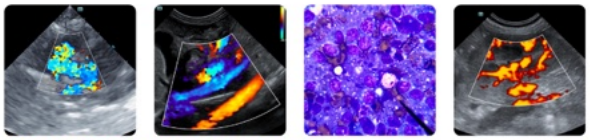


PATIENT

Skip Palmieri

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

12 years

WEIGHT

12.4 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

John Ammeraal, DVM

HOSPITAL NAME

Sova

REFERRING VET

Dr. Dodson

INVOICE

70089

DATE

1/13/26

PRESENTING CLINICAL SIGNS

History: Pet vomiting and not wanting to eat and going on for a while vomits quick after eating roughly 10-15 min after O's parents have been taking care of him the past 4-5 days, vomiting since that started; not always getting pred dose in Cytology done early December as mixed inflammation
BCS 6/9, Mid abdominal mass palpable No recent labwork since last US

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the urinary bladder wall appears thin and smooth. The urine is anechoic. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no sonographic evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 3.46×2.32 cm, with a cortical thickness of 0.32 cm in the sagittal plane. The renal cortex is diffusely hyperechoic relative to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified.

The right kidney is normal in shape and size, measuring 3.47×2.13 cm, with a cortical thickness of 0.31 cm in the sagittal plane. The renal cortex is diffusely hyperechoic relative to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified.

Adrenal Glands

The left adrenal gland is not visualized. The right adrenal gland measures approximately 0.36 cm at the cranial pole and 0.30 cm at the caudal pole and appears normal.

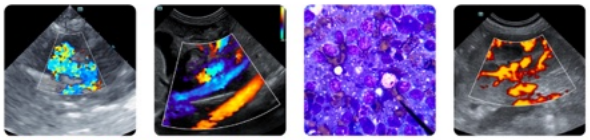
Spleen

Splenic thickness measures approximately 0.57 cm. The splenic parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp margins and a regular contour. The hepatic parenchyma is homogeneous and isoechoic relative to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The gallbladder wall is thin, and the contents are predominantly anechoic with a very small amount of biliary sludge. No dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach is empty and folded, with a moderate amount of intraluminal gas. Gastric mural thickness is approximately 2.10 mm with preserved layering in unaffected regions. However, marked focal gastric wall thickening is identified, measuring up to approximately 4.88 cm in length along the ventral gastric wall and up to 1.09 cm in thickness dorsally.

The pyloric region demonstrates marked mural thickening, measuring approximately 1.11–1.18 cm, with complete loss of normal wall layering.

The duodenal wall measures approximately 2.39 mm and appears within normal limits. Jejunal wall thickness measures approximately 2.22 mm, and ileal wall thickness measures approximately 2.13 mm, with preserved wall layering.

The ileocecal junction measures approximately 3.09 mm, with a muscularis thickness of approximately 1.08 mm.

Additionally, a separate intestinal segment, most consistent with jejunum, demonstrates severe focal mural thickening forming a mass-like lesion, measuring approximately 4 cm in length and up to 1.04 cm in wall thickness, with complete loss of wall stratification. Accurate anatomic localization is limited due to the absence of a clear longitudinal long-axis view.

The colonic wall measures approximately 0.87 mm, with formed fecal material present in the descending colon.

Pancreas

The pancreas is not clearly visualized. No sonographic evidence of peripancreatic inflammation is identified.

Peritoneal Cavity

No abdominal effusion or sonographic signs of peritonitis are observed. However, the mesenteric fat surrounding the affected jejunal region appears mildly hyperechoic, suggestive of early inflammatory or infiltrative change. No free abdominal fluid or free gas is identified to suggest gastrointestinal perforation. Cranial mesenteric and ileocecal lymph nodes are not visualized. A pancreaticoduodenal lymph node measuring approximately 4×5 mm is identified and appears normal in shape and echogenicity. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Marked focal gastric wall thickening involving the gastric body and pyloric region, with loss of normal wall layering.
- Severe focal intestinal wall thickening (likely jejunal), measuring approximately 4 cm in length, with complete loss of stratification.

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SECONDARY FINDINGS

- Mild hyperechogenicity of the mesenteric fat surrounding the affected jejunal region.
- Diffuse bilateral renal cortical hyperechogenicity, compatible with chronic renal change or age-related.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

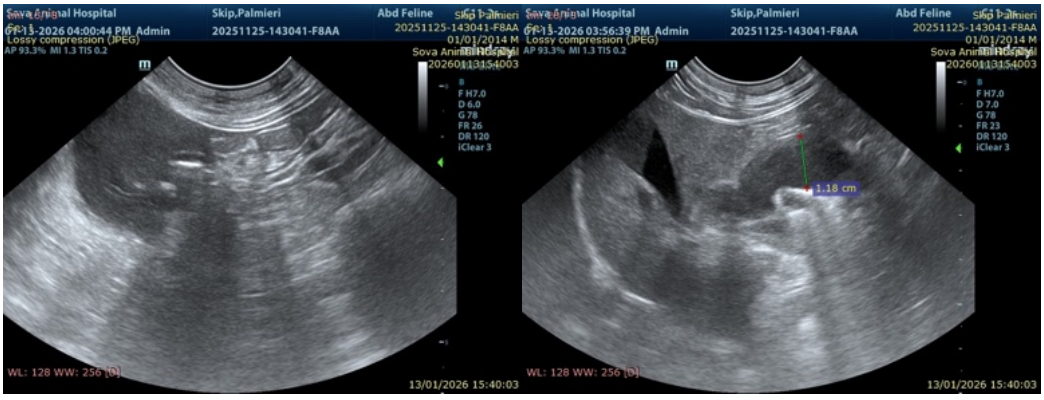
Abdominal ultrasonography demonstrates severe focal gastric and intestinal wall thickening with loss of normal wall layering, forming mass-like lesions involving the pyloric region and a segment of small intestine (most consistent with jejunum). These findings are highly suspicious for an infiltrative or neoplastic gastrointestinal process. Primary differential diagnoses include gastrointestinal lymphoma (particularly large-cell or transmural lymphoma) and less likely adenocarcinoma or severe granulomatous inflammatory disease.

The absence of abdominal lymphadenopathy or effusion does not exclude gastrointestinal neoplasia. Prior intermittent corticosteroid administration may partially modify imaging appearance.

Overall, the ultrasonographic findings correlate well with the patient's clinical signs of postprandial vomiting and the presence of a palpable abdominal mass.

Recommendations

- A prior fine-needle aspirate performed approximately one month ago reportedly demonstrated mixed inflammation; however, cytology may be nondiagnostic in cases of focal, transmural, or heterogeneous gastrointestinal disease and does not exclude neoplasia.
- Definitive diagnosis would require histopathologic evaluation obtained via surgical biopsy or exploratory laparotomy.



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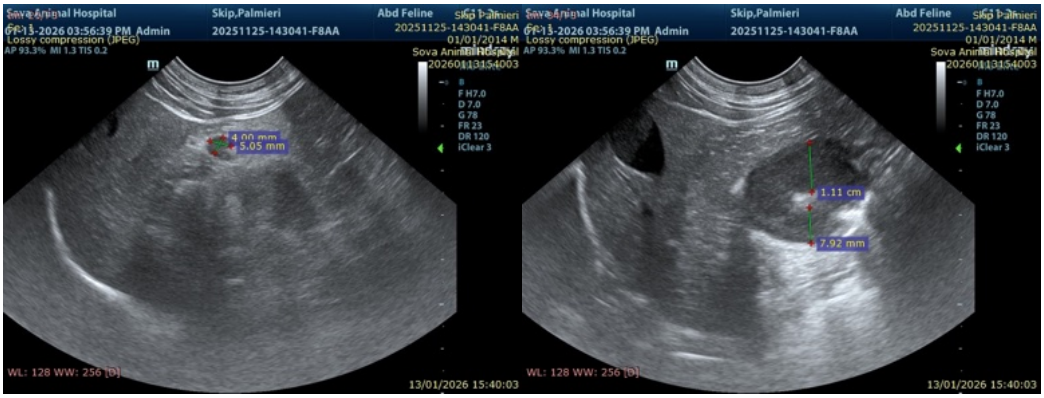

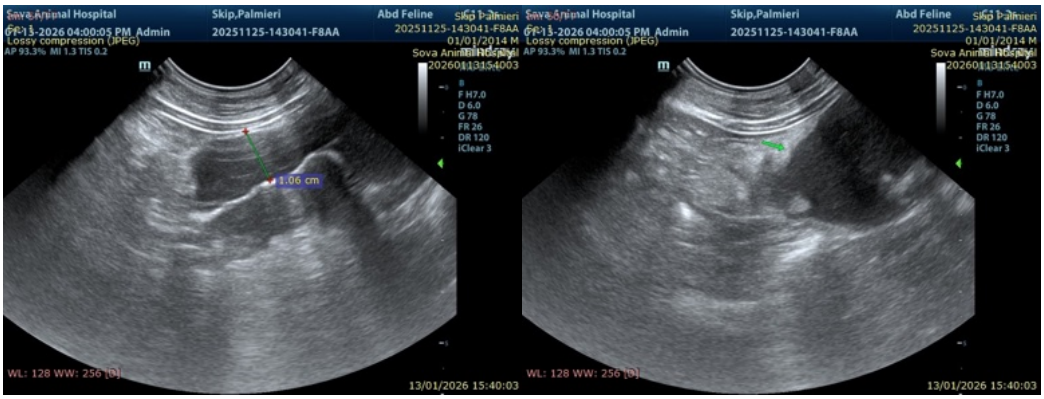

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

MV Esp Ultrasound in Domestic and Wild Animals

info@SonoPath.com