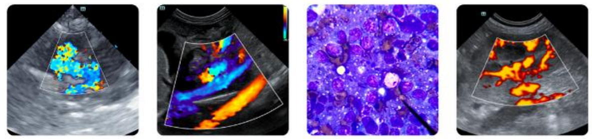


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

Jasper Joyce

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

8yr

WEIGHT

6.2kg

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Louise Corbeil

HOSPITAL NAME

Cochrane Animal Clinic

REFERRING VET

Dr. Louise Corbeil

INVOICE

24746

DATE

05/07/2026

PRESENTING CLINICAL SIGNS

History: One-and-a-half-month history of daily vomiting and significant weight loss
Abnormal PE/Chem/CBC/UA Results: 04-21-2026 - complete blood count, chemistry panel, and urinalysis. Results were largely within normal limits, showing only mild hypokalemia (3.4 mmol/L) and a low BUN (5.0 mmol/L). The total T4 was normal (18 nmol/L), and the SDMA was 10 µg/dL. Urinalysis revealed a specific gravity of >1.050 and the suspected presence of cocci bacteria, though no white or red blood cells were noted. FeLV FIV status - unknown/not tested

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 anechoic. Normal appearance of the bladder neck and proximal urethra. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.96×2.28cm, and the thickness of the cortex is 0.37cm in the sagittal plane. The renal cortex is mildly hyperechoic compared to the liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Doppler color evaluation shows a normal vascular pattern.

The right kidney is normal in shape and size: 4.01×2.20cm, and the thickness of the cortex is 0.30cm in the sagittal plane. The renal cortex is mildly hyperechoic compared to the liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Doppler color evaluation shows a normal vascular pattern.

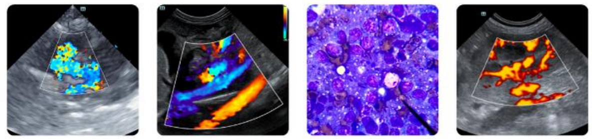
Adrenal Glands

Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.24 cm at the cranial pole and 0.25 cm at the caudal pole. The right adrenal gland was not confidently visualized. The image labeled as the right adrenal region did not clearly correspond to the expected anatomic location of the right adrenal gland, precluding reliable assessment.

Spleen

Splenic thickness is 0.87 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver



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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.

Gallbladder

The gallbladder lumen is normally distended. The wall is thin and smooth. A moderate amount of biliary sludge is present. Small hyperechoic mineralized foci compatible with choleliths or mineralized biliary sediment are identified within a focal region of the intrahepatic biliary tree. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal Tract

The stomach is predominantly empty and folded. Gastric wall thickness at the level of the gastric body measures 1.66 mm, with preserved wall layering. However, a diffuse region involving the pyloric/antral region demonstrates diffuse mural thickening measuring up to 7.7–8.2 mm, associated with marked loss of normal wall layering and mural architectural definition.

Duodenum: 1.85 mm, with preserved wall layering.
Jejunum: 1.99 mm, with preserved wall layering.
Ileum: 1.97 mm, with preserved wall layering.

The ileocecal junction measures 2.66 mm in total wall thickness, with muscularis propria thickness measuring 1.23 mm. Wall layering remains preserved.

No evidence of mechanical ileus or gastrointestinal foreign material is identified.

The colon measures 0.61 mm in wall thickness and contains soft fecal material within the lumen.

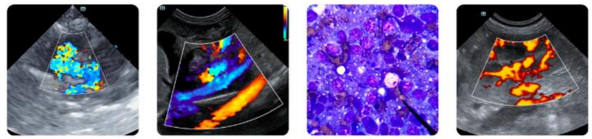
Pancreas

The pancreas measures 4.79 mm in thickness. The pancreatic parenchyma is isoechoic relative to the adjacent mesenteric fat. The pancreatic duct measures 0.78 mm in diameter, which is mildly dilated for a cat. No definite peripancreatic hyperechoic fat or free fluid is identified. The evaluated pancreatic regions do not show evidence of overt pancreatic mass lesions.

Free Abdomen

No abdominal effusion or diffuse peritonitis is observed. The cranial mesenteric and ileocecal lymph nodes are not confidently visualized, although the surrounding regions appear unremarkable.

A right gastric lymph node measures 7.33×8.98mm and is enlarged, rounded, and hypoechoic. Multiple additional regional gastric/hepatic lymph nodes are enlarged, rounded, and hypoechoic, with associated hyperechogenicity of the surrounding perinodal fat. The iliac trifurcation lymph nodes are within normal limits.



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PRIMARY FINDINGS

- Severe gastric mural thickening (7.7–8.2mm) with marked loss of wall layering.
- Multiple enlarged rounded hypoechoic regional gastric/heatic lymph nodes with reactive hyperechoic perinodal fat.
- Mild muscularis thickening at the ileocecal junction with increased muscularis-to-mucosa ratio.

SECONDARY FINDINGS

- Mild bilateral renal cortical hyperechogenicity.
- Moderate biliary sludge with small mineralized biliary concretions/choleliths within a focal intrahepatic biliary region.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

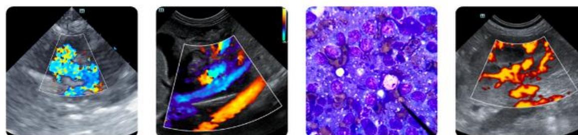
The dominant ultrasonographic abnormality is the severe focal infiltrative lesion affecting the pyloric/antral gastric region, characterized by marked mural thickening and loss of normal wall layering, accompanied by regional lymphadenopathy. In a middle-aged to older cat with chronic vomiting and significant weight loss, these findings are highly concerning for gastric neoplasia, with gastric lymphoma and adenocarcinoma considered the primary differentials.
The degree of wall thickening, architectural effacement, focality of the lesion, and associated regional lymph node changes make severe inflammatory disease substantially less likely, although ultrasound alone cannot definitively differentiate infiltrative neoplasia from severe granulomatous or lymphoplasmacytic gastritis. The rounded morphology and hypoechoic appearance of the regional lymph nodes raise suspicion for metastatic or infiltrative nodal involvement.

The mild muscularis thickening at the ileocecal junction is nonspecific and may reflect concurrent chronic enteropathy. In cats, increased muscularis-to-mucosa ratios may be seen with inflammatory bowel disease or low-grade alimentary lymphoma; however, this change is mild, localized, and clinically overshadowed by the severe gastric lesion.

The mild bilateral renal cortical hyperechogenicity is nonspecific and may represent mild chronic nephropathy or incidental age-related change. Renal architecture and size remain preserved.

Recommendations

- Sampling of the enlarged regional gastric/hepatic lymph nodes by ultrasound-guided FNA is recommended as the least invasive first diagnostic step. This may provide rapid cytologic support for lymphoma or another round-cell/neoplastic process; however, a nondiagnostic or reactive result would not exclude gastric neoplasia.
- If lymph node cytology is nondiagnostic or if carcinoma versus lymphoma versus severe inflammatory disease must be distinguished, gastric tissue biopsy is recommended. Endoscopic biopsy is generally preferred over blind transmural gastric wall FNA when the lesion is accessible endoscopically, because it allows direct visualization and targeted mucosal sampling; however, it may still miss deeper/submucosal or transmural disease.
- Ultrasound-guided FNA of the gastric wall can be considered when there is a discrete, thickened/mass-like lesion and endoscopy is not feasible, but it has only moderate diagnostic accuracy and a substantial nondiagnostic rate, so it should not be presented as equivalent to biopsy.
- FeLV/FIV testing is recommended given the differential diagnosis of lymphoma.



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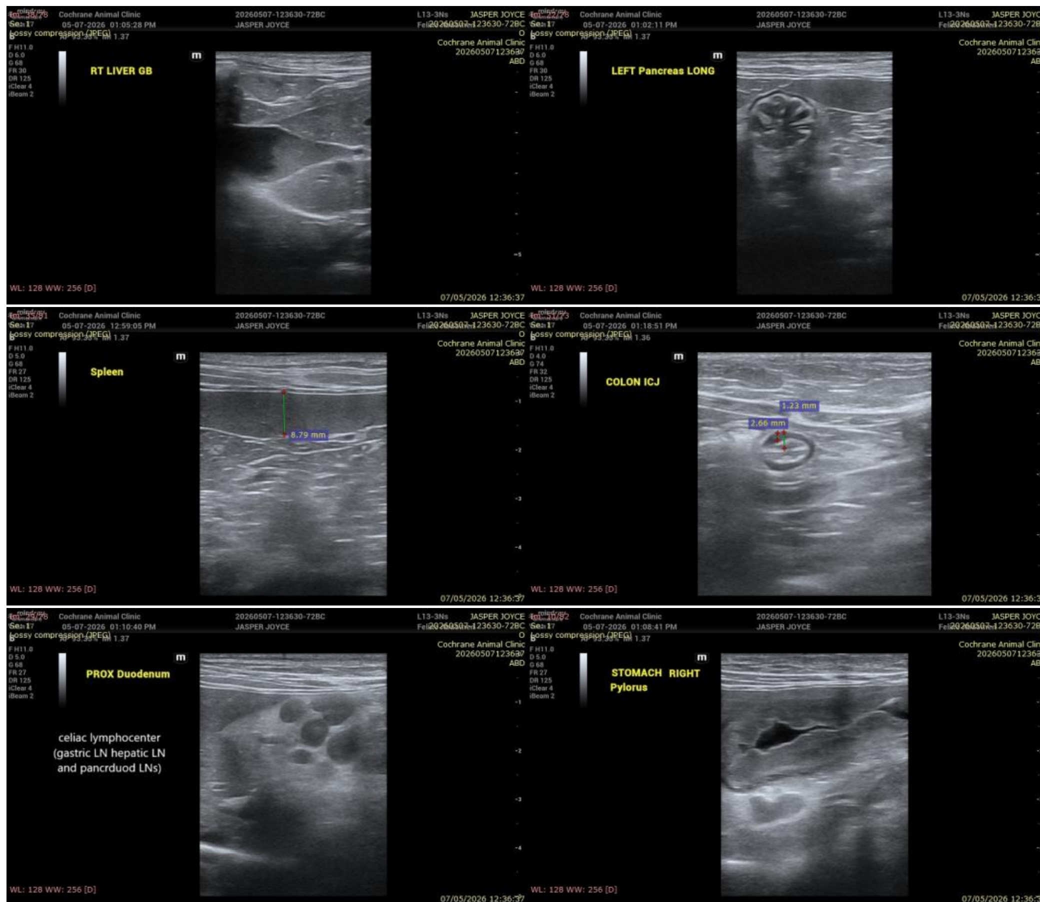
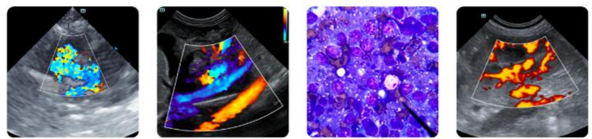
- Supportive management for vomiting, nutritional support, and correction/monitoring of hypokalemia are recommended while pursuing definitive diagnosis.

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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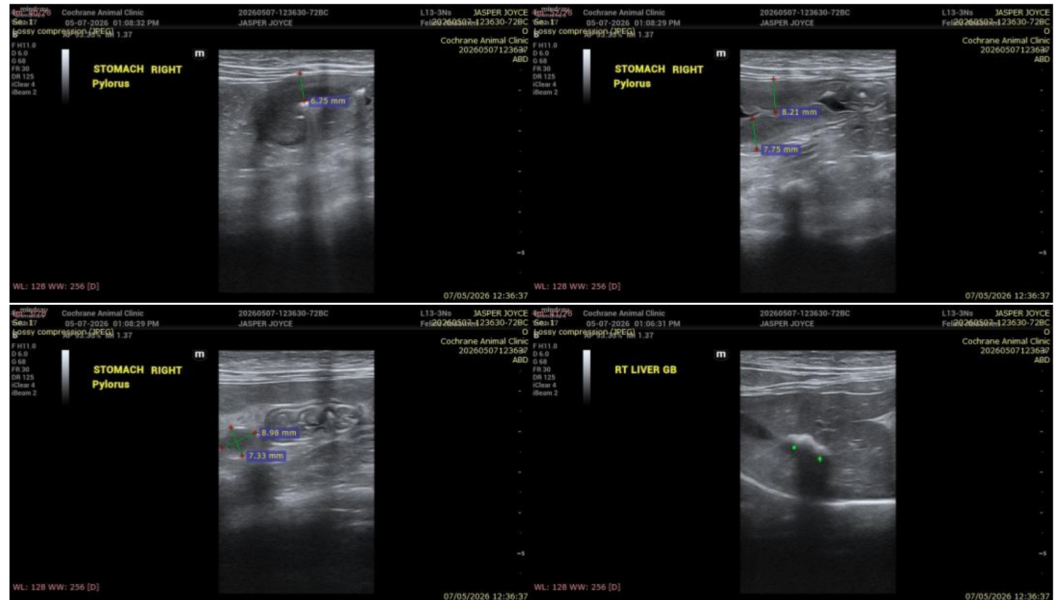

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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