



## PATIENT

Kali Roybal

## SPECIES

Feline

## BREED

Domestic Shorthair

## SEX

Spayed female

## AGE

12 years

## WEIGHT

11.9 lbs

## INTERPRETED BY

Alicia Angosto  
Guerrero, DMV,  
PgDip, MSc.

## IMAGING PERFORMED BY

Quinn Robinson, RVT

## HOSPITAL NAME

Hess Ridge AH

## REFERRING VET

Michael Skarie, DVM

## INVOICE

75275

## DATE

5/6/26

## PRESENTING CLINICAL SIGNS

History: 12-year-old FS feline presenting for abdominal ultrasound due to 6–9 month history of progressive polyphagia/ravenous appetite, foodseeking behavior, irritability/aggression, and concern for discomfort. Owner reports she will eat any food left out, tries to eat dog/human food, and has become more reactive around meal times.

Weight has decreased from 12.8 lb in 7/2025 to 11.9 lb on 5/1/2 despite increased appetite. Known history of hypertrophic cardiomyopathy diagnosed in 2022; currently managed with clopidogrel 18.75 mg PO SID and benazepril 2.5

mg PO SID. Prior cardiology report noted HCM with moderate LA dilation and mild LVOT obstruction  
Abnormal PE/Chem/CBC/UA Results: 5/1/26: CBC largely WNL except mild monocytosis 0.697 K/ $\mu$ L. Chemistry: amylase 3,254 U/L H, chloride 111 mmol/L L. Creatinine 1.3, BUN 32, SDMA 12, ALT 76, ALP 14, bilirubin WNL. Lipase normal at 8. TT4 1.8 and free T4 0.9, both WNL

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder lumen is underdistended. The urinary bladder wall measures approximately 2.19 mm in thickness and remains smooth and regular in appearance. Due to underdistension, urinary bladder wall thickness may be mildly overestimated. The urine is predominantly anechoic with scant suspended echogenic debris. The bladder neck and proximal urethra are unremarkable. No cystoliths or sonographic evidence of inflammatory or neoplastic urinary bladder disease are identified.

The left kidney is normal in shape and size, measuring 3.72×2.58 cm. Cortical thickness measures 0.39 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. Corticomedullary ratio and corticomedullary distinction are preserved. No pyelectasia, hydronephrosis, or nephrolithiasis is identified. Color Doppler evaluation demonstrates a subjectively normal vascular pattern.

The right kidney is normal in shape and size, measuring 4.31×3.10 cm. Cortical thickness measures 0.47 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. Corticomedullary ratio and corticomedullary distinction are preserved. No pyelectasia, hydronephrosis, or nephrolithiasis is identified. Color Doppler evaluation demonstrates a subjectively normal vascular pattern.

### Adrenal Glands

Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.46 cm at the cranial pole and 0.50 cm at the caudal pole. The right adrenal gland measures 0.40 cm at the cranial pole and 0.44 cm at the caudal pole

### Spleen

Splenic thickness is 0.67 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 gallbladder wall measures approximately 0.87 mm in thickness. The contents are predominantly anechoic with a very small amount of biliary sludge. The common bile duct measures approximately 3.38 mm proximally, tapering distally to approximately 2.45 mm and 1.85 mm.

## Gastrointestinal Tract

The stomach contains small amounts of ingesta and gas. Gastric wall thickness measures approximately 1.91–1.97 mm with preserved mural layering. The pyloric wall measures 3.41 mm. Duodenal wall thickness measures 2.12 mm. Jejunal wall thickness measures approximately 2.84–3.03 mm, with: Mucosa: 2.50 mm. Submucosa: 0.44 mm. Muscularis propria: 0.40 mm. The ileal wall measures approximately 1.61–1.75 mm. The mural layers are very thin and difficult to measure accurately, although layering remains preserved. The ileocecal junction measures approximately 3.64 mm in thickness, with muscularis thickness measuring approximately 1.18 mm. No focal gastrointestinal mass lesion, obstructive ileus, or regional inflammatory change is identified. Colonic wall thickness measures approximately 0.97–1.41 mm, with formed fecal material present within the descending colon.

## Pancreas

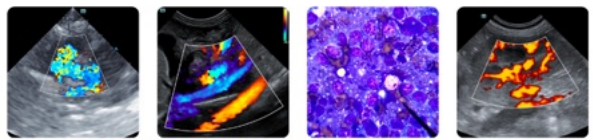
The pancreas measures approximately 7.44 mm in thickness. The pancreatic parenchyma is isoechoic relative to the adjacent omental fat. The pancreatic duct measures approximately 0.96 mm in diameter. No sonographic evidence of active pancreatitis, peripancreatic inflammation, or focal pancreatic mass lesion is identified.

## Free Abdomen

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

## PRIMARY FINDINGS

- Mild prominence of the ileocecal muscularis layer.
- Mild extrahepatic biliary duct prominence.



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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Mild muscularis layer prominence is present at the ileocecal junction with preservation of mural layering and without associated intestinal mass effect, mesenteric inflammatory change, or lymphadenopathy. In cats, this appearance may be observed with mild chronic enteropathy or early low-grade infiltrative intestinal disease, although the current changes are mild and nonspecific.

Mild prominence of the common bile duct and pancreatic duct is present without evidence of obstructive biliary disease, cholecystitis, or active pancreatitis. In older cats, mild ductal prominence may occur as an age-related or chronic low-grade remodeling change. Mild chronic subclinical hepatobiliary-pancreatic remodeling cannot be completely excluded sonographically.

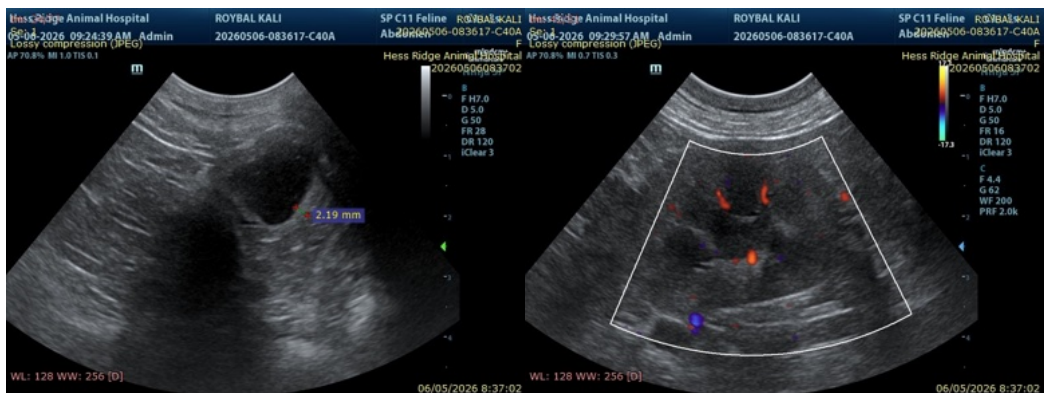
Importantly, no sonographic evidence of a clinically significant infiltrative gastrointestinal disease is identified to explain the reported progressive polyphagia, behavioral change, and weight loss.

Given the clinical presentation, early or intermittent hyperthyroidism remains a consideration despite currently normal thyroid hormone concentrations, as some cats with early disease may demonstrate fluctuating or initially equivocal hormonal results.

**Recommendations**

- Continued clinical and biochemical monitoring is recommended, including repeat thyroid assessment if clinical suspicion for evolving hyperthyroidism persists.
- Correlation with blood pressure monitoring and ongoing cardiac follow-up is recommended given the known hypertrophic cardiomyopathy.
- If gastrointestinal signs, weight loss, or behavioral changes progress, further investigation of the mild ileocecal change could be considered, including serum cobalamin assessment and/or gastrointestinal sampling if clinically indicated.
- Serial abdominal ultrasound may be considered if clinical progression occurs.

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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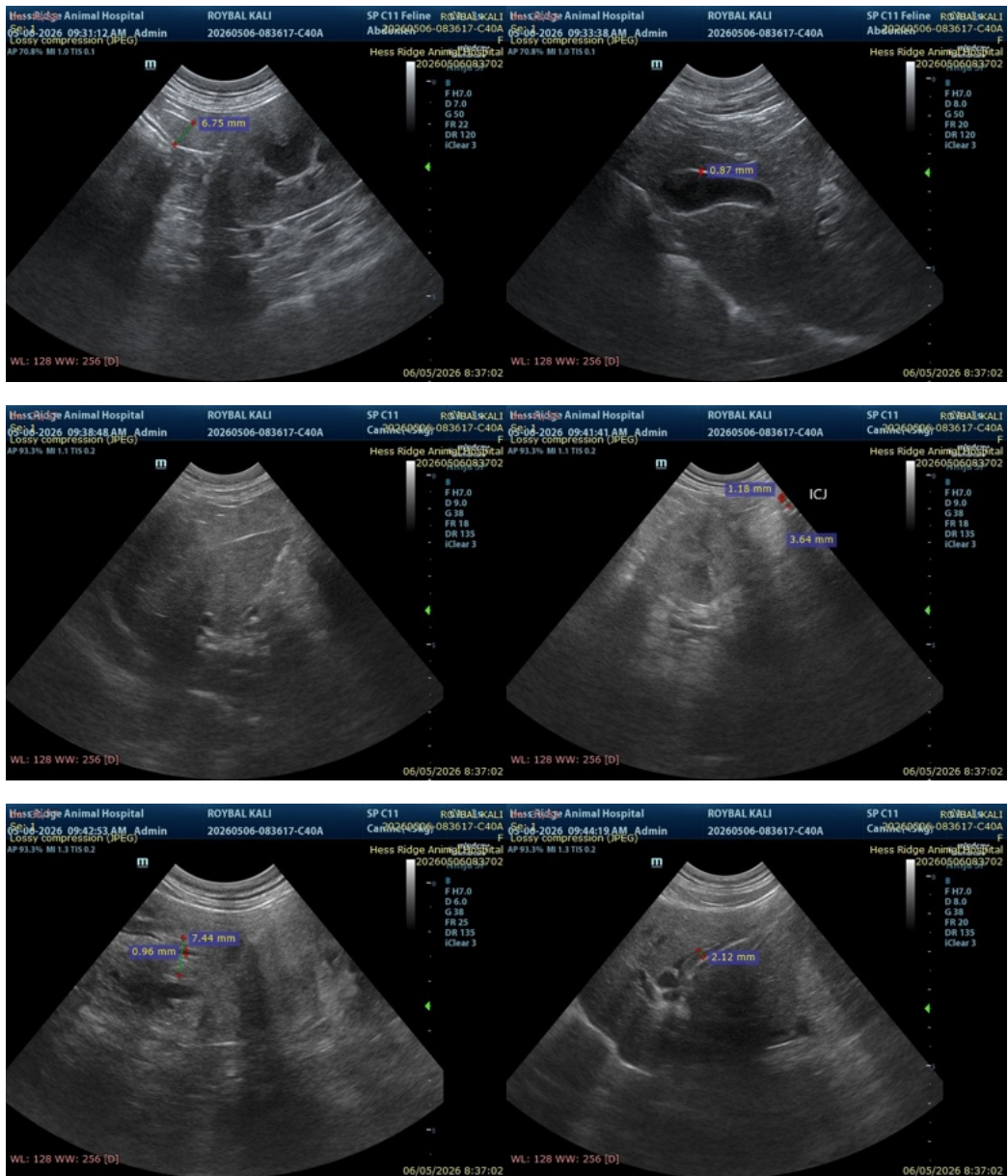
Michael Skarie, DVM

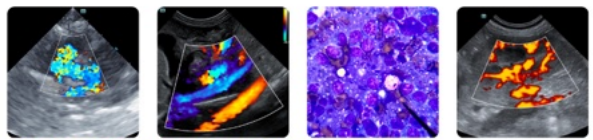
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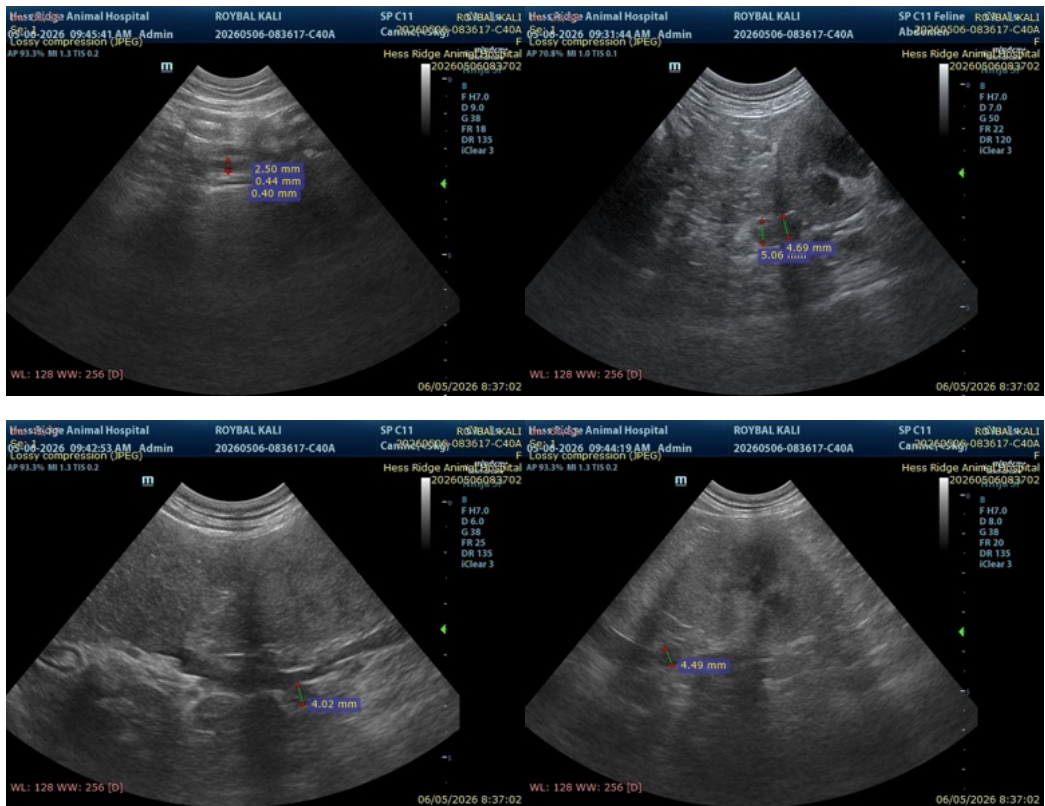
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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