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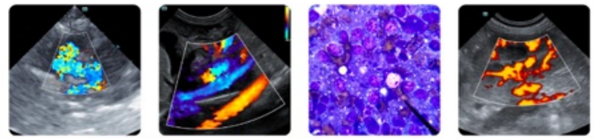


Clinical Sonography & Telecytology

Educational Teleconsultation Services™

PATIENT

Norman Coby

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

13 years

WEIGHT

13 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Renee Ziegler Post

HOSPITAL NAME

For Cats Only VC

REFERRING VET

Dr. Ziegler Post

INVOICE

78025

DATE

PRESENTING CLINICAL SIGNS

History: Not eating, vomiting, just started immunotherapy injections. Wanted to rule out concurrent comorbidities.

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 measures 3.47×2.11 cm, with cortical thickness measuring 0.25 cm in the sagittal plane. The right kidney measures 3.40×2.22 cm, with cortical thickness measuring 0.26 cm in the sagittal plane. Both kidneys demonstrate mildly irregular contours. The renal cortices are diffusely hyperechoic relative to the hepatic parenchyma. The corticomedullary ratio remains within normal limits and corticomedullary definition is preserved. Mild medullary nephrocalcinosis/mineralization is present, more pronounced in the right kidney. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

The left adrenal gland is visualized and measures 0.28 cm at the caudal pole. The right adrenal gland is not confidently visualized.

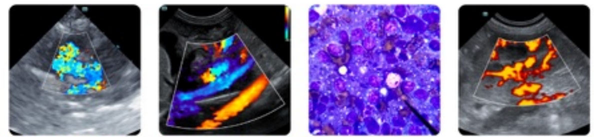
Spleen

Splenic thickness is 0.74 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 is normally distended. The wall remains thin and smooth. A moderate amount of non-shadowing biliary sludge is present within the lumen. The common bile duct measures 2.26 mm, without convincing evidence of extrahepatic biliary obstruction.



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Gastrointestinal tract

The stomach is mildly distended with food material. Gastric wall thickness measures 1.53 mm with preserved wall layering. The pylorus measures 2.49 mm in wall thickness. The duodenum measures 1.51 mm in wall thickness. The jejunum measures 1.92 mm in total wall thickness. The mucosa measures 0.67 mm, submucosa 0.53 mm, and muscularis propria 0.66 mm, resulting in a mildly increased muscularis-to-mucosa ratio. The ileum measures 1.50 mm in total wall thickness. The mucosa measures 0.48 mm, submucosa 0.51 mm, and muscularis propria 0.45 mm. Wall layering remains preserved. The ileocecal junction measures 2.45 mm, with mucosa measuring 0.88 mm and muscularis propria 0.87 mm, resulting in marked muscularis prominence at the ileocecal region. An additional segment of small intestine measures 2.47 mm in wall thickness, with mucosa measuring 0.60 mm and muscularis propria measuring 1.29 mm, indicating marked muscularis-predominant mural thickening. The colon measures 1.28 mm in wall thickness and is largely empty.

Pancreas

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

Free Abdomen

No abdominal effusion or peritonitis is identified. The cranial mesenteric lymph nodes measure approximately 3.55-4.33 mm in thickness and maintain normal shape and echogenicity. The ileocecal lymph nodes are not confidently visualized, although the surrounding mesentery appears unremarkable. The iliac trifurcation lymph nodes are within normal limits.

PRIMARY FINDINGS

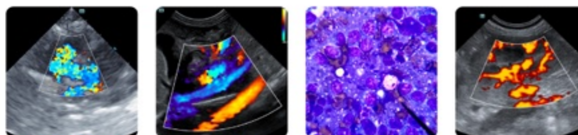
- Diffuse muscularis-predominant small intestinal mural thickening, most pronounced at the ileocecal junction and within one focal small intestinal segment

SECONDARY FINDINGS

- Mild chronic bilateral renal change/remodeling with medullary nephrocalcinosis.
- Moderate biliary sludge accumulation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This examination demonstrates a diffuse muscularis-predominant small intestinal mural thickening with preserved wall layering, most pronounced at the ileocecal junction and within one segment of small intestine. In a geriatric cat with vomiting and hyporexia, these findings are most compatible with chronic inflammatory enteropathy/chronic enteritis. However, early or low-grade alimentary lymphoma cannot be completely excluded ultrasonographically, particularly given the focal segment demonstrating more marked muscularis thickening and the known ultrasonographic overlap between chronic inflammatory enteropathy and low-grade feline alimentary lymphoma.



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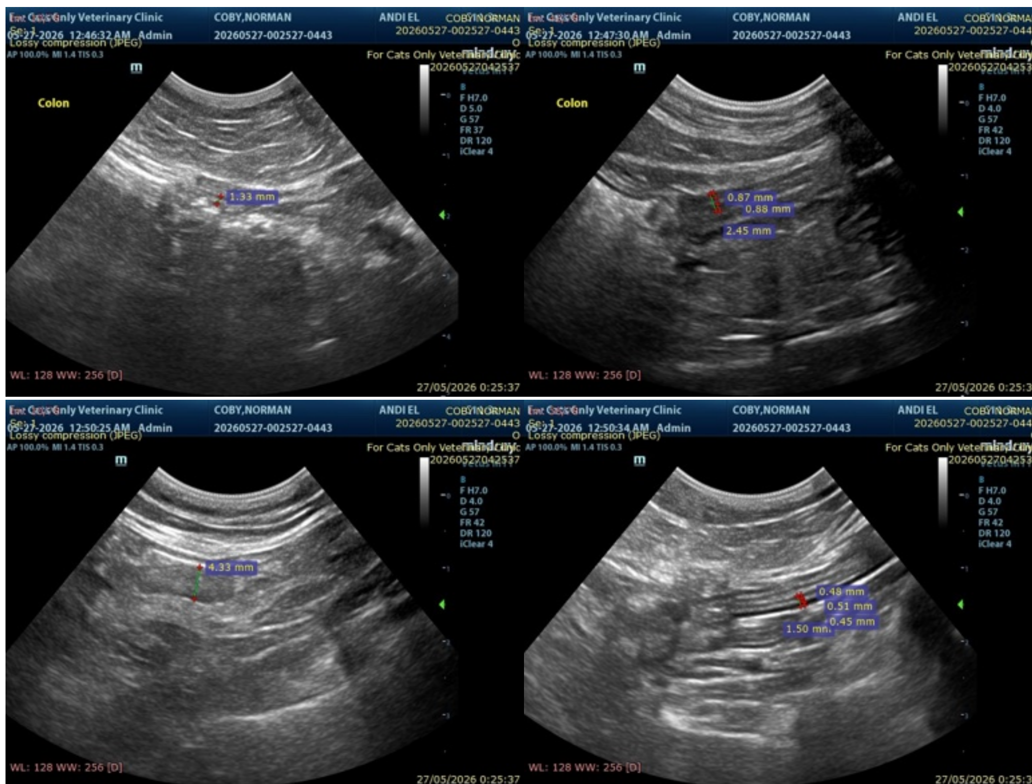
The moderate biliary sludge is nonspecific and may represent incidental chronic biliary stasis secondary to vomiting and hyporexia. No convincing ultrasonographic evidence of extrahepatic biliary obstruction or clinically significant pancreatobiliary inflammation is identified at this time.

Chronic renal remodeling/nephrocalcinosis is also present.

Recommendations

- Correlation with CBC, serum biochemistry, cobalamin/folate testing, and GI panel is recommended if not already performed.
- Empiric medical management directed toward chronic inflammatory enteropathy may be reasonable depending on overall clinical progression and attending clinician preference.
- If clinical signs persist or progress despite therapy, repeat abdominal ultrasound and/or intestinal biopsy may ultimately be required to better differentiate chronic inflammatory enteropathy from early low-grade alimentary lymphoma.
- Correlation with renal parameters, urinalysis, blood pressure, and calcium-phosphorus metabolism is reasonable given the renal mineralization/remodeling changes.

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