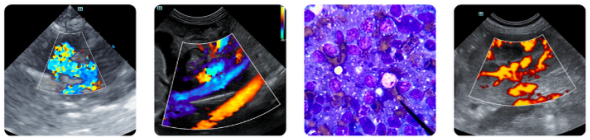


PATIENT

Roy Pratt

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

14 years

WEIGHT

10 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

78813

DATE

6/17/26

PRESENTING CLINICAL SIGNS

History: Has been on Prednisolone for 2 years for suspected IBD. Now he is not eating. Concerned about duodenum.

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 markedly turbid with abundant suspended echogenic material. The trigone and proximal urethra have a normal ultrasonographic appearance. No calculi are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic disease.

The left kidney is normal in shape and size, measuring 3.78×2.24 cm, with a cortical thickness of 0.36 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 4.30×2.49 cm, with a cortical thickness of 0.36 cm in the sagittal plane.

Both kidneys demonstrate mildly increased cortical echogenicity relative to the hepatic parenchyma. Corticomedullary distinction and corticomedullary ratio are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler interrogation demonstrates a normal vascular pattern.

Adrenal Glands

Not confidently visualized.

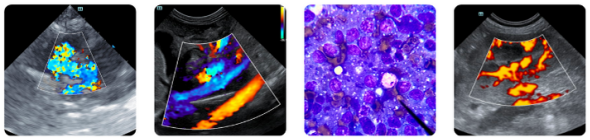
Spleen

Splenic thickness is 0.72 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 lumen is normally distended. The wall is thin and smooth, and the contents are predominantly anechoic. The common bile duct measures 3.47 mm. No cystic duct or common bile duct dilation is identified.



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Gastrointestinal tract

The stomach is empty and folded. Gastric wall thickness measures 2.16 mm with preserved wall layering.

The pylorus measures 3.41 mm and maintains normal wall layering.

The duodenum measures 2.47-2.60 mm.

The jejunum measures 2.28 mm in thickness. The mucosa measures 1.12 mm, the submucosa 0.48 mm, and the muscularis propria 0.32 mm. Wall layering is preserved.

The ileum measures 2.15 mm in thickness. The mucosa measures 0.38 mm, the submucosa 1.03 mm, and the muscularis propria 0.70 mm. Wall layering is preserved.

The ileocecal junction measures 2.98 mm in thickness, with the muscularis propria measuring 1.20 mm. Wall layering is preserved.

The colon measures 0.63-1.16 mm in wall thickness and contains formed fecal material within the descending segment.

Pancreas

The pancreas measures up to 1.08 cm in thickness. Pancreatic parenchyma is isoechoic to the adjacent mesenteric fat. The pancreatic duct measures 1.70-1.94 mm in diameter. No focal pancreatic mass lesions are identified. No ultrasonographic evidence of active peripancreatic inflammation is observed.

Free Abdomen

No abdominal effusion or peritonitis is identified.

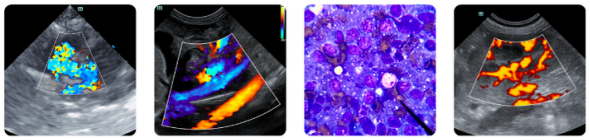
The cranial mesenteric lymph nodes measure 6.60-6.80 mm in thickness. The ileocecal lymph nodes measure 2.42-3.65 mm and maintain normal shape and echogenicity. The iliac trifurcation region is normal.

PRIMARY FINDINGS

- Mild muscularis thickening of the ileum (muscularis:mucosa ratio approximately 1.8).
- Moderate muscularis thickening at the ileocecal junction.
- Mild enlargement of the cranial mesenteric lymph nodes.
- Pancreatic enlargement and pancreatic duct dilation.

SECONDARY FINDINGS

- Mild diffuse renal cortical hyperechogenicity.
- Markedly turbid urine with abundant suspended echogenic debris.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most significant gastrointestinal findings consist of muscularis thickening affecting the ileum and, more prominently, the ileocecal junction, together with mild enlargement of the cranial mesenteric and ileocecal lymph nodes. In cats, muscularis thickening with preservation of wall layering is a recognized feature of chronic enteropathy and may be observed with both inflammatory bowel disease and low-grade alimentary lymphoma. The absence of focal masses, transmural loss of layering, obstructive changes, or marked lymphadenopathy favors chronic enteropathy over advanced intestinal neoplasia; however, significant ultrasonographic overlap exists between inflammatory bowel disease and low-grade lymphoma.

The pancreas is diffusely enlarged, and the pancreatic duct is mildly dilated (1.70-1.94 mm). These findings are abnormal and raise concern for pancreatic disease. Given the patient's anorexia, concurrent intestinal abnormalities, and history of presumed chronic enteropathy, chronic pancreatitis with possible acute exacerbation is considered a significant differential diagnosis. Feline triaditis should also be considered. Importantly, the absence of ultrasonographically evident peripancreatic fat inflammation does not exclude pancreatitis in cats.

The marked urinary sediment is nonspecific and may represent cellular debris, proteinaceous material, crystalluria below ultrasonographic resolution, or inflammatory material. Correlation with urinalysis is recommended.

Recommendations

- Correlate with serum cobalamin, folate, and a feline gastrointestinal panel if not previously performed.
- Pancreatic lipase testing (Spec fPL) is recommended.
- Review the current prednisolone protocol and clinical response, given the persistence or progression of gastrointestinal signs despite long-term treatment.
- If anorexia persists or clinical signs continue to progress, intestinal biopsies should be considered to differentiate inflammatory bowel disease from low-grade alimentary lymphoma. Interpretation of histopathology should take into account the patient's prolonged prednisolone therapy, which may modify inflammatory and neoplastic infiltrates and potentially reduce diagnostic sensitivity.
- Repeat urinalysis with sediment examination is recommended to further characterize the marked echogenic urinary debris.

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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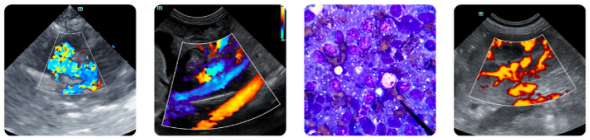

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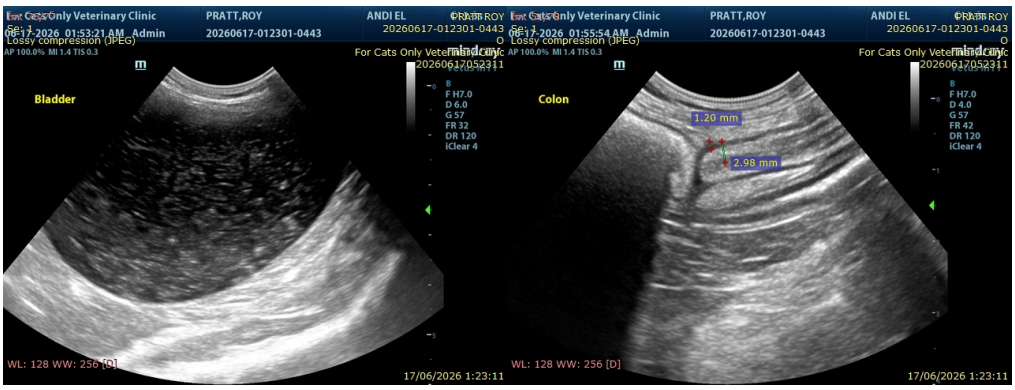

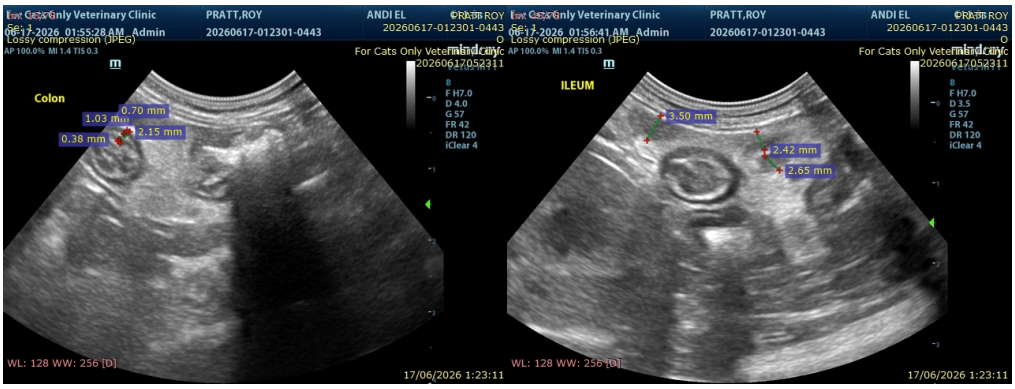

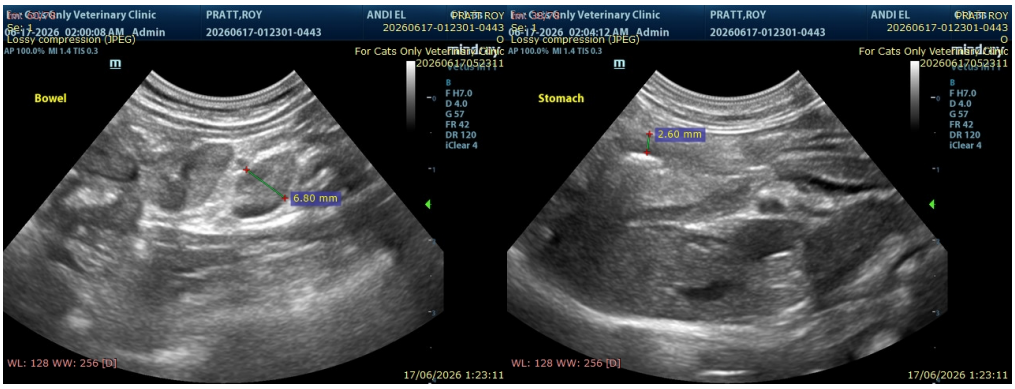

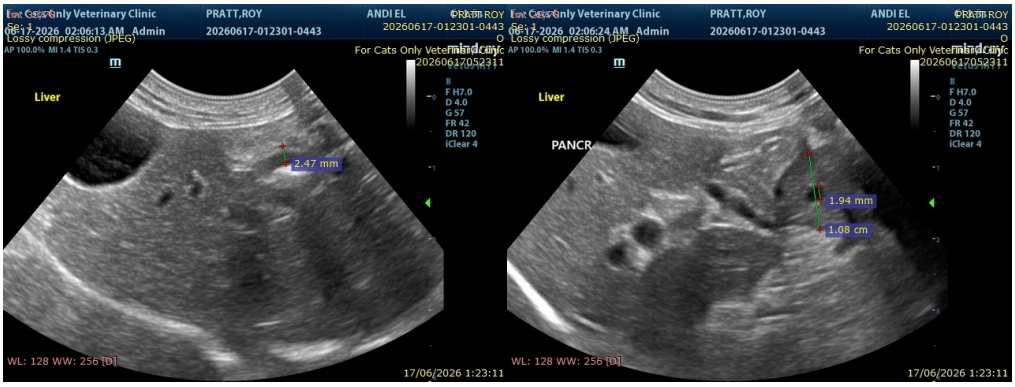

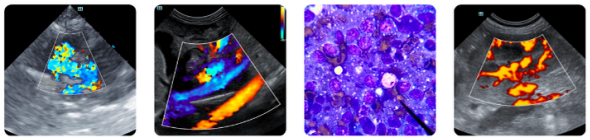

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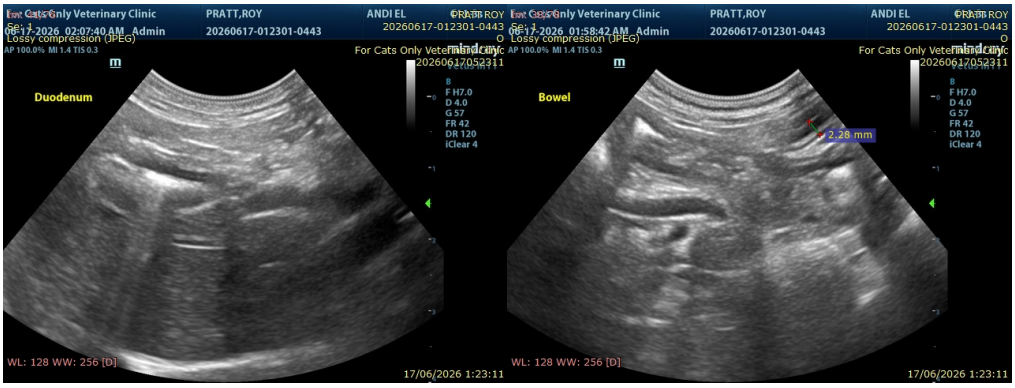

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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