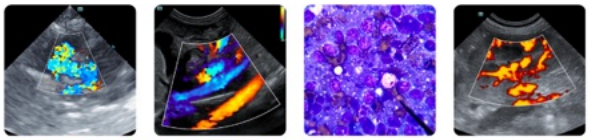

PATIENT

Elliot Craddock

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

15 years

WEIGHT

8 lbs 4 oz

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Bay

HOSPITAL NAME

For Cats Only VC

REFERRING VET

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70180

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PRESENTING CLINICAL SIGNS

History: Weight loss, elevated liver values, vomiting, urinating outside litterbox

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The urinary bladder wall appears thin, smooth, and regular. The bladder lumen contains mildly turbid urine with scant suspended echogenic material. The bladder neck and proximal urethra are unremarkable. There is no sonographic evidence of urolithiasis or inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 3.24×2.22 cm, with a cortical thickness of 0.41 cm in the sagittal plane. The renal cortex is mildly hyperechoic relative to the liver parenchyma. Corticomedullary ratio and corticomedullary definition are preserved. The renal pelvis measures approximately 1.36 mm, which is within normal limits. There is no evidence of nephrolithiasis.

The right kidney was not evaluated in the provided images or video clips and therefore could not be assessed.

Adrenal Glands

The adrenal glands are not visualized.

Spleen

The spleen measures approximately 1.20 cm in thickness, with mildly rounded margins. The splenic parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture without focal lesions. The splenic capsule is smooth and regular.

Liver

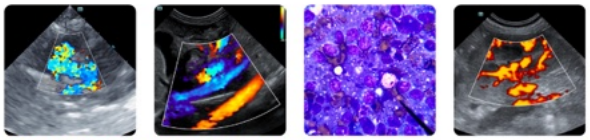
The liver is subjectively normal in size, with sharp margins and a smooth contour. The hepatic parenchyma is uniform and isoechoic relative to the falciform fat, with normal echotexture. No hepatic lymphadenopathy is identified.

The gallbladder is moderately to markedly distended. The gallbladder wall is thin, and the lumen contains a moderate amount of biliary sludge. The common bile duct measures approximately 3.93 mm proximally, 2.68 mm mid-portion, and 1.49 mm distally.

Gastrointestinal

The stomach contains food, fluid, and gas. Gastric wall thickness measures approximately 1.95 mm, with preserved wall layering. The duodenum measures approximately 2.47 mm.

The jejunum measures approximately 2.89 mm, with the following layer measurements:



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- Mucosa: 1.46 mm, Submucosa: 0.80 mm, Muscularis propria: 0.57 mm

The ileum measures approximately 2.45 mm, with preserved wall layering:

- Mucosa: 0.64 mm, Submucosa: 0.83 mm, Muscularis propria: 0.77 mm

The ileocecal junction measures approximately 3.16 mm, with a muscularis layer of 1.29 mm.

The colon measures approximately 0.85 mm, with formed fecal material present in the descending segment.

Pancreas

The pancreas measures approximately 5.6 mm in thickness. Pancreatic parenchyma is mildly hypoechoic relative to the adjacent omental fat. The pancreatic duct measures approximately 0.81 mm in diameter. There is no sonographic evidence of peripancreatic fat inflammation.

Peritoneal Cavity

A small amount of abdominal effusion is identified between intestinal loops.

A cranial mesenteric lymph node is markedly enlarged, measuring approximately 3.19×2.32 cm (maximum thickness), with a heterogeneous echotexture and multiple small peripheral cystic areas. Color Doppler evaluation demonstrates predominantly hilar vascularization, without evidence of aberrant peripheral vascular patterns.

Ileocecal lymph nodes are not visualized.

The iliac trifurcation is unremarkable.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Markedly enlarged, heterogeneous cranial mesenteric lymph node with peripheral cystic changes.
- Small volume abdominal effusion.
- Mild ileocecal muscularis prominence.

SECONDARY FINDINGS

- Gallbladder distension with biliary sludge and mild common bile duct dilation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most clinically significant ultrasonographic finding is marked cranial mesenteric lymphadenopathy, characterized by substantial enlargement, heterogeneous echotexture, and multiple small peripheral cavitary ('cyst-like') changes. Such cavitary changes may reflect necrosis/licuefaction (neoplastic or

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severe inflammatory), hemorrhage/degeneration, or less commonly lymphatic ectasia. While preservation of predominantly hilar vascularization may be seen in reactive or inflammatory lymph nodes, the degree of enlargement, heterogeneity, and cystic change are concerning and raise suspicion for neoplastic lymph node involvement, particularly lymphoma. A severe inflammatory or granulomatous process remains a differential consideration.

Small intestinal wall layering is largely preserved; however, there is mild muscularis propria prominence, most notably within the jejunum (muscularis ~0.57 mm) and ileum (muscularis ~0.77 mm). The muscularis-to-submucosa ratios remain <1 (jejunal ~0.71; ileal ~0.93), which is less supportive of a classic 'muscularis-dominant' enteropathy, but mild muscularis thickening can be seen with chronic inflammatory enteropathy and small-cell lymphoma in cats and overlaps with normal variation. Therefore, there is no definitive ultrasonographic evidence of a severe diffuse enteropathy, although early infiltrative intestinal disease cannot be excluded, particularly in the presence of marked mesenteric lymphadenopathy.

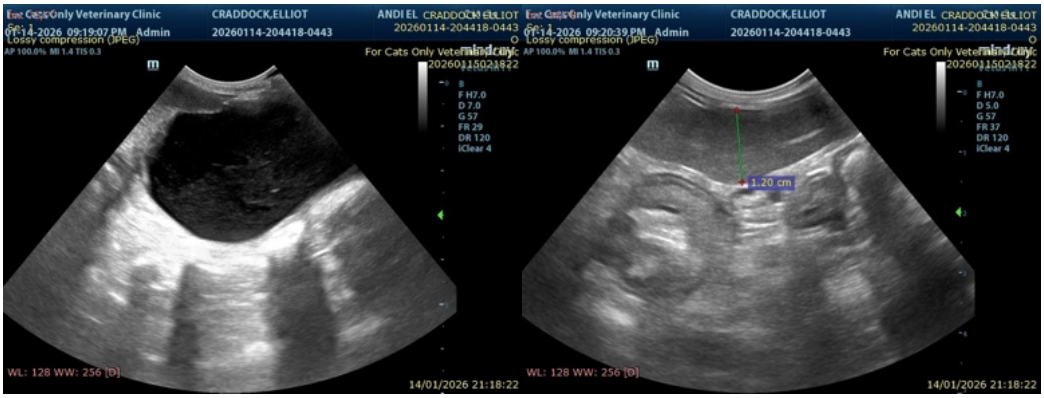
Hepatobiliary findings include gallbladder distension with biliary sludge and mild dilation of the proximal common bile duct. In the absence of focal hepatic lesions or biliary obstruction, these changes may reflect cholestasis or functional biliary stasis, potentially correlating with the reported elevation in liver enzymes.

A small volume of abdominal effusion further supports the presence of a clinically significant underlying process, such as neoplasia or severe inflammation.

Mildly turbid urine with scant suspended echoes is a nonspecific finding and may reflect scant urinary sediment or urine concentration in the absence of urolithiasis or bladder wall abnormalities. Mild left renal cortical hyperechogenicity with preserved size and corticomedullary definition is commonly incidental in geriatric cats and is not considered contributory to the current clinical signs.

Recommendations

- Ultrasound-guided fine-needle aspiration or biopsy of the cranial mesenteric lymph node is strongly recommended, as this lesion represents the most diagnostically significant abnormality and is likely to yield clinically actionable information.
- Intestinal biopsies may be considered depending on staging goals and clinical progression.
- Correlation with CBC, full chemistry panel, and hepatic parameters, and consideration of FeLV/FIV testing, if not already performed, are advised in light of the lymphadenopathy, effusion, and weight loss.



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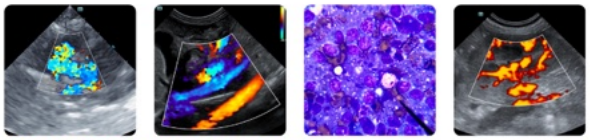

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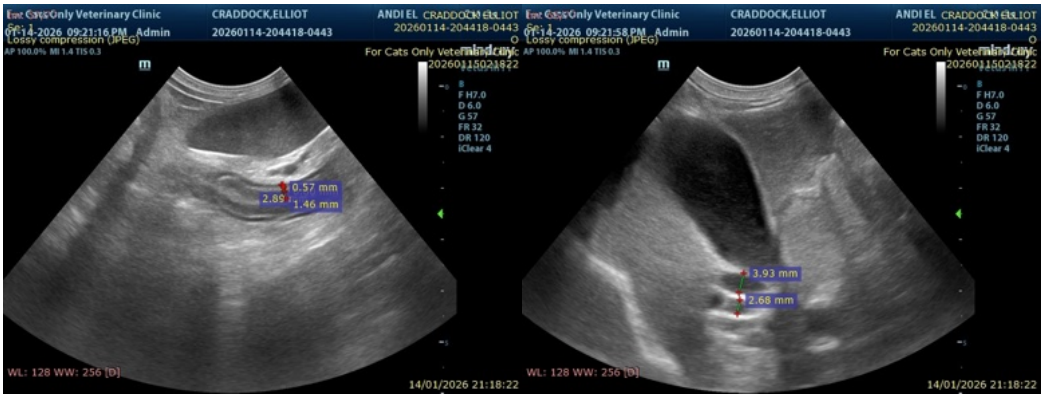

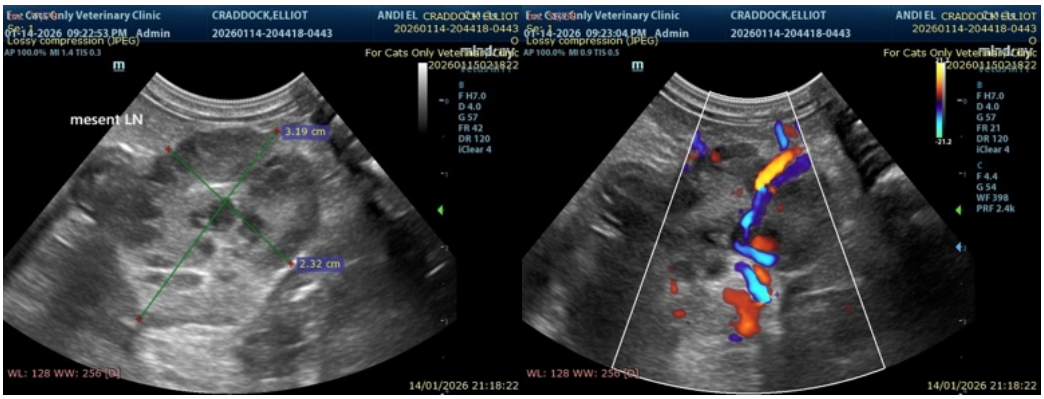

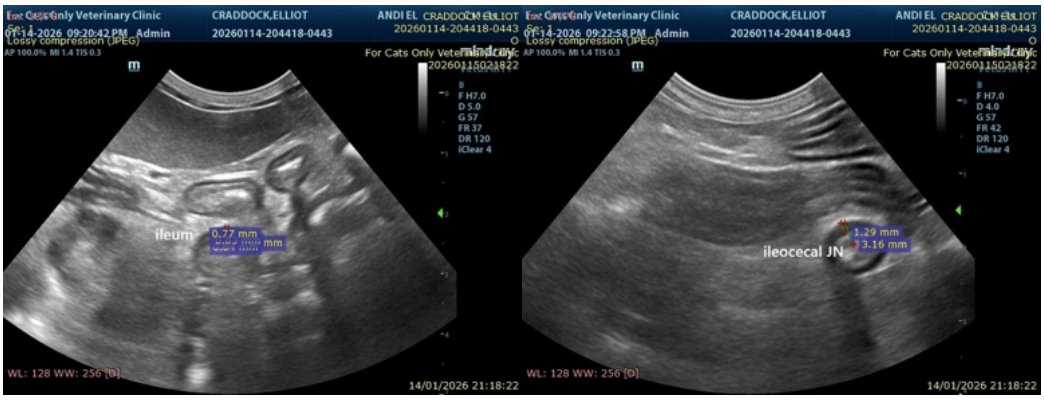

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

MV Esp Ultrasound in Domestic and Wild Animals

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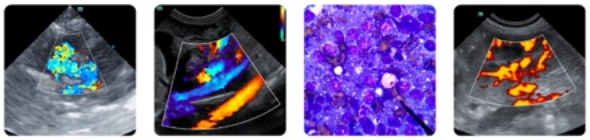

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