



**DATE PRESENTING CLINICAL SIGNS**

12/15/25

**Patient History:** Cat has exhibited chronic diarrhea over the past 1-2 years with no regular vomiting issues. A variety of prescription diets have proven ineffective in controlling the diarrhea and the cat is exhibiting a gradual decline in weight over time. Blood profile 8/2025 - WNL. The cat has also had therapeutic trials with cortisone again with little improvement in the diarrhea.

**PATIENT**

Stetson Ricks

**SPECIES**

Feline

**BREED**

Domestic shorthair

**SEX**

Male, neutered

**AGE**

12/14/2016

**WEIGHT**

10.6 lbs.

**INTERPRETED BY**

Andrea Nicastro, DVM,  
Diplomate ACVIM  
(Small Animal Internal  
Medicine)

**HOSPITAL NAME**

Fork VH

**REFERRING VET**

Dr. Doherty

**INVOICE**

13437

**Current Medications:** Vitamin B12 q 30 days - 0.25 cc, Probiotics daily, DepoMedrol 12.5 mg last given 11/6/2025 with little improvement

**Labwork Results:** Labwork attached.

**Date of Previous IntraPet Ultrasound:** No previous.

**Sedation:** IV Ketamine and midazolam.

**Stat Report:** Not approved.

**Imaging Performed by:** Rachel Brillhart, RDMS.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A small amount of suspended echogenic debris is observed in the lumen. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal in size (4.00 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (4.01 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal size (0.41 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.46 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

**Spleen**

The spleen is normal in size (0.78 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

**Liver**

The liver is subjectively normal in size with normal peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogeneous in appearance. There is a subtle increase in portal markings. Vascular is of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1:1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small to moderate amount of aggregated, echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

### ***Gastrointestinal***

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal to borderline thickened (up to 0.26 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio. Discreet masses are not identified. The descending colonic wall is normal to mildly thickened (up to 0.31 cm) with retention of the normal layering pattern. No obvious obstructive disease is noted.

### ***Pancreas***

The base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is borderline dilated (up to 0.25 cm in width). There is no evidence of peripancreatic inflammation or effusion.

### ***Lymph nodes***

A 0.89 x 0.46 cm lymph node is observed in the mid to caudal abdomen, adjacent to the descending colon. In addition, a few prominent mesenteric lymph nodes are seen, one of the nodes measuring 1.68 x 0.28 cm.

### ***Free Abdomen***

There is no obvious evidence of free fluid.

### ***Other***

In the right cranial abdomen, a 0.5 cm mineralized shadowing structure is observed within the mesentery.

## **ULTRASONOGRAPHIC FINDINGS**

### **Primary Findings:**

- The small intestinal and colonic wall changes could be consistent with inflammatory bowel disease or less likely, emerging small cell lymphoma.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

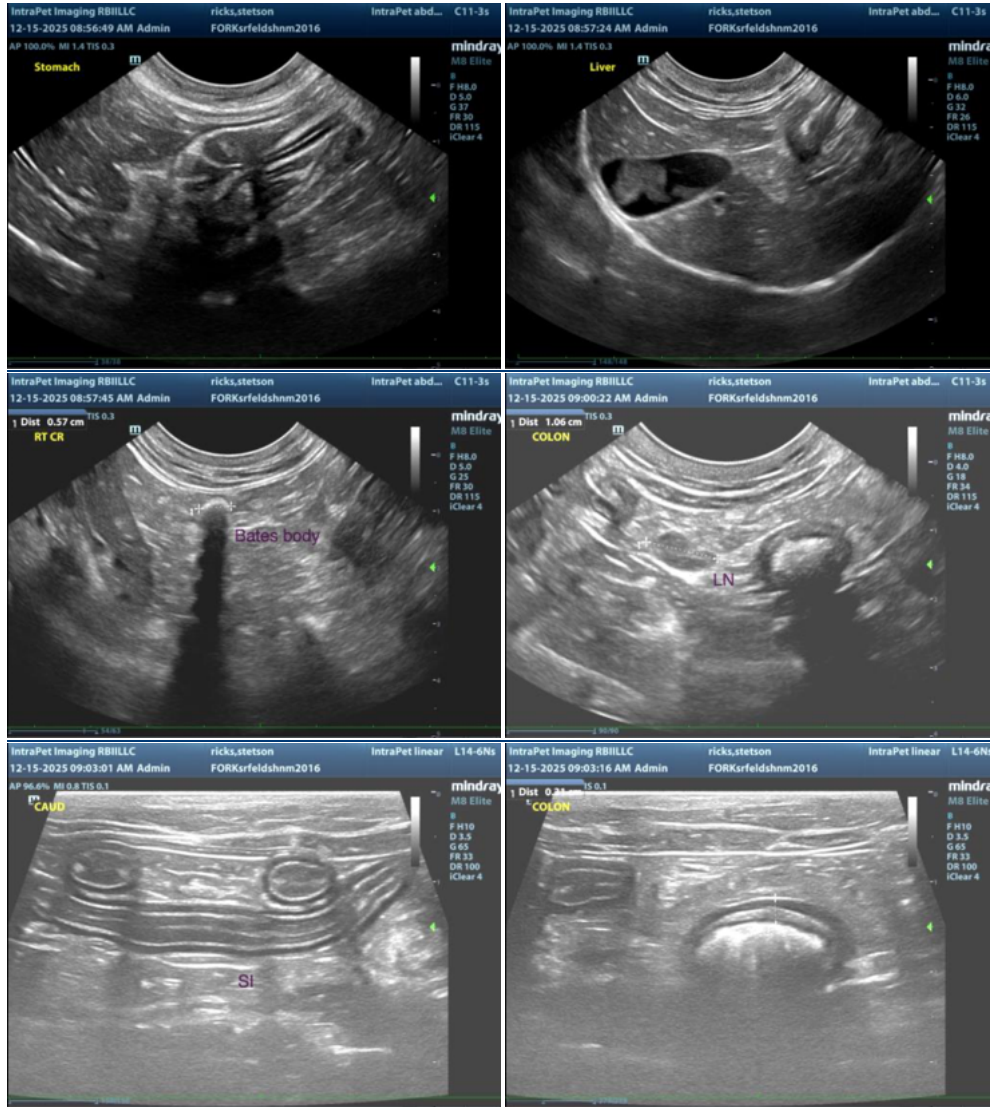
### **Secondary Findings:**

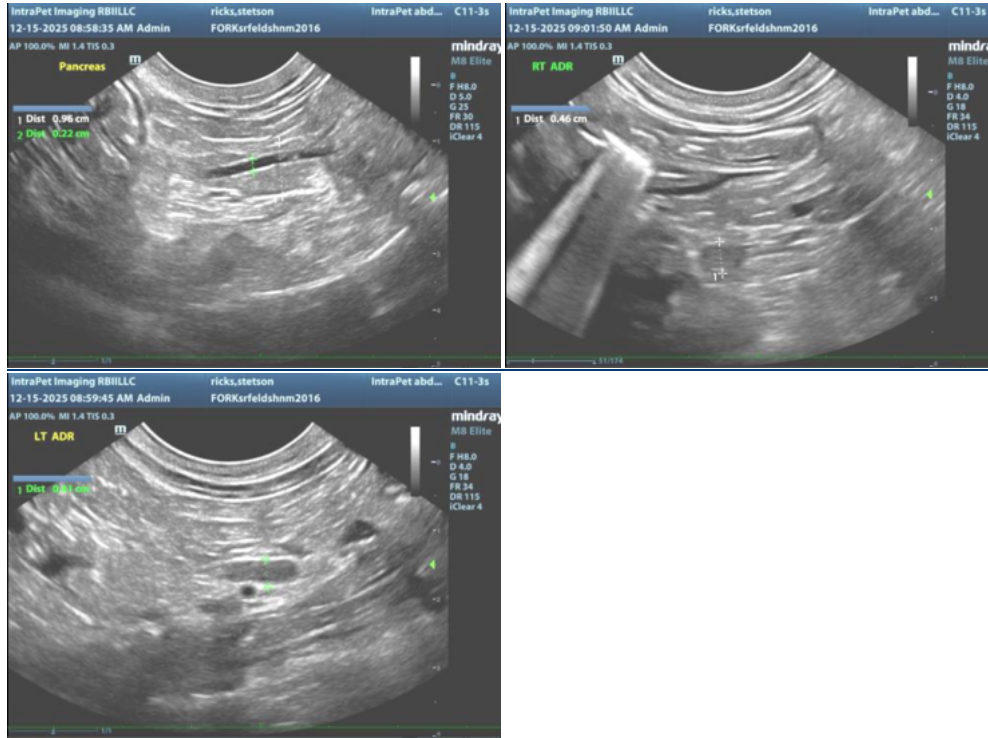
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Bilateral non-specific age-related renal changes
- The increase in hepatic portal markings may be a normal variant for this patient or could be consistent with an inflammatory hepatopathy. Correlation with the patient's liver values is recommended.
- Suspected Bates body in the right cranial quadrant. This is typically a benign incidental finding in cats.

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

1. A fecal evaluation for ova and Giardia and a fecal PCR infectious disease panel should be considered along with prophylactic deworming with fenbendazole.
2. A fiber supplement (i.e., psyllium) may also prove beneficial.

3. A limited antigen or hydrolyzed protein diet is also recommended (if not already tried).
4. Ultimately, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis. If pursued, the patient should be weaned off of corticosteroids for several weeks prior to biopsies to avoid masking of underlying pathology.





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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine) [info@SonoPath.com](mailto:info@SonoPath.com)