

## PATIENT

Eevee Ur

## SPECIES

Feline

## BREED

Domestic Shorthair

## SEX

Spayed female

## AGE

17 ½ years

## WEIGHT

6.5 lbs

## INTERPRETED BY

Alicia Angosto  
Guerrero, DMV,  
PgDip, MSc.

## IMAGING PERFORMED BY

Arielle Roldan, CVT

## HOSPITAL NAME

Milford AH

## REFERRING VET

Dr. Aleksandra Ascione

## INVOICE

78793

## DATE

6/17/26

## PRESENTING CLINICAL SIGNS

History: Pt came in for Hematochezia yesterday, recommended abdominal US and echo due to heart marker levels, owner wants only abd us at this time.

Patient has history of chronic kidney dz and diabetes mellitus treated with insulin and porus one currently.

T4: 4.29 gray zone SDMA 20.9 abnormal TNL 6.2 abnormal Probnp 158.9 abnormal

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

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

The left kidney measures 3.56×2.54 cm in the sagittal plane. Mild pyelectasia is present, measuring approximately 4.72 mm. The proximal ureter is mildly dilated, measuring approximately 2.42 mm before becoming obscured. The renal cortex demonstrates normal echogenicity. Corticomedullary distinction is mildly reduced. No nephroliths or hydronephrosis are identified.

The right kidney measures 2.77×1.79 cm. The renal cortex is mildly hyperechoic relative to the liver. Corticomedullary distinction is mildly reduced. No pyelectasia, nephrolithiasis, or hydronephrosis is identified

### Adrenal Glands

The adrenal glands are not visualized.

### Spleen

Splenic thickness is 0.63 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 smooth. The contents are predominantly anechoic with a small amount of biliary sludge. The common bile duct measures approximately 1.12–2.09 mm and is not dilated.



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## ***Gastrointestinal tract***

The stomach is markedly distended with fluid and residual ingesta. Gastric wall thickness measures 1.03 mm, and normal wall layering is preserved.

The duodenum measures 2.01 mm in thickness and maintains normal wall layering.

The jejunum measures 2.31 mm in thickness. Mucosal thickness measures 1.95 mm, submucosal thickness 0.69 mm, and muscularis propria thickness 0.32 mm. Wall layering is preserved.

The ileum measures 1.21 mm in thickness and maintains normal wall layering.

The ileocecolic junction could not be identified.

No evidence of gastrointestinal obstruction, focal intestinal mass, foreign material, or inflammatory mural thickening is identified.

The colon measures 1.04 mm in thickness and contains formed fecal material.

## ***Pancreas***

The pancreas measures approximately 1.04 cm in thickness. The pancreatic parenchyma is mildly hypoechoic and mildly heterogeneous relative to the adjacent fat and contains a few small hypoechoic nodules. The pancreatic duct measures approximately 1.36 mm in diameter. No peripancreatic fluid accumulation or regional fat hyperechogenicity is identified.

## ***Free Abdomen***

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

## **PRIMARY FINDINGS**

- Bilateral chronic renal changes. Mild left pyelectasia with mild proximal ureteral dilation.
- Marked gastric distension with fluid and residual ingesta.
- Pancreatic enlargement and heterogeneity with small hypoechoic nodules. Pancreatic duct dilation (1.36 mm).

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

Mild bilateral renal changes are present, including decreased corticomedullary distinction, mild right renal cortical hyperechogenicity, and mild left-sided pyelectasia with proximal ureteral dilation. These findings are compatible with the patient's known chronic kidney disease. No clear obstructive uropathy is identified.

The pancreas is enlarged, mildly heterogeneous, and contains several small hypoechoic nodules. Pancreatic duct dilation is also present. These findings are compatible with chronic pancreatic disease,



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including chronic pancreatitis and chronic pancreatic nodular change. Although no convincing peripancreatic fat inflammation or focal peripancreatic fluid is identified, acute-on-chronic pancreatitis cannot be excluded, particularly in cats, where active pancreatic inflammation may occur with only subtle or nonspecific ultrasonographic abnormalities.

The stomach is markedly distended with fluid and residual ingesta. While this may reflect recent food intake, delayed gastric emptying cannot be completely excluded. No convincing evidence of mechanical intestinal obstruction is identified. However, assessment of the pyloric region and pyloroduodenal junction was incomplete.

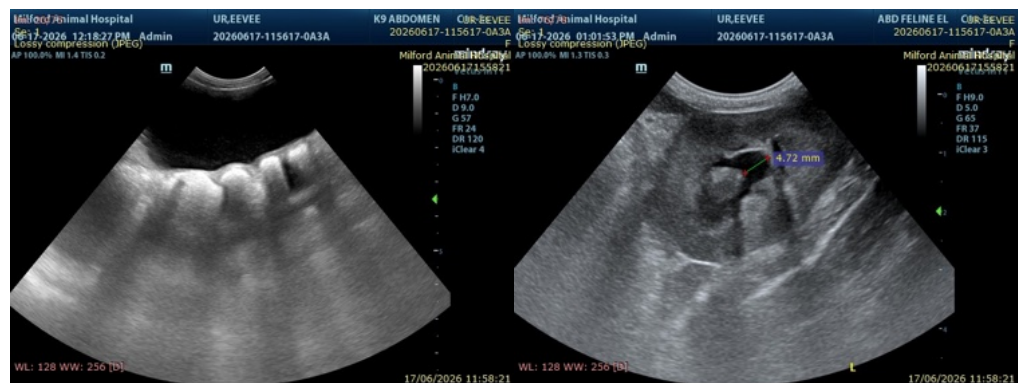
No convincing ultrasonographic explanation for the reported hematochezia is identified. Importantly, evaluation of the ileocecolic junction was not possible, and this region can be a clinically important site of inflammatory and neoplastic disease in cats.

The combination of progressive weight loss despite a reportedly normal or increased appetite, borderline-high thyroid hormone concentration, chronic kidney disease, diabetes mellitus, and chronic pancreatic abnormalities likely reflects a multifactorial geriatric disease process.

### Recommendations

- Correlate the pancreatic findings with clinical signs and pancreatic-specific testing if not recently performed.
- Repeat total T4 and/or consider free T4 testing given the borderline elevation and history of progressive weight loss despite a preserved or increased appetite.
- Monitor renal parameters, SDMA, blood pressure, urine protein status, and hydration status as clinically indicated.
- If hematochezia persists, further investigation of the distal intestinal tract and ileocecolic region may be warranted, including advanced imaging, endoscopy, or biopsy if clinically appropriate.
- Echocardiography remains advisable given the elevated NT-proBNP concentration, particularly if hyperthyroidism is subsequently confirmed.

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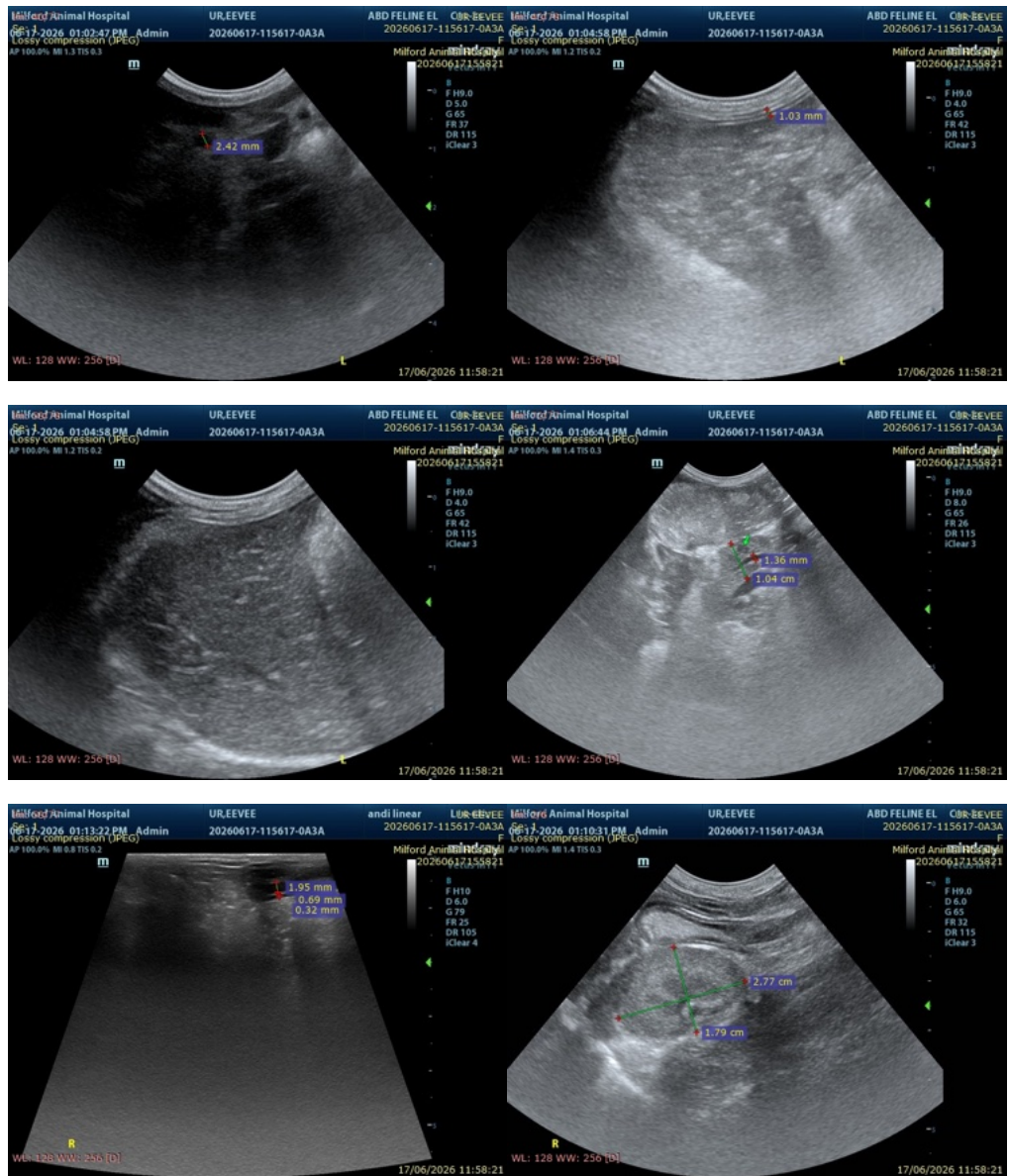
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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