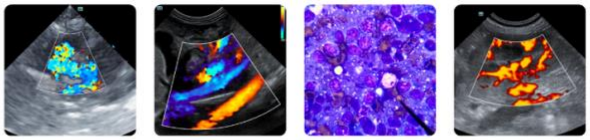


PATIENT

Piper Boucher

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

15 Years

WEIGHT

4.9 Pounds

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Emma Flott

HOSPITAL NAME

Portland VWC

REFERRING VET

Dr. Mary-Ann Onuta

INVOICE

37262

DATE

5/28/26

PRESENTING CLINICAL SIGNS

History: patient was started on hydrolyzed diet 9 weeks ago for chronic vomiting; vomiting has reduced but patient has continued to have intermittent vomiting and weight loss.

Abnormal PE/Chem/CBC/UA Results: Most recent labs from March 2026 CBC - eosinophilia (1.7) Chem - hypoalbuminemia 2.4 UA - USG 1.026 T4 - 5 PE - intestines palpate ropey, decreased skin turgor.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the wall appears thin and smooth. The urine is anechoic. The bladder neck and proximal urethra have a normal ultrasonographic appearance. No calculi or sonographic evidence of inflammatory or neoplastic disease are identified.

The left kidney is normal in shape and size, measuring 2.93×1.92 cm. The cortical thickness measures 0.32 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 3.13×1.74 cm. The cortical thickness measures 0.38 cm in the sagittal plane.

The renal cortices are isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.25 cm at the cranial pole and 0.27 cm at the caudal pole. The right adrenal gland measures 0.22 cm at the cranial pole and 0.22 cm at the caudal pole.

Spleen

Splenic thickness is 0.44 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

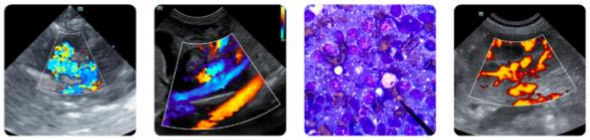
Liver

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 is thin, and the contents are predominantly anechoic with a small amount of dependent biliary sludge. The common bile duct measures 2.74 mm. No evidence of biliary obstruction is identified.

Gastrointestinal tract

The stomach is empty and folded. Gastric wall thickness measures 1.33 mm, with preserved wall layering.



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The pyloric wall measures 3.03 mm.

The duodenal wall measures 2.13 mm.

The jejunal wall measures 1.52 mm. The mucosa measures 0.55 mm, the submucosa 0.59 mm, and the muscularis propria 0.38 mm. Wall layering is preserved.

The ileal wall measures 2.29 mm. The mucosa measures 0.66 mm, the submucosa 0.72 mm, and the muscularis propria 0.56 mm. Wall layering is preserved.

The ileocecal junction measures 3.72 mm. The mucosa measures 1.29 mm and the muscularis propria measures 1.90 mm. Wall layering is preserved.

No evidence of gastrointestinal obstruction, ileus, or foreign material is identified.

The colonic wall measures 0.79 mm. Formed fecal material is present within the descending colon.

Pancreas

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

Free Abdomen

No abdominal effusion or sonographic evidence of peritonitis is identified.

The cranial mesenteric lymph nodes measure approximately 0.50–0.60 cm in thickness, are mildly hypoechoic, and maintain an elongated shape. The ileocecal lymph nodes are not definitively visualized.

PRIMARY FINDINGS

- Mild muscularis propria thickening of the ileum and, more notably, the ileocecal junction.
- Mildly enlarged hypoechoic cranial mesenteric lymph nodes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mild muscularis propria thickening involving the ileum and, most prominently, the ileocecal junction, together with mild cranial mesenteric lymphadenopathy, supports chronic enteropathy. In the context of chronic vomiting, weight loss, hypoalbuminemia, eosinophilia, and palpably ropey intestines, the findings are most concerning for inflammatory bowel disease/chronic inflammatory enteropathy. Eosinophilic enteritis is an important consideration given the documented peripheral eosinophilia.

Early low-grade alimentary lymphoma cannot be completely excluded, particularly given the patient's age and weight loss; however, the preserved wall layering, absence of a discrete mass lesion, lack of marked intestinal thickening, and only mild lymph node changes favor chronic inflammatory gastrointestinal disease over an aggressive infiltrative neoplasm.

No sonographic evidence of mechanical gastrointestinal obstruction, pancreatitis, or other obvious cause of vomiting is identified.

Recommendations:

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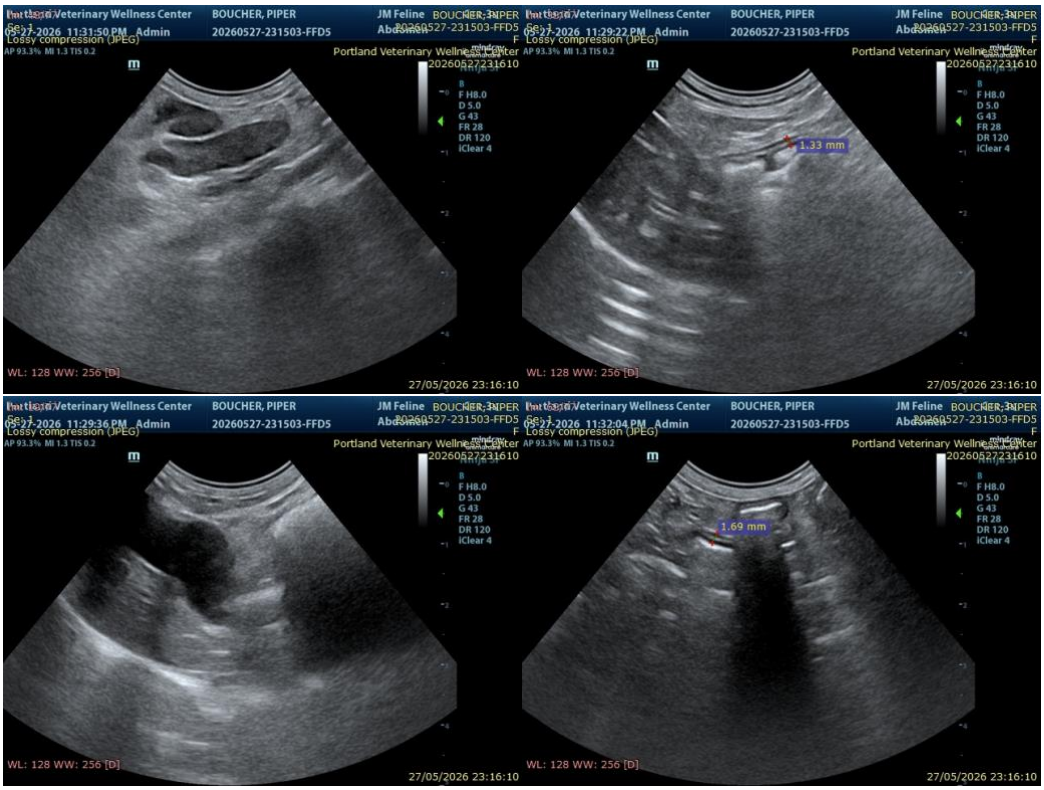
- Correlation with serum cobalamin, folate, and gastrointestinal panel testing is recommended if not previously performed.
- Intestinal biopsy may be considered if definitive differentiation between chronic inflammatory enteropathy and low-grade alimentary lymphoma is desired.
- If intestinal biopsy is not pursued, empiric management for chronic enteropathy may be considered, including continued dietary therapy, cobalamin supplementation as indicated, and appropriate anti-inflammatory treatment based on the patient's clinical progression and attending clinician preference.
- Serial monitoring of body weight, serum albumin concentration, and clinical response 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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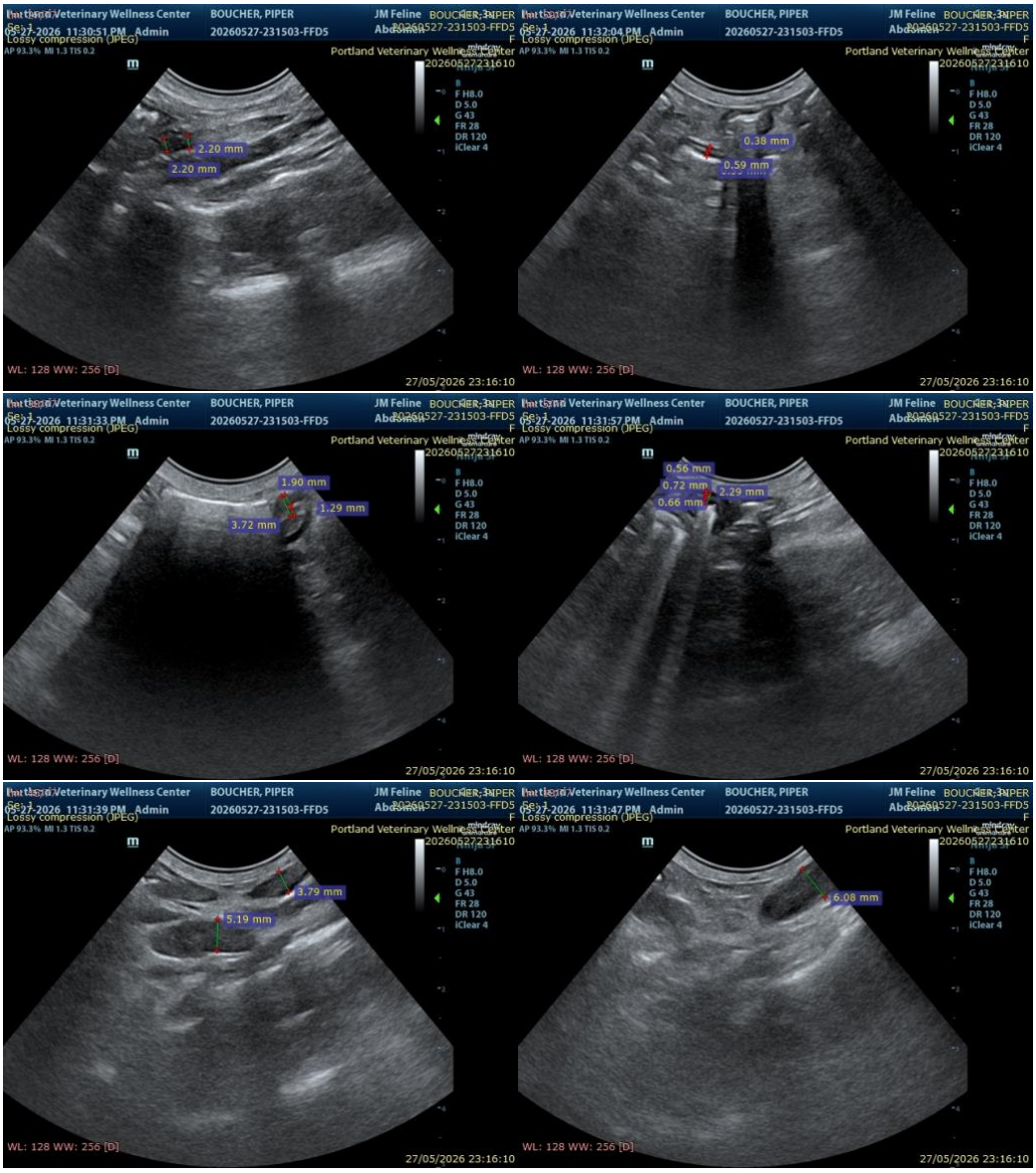

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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