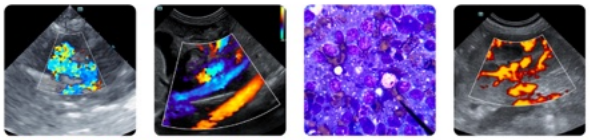


PATIENT

Patrick Day

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

12 years

WEIGHT

16.6 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Saum Hadi

HOSPITAL NAME

Nimbus Pet Hospital

REFERRING VET

Sophie Sullivan

INVOICE

78355

DATE

6/3/26

PRESENTING CLINICAL SIGNS

History: Patrick presents for AUS due to chronic intermittent vomiting. will vomit a few times a week undigested food. normally eats c/d diet
BW performed in 4/9/26 - unremarkable.
AUS performed under general anesthesia.
Abnormal PE/Chem/CBC/UA Results: Creatinine 1.9, BUN: 25, SDMA 12, USG: 1053

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 predominantly anechoic with a small amount of suspended echogenic material. Two punctate hyperechoic intraluminal foci consistent with mineral sediment are identified, the largest measuring approximately 1.37 mm. Additional small mobile hyperechoic echoes are present within the urine. The bladder neck and proximal urethra appear normal. No sonographic evidence of cystolithiasis, inflammatory disease, or proliferative disease is identified.

The left kidney is normal in shape and size, measuring 3.82×1.97 cm, with a cortical thickness of 0.33 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 3.57×1.99 cm, with a cortical thickness of 0.30 cm in the sagittal plane.

In both kidneys, cortical echogenicity is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified.

Adrenal Glands

Not confidently visualized.

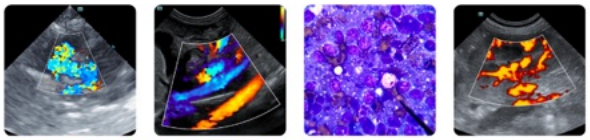
Spleen

Splenic thickness is 1.02 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 the contents are primarily anechoic. No evident dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal tract

The stomach is empty and folded, containing a small amount of luminal fluid. Gastric wall thickness measures 2.06 mm and normal wall layering is preserved.

The duodenal wall measures 1.39 mm.

The jejunal wall measures 1.94 mm. Individual wall layers measure as follows: mucosa 0.79 mm, submucosa 0.40 mm, and muscularis propria 0.70 mm. The muscularis-to-mucosa ratio is approximately 0.89.

The ileal wall measures 2.11 mm. Individual wall layers measure as follows: mucosa 0.83 mm, submucosa 0.87 mm, and muscularis propria 0.45 mm. The muscularis-to-mucosa ratio is approximately 0.54.

Normal wall layering is preserved throughout the examined gastrointestinal tract. The ileocecocolic junction was not confidently visualized.

No sonographic evidence of gastrointestinal obstruction, focal mural mass, ileus, or foreign material is identified.

The colonic wall measures 0.69 mm and contains formed fecal material within the descending colon.

Pancreas

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

Free Abdomen

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

PRIMARY FINDINGS

- Diffuse thickening of the jejunal muscularis propria with an increased muscularis-to-mucosa ratio (approximately 0.89).
- Mild mineral sediment within the urinary bladder lumen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Diffuse thickening of the jejunal muscularis propria is present with preservation of normal wall layering. The jejunal muscularis-to-mucosa ratio is increased (approximately 0.89). This pattern is commonly associated with chronic enteropathy and, in the absence of abdominal lymphadenopathy, focal intestinal masses, or loss of wall layering, is considered slightly more suggestive of inflammatory disease than infiltrative neoplasia. However, significant ultrasonographic overlap exists between inflammatory bowel disease, food-responsive enteropathy, and small-cell lymphoma, and definitive differentiation is not possible based on ultrasonographic findings alone.

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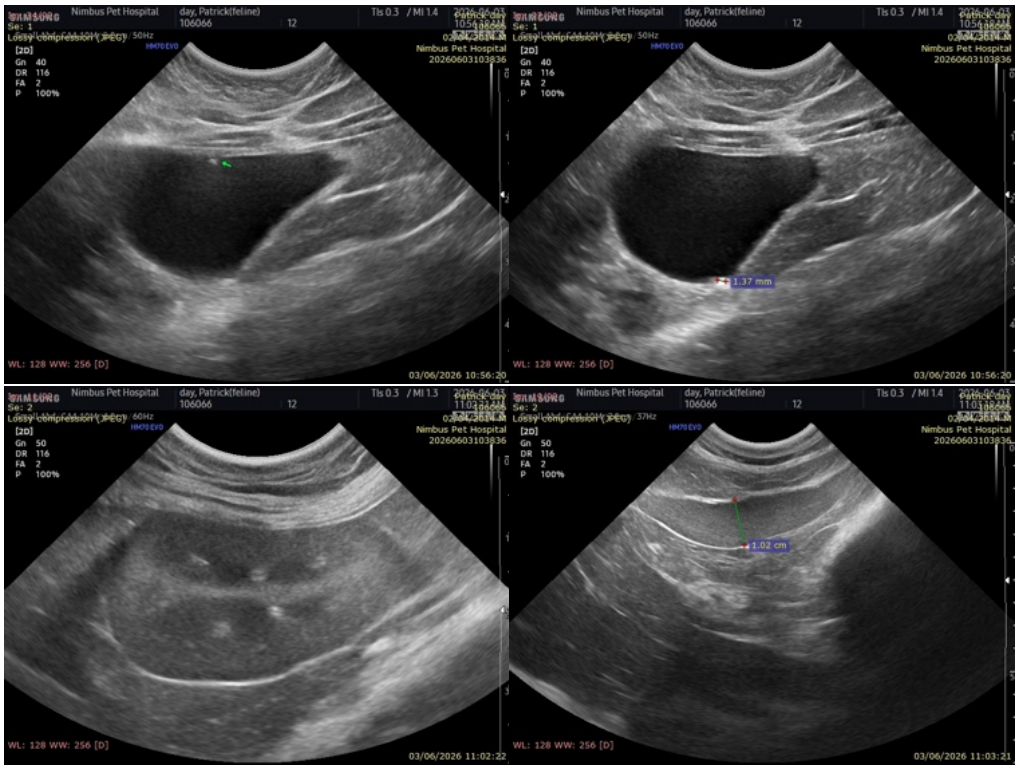
No sonographic evidence of gastrointestinal obstruction, focal gastrointestinal mass, abdominal lymphadenopathy, pancreatitis, or other significant abdominal abnormality is identified.

Mild mineral sediment is present within the urinary bladder lumen without evidence of cystolithiasis or lower urinary tract obstruction.

Recommendations

- Correlation with serum cobalamin and folate concentrations is recommended.
- Because the patient is currently maintained on a therapeutic urinary diet, additional dietary trials may be limited. If vomiting persists or worsens, empirical medical management for chronic enteropathy (e.g., cobalamin supplementation, antiemetic therapy, gastrointestinal anti-inflammatory therapy, or other treatments deemed appropriate by the attending veterinarian) may be considered.
- If clinical signs persist or progress, intestinal biopsy may be considered for definitive differentiation between inflammatory bowel disease and small cell lymphoma.

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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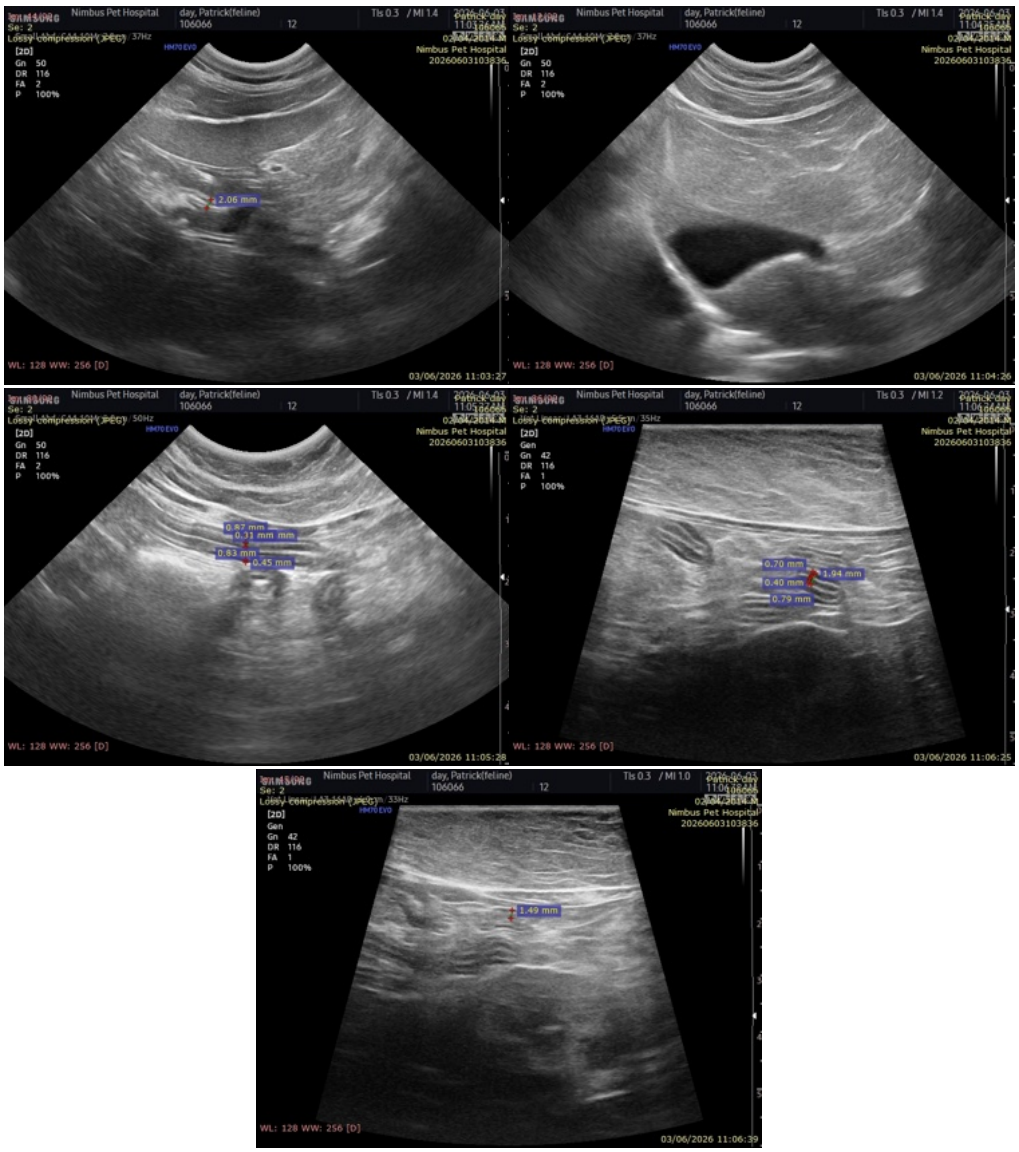

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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