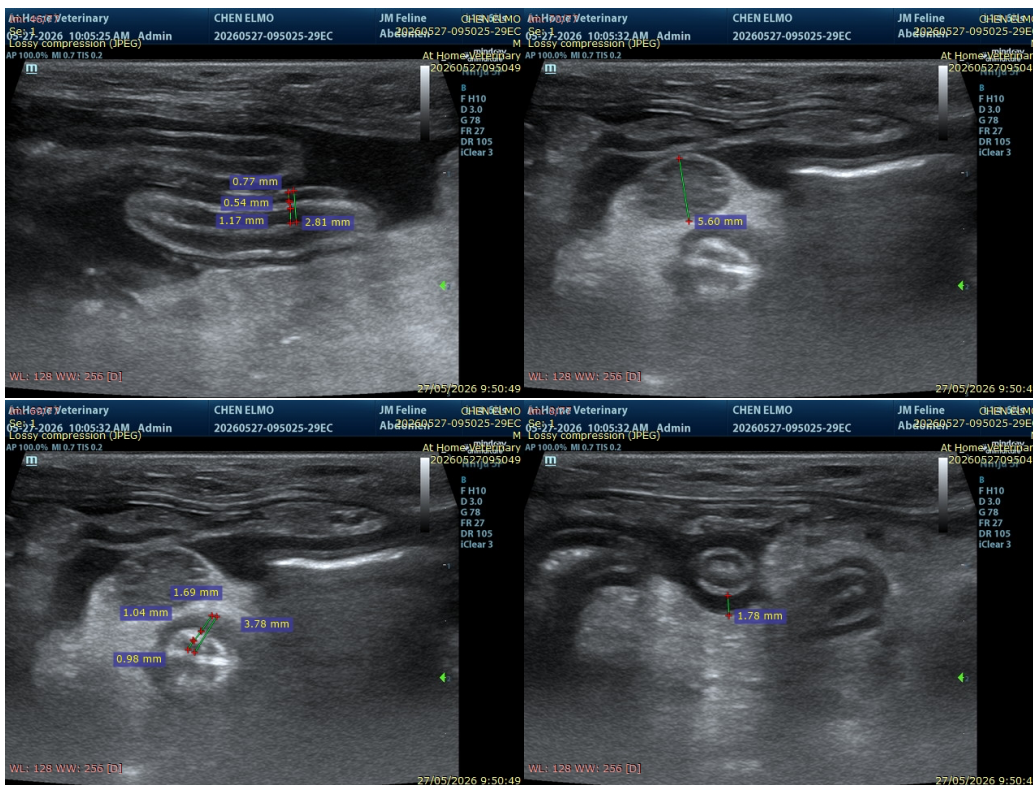
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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