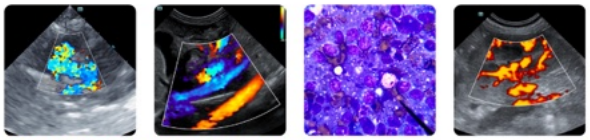


PATIENT

Natty Gann Hall

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

15 years

WEIGHT

8.8 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Nikki Wright

HOSPITAL NAME

Bush AH

REFERRING VET

Dr. Blystone

INVOICE

70296

DATE

1/19/26

PRESENTING CLINICAL SIGNS

- Vomiting, Diarrhea (Chronic intermittent), weight loss
- low albumin, thickened intestines on exam
- hyperthyroid (well controlled on methimazole)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is thin and smooth, and the urine is anechoic. The bladder neck and proximal urethra have a normal ultrasonographic appearance. No uroliths are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic changes.

Left kidney: Normal in shape and size, measuring 3.49 × 2.42 cm. Cortical thickness is 0.37 cm in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. No pyelectasia, nephroliths, or hydronephrosis are observed

Right kidney: Normal in shape and size, measuring 3.54 x 2.04 cm. Cortical thickness is 0.31 cm in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. No pyelectasia, nephroliths, or hydronephrosis are observed.

Adrenal Glands

Both adrenal glands have normal shape and echogenicity. Left adrenal gland measures approximately 0.21 cm at both the cranial and caudal poles. Right adrenal gland measures approximately 0.27 cm at both the cranial and caudal poles.

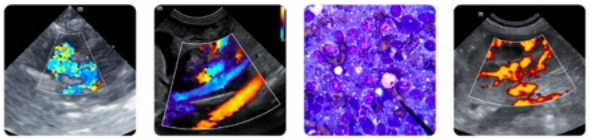
Spleen

Splenic thickness measures approximately 1.24 cm. The splenic parenchyma has normal echogenicity and a fine, homogeneous echotexture, with no focal parenchymal abnormalities identified. The splenic capsule is smooth and regular.

Liver

The left hepatic lobes contain at least two large, solid masses with internal cystic components. The largest mass measures at least 7.47×4.25 cm. A second mass, slightly more hypoechoic and similarly containing cystic areas, measures approximately 4.35×2.21 cm. The remaining hepatic parenchyma appears normal.

The gallbladder is normally distended. The wall is thin, and the contents are predominantly anechoic. No dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

Stomach: Empty and folded, with normal mural thickness (1.69 mm) and preserved wall layering.

Pylorus: Wall thickness approximately 3.20 mm.

Duodenum: Wall thickness approximately 1.83 mm, with preserved layering.

Jejunum: Wall thickness approximately 2.40 mm.

- Mucosa: 1.38 mm, Submucosa: 0.53 mm, Muscularis propria: 0.53 mm

Ileum: Wall thickness approximately 2.31 mm.

- Mucosa: 0.67 mm, Submucosa: 0.70 mm, Muscularis propria: 0.92 mm. Wall layering is preserved.

Ileocecal junction: Measures approximately 4.37 mm in thickness, with a muscularis component measuring approximately 2.76 mm.

No ultrasonographic evidence of obstruction, ileus, or foreign material is identified.

Colon: Wall thickness approximately 1.06 mm, with formed feces present in the descending colon.

Pancreas

The pancreas is visualized, with the right limb, body, and left limb appearing normal in shape. The pancreatic parenchyma is hypoechoic relative to the adjacent omental fat. Pancreatic body thickness: approximately 7.73 mm Left limb thickness: approximately 8.58 mm. The pancreatic duct measures approximately 1.69 mm in diameter. No ultrasonographic evidence of peripancreatic inflammation is observed.

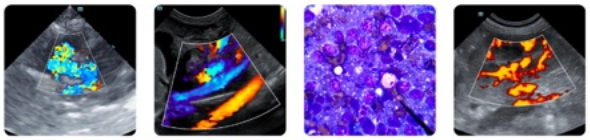
Peritoneal Cavity

No abdominal effusion or evidence of peritonitis is identified.

Cranial mesenteric lymph nodes measure approximately 4.54 mm in thickness. Ileocecal lymph nodes measure approximately 2.14–2.50 mm. The lymph nodes have normal shape and echogenicity.
The iliac trifurcation has a normal appearance.

ULTRASONOGRAPHIC FINDINGS

- Two large, solid hepatic masses with internal cystic components involving the left hepatic lobes.
- Segmental intestinal muscularis thickening, most pronounced at the ileum and ileocecal junction, with preserved wall layering.
- Mild pancreatic enlargement with hypoechoic parenchyma relative to adjacent fat.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most significant abnormality is the presence of large, solid hepatic masses with internal cystic components involving the left hepatic lobes. In a geriatric cat, this appearance is highly suspicious for primary hepatic neoplasia, with differentials including hepatocellular carcinoma, biliary carcinoma, cystadenoma. Ultrasonography alone cannot definitively distinguish among hepatic tumor types, and tissue sampling is required for definitive diagnosis.

Separately, the gastrointestinal tract demonstrates preserved wall layering throughout, with segmental muscularis thickening most notable at the ileum and ileocecal junction. This pattern, in combination with chronic gastrointestinal signs and hypoalbuminemia, is most compatible with a chronic inflammatory enteropathy versus small-cell (low-grade) intestinal lymphoma. Importantly, these two entities show marked ultrasonographic overlap in cats, and preserved layering does not exclude lymphoma. The normal size and appearance of the mesenteric and ileocecal lymph nodes slightly favor inflammatory disease but do not rule out low-grade lymphoma.

The pancreas appears mildly enlarged and hypoechoic relative to surrounding fat, without peripancreatic inflammatory changes. This finding may represent chronic pancreatic change, which can coexist with chronic feline enteropathies and does not, by itself, indicate acute pancreatitis.

Recommendations

- Further characterization of the hepatic masses is recommended. Ultrasound-guided sampling may be considered; however, it should be noted that fine-needle aspiration of complex hepatic masses in cats may be nondiagnostic, particularly in the presence of cystic or necrotic components. Histopathology provides superior diagnostic accuracy if definitive tumor characterization is required, and coagulation status should be assessed prior to any invasive procedure.
- Correlation with clinicopathologic data (particularly albumin trends, cobalamin, folate, and pancreatic markers if available) is recommended to support interpretation of the gastrointestinal and pancreatic findings.
- Further evaluation of chronic enteropathy is advised. Intestinal biopsies should be considered if results would alter management, recognizing the known overlap between inflammatory bowel disease and small-cell lymphoma in cats.
- If invasive diagnostics are declined or deferred, empirical medical management and close clinical monitoring may be considered, with follow-up abdominal ultrasound to assess progression of both hepatic and intestinal findings.

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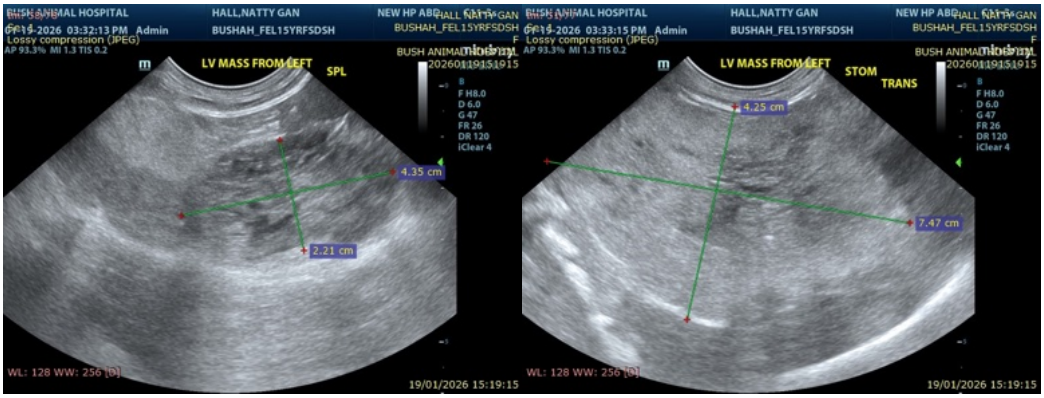

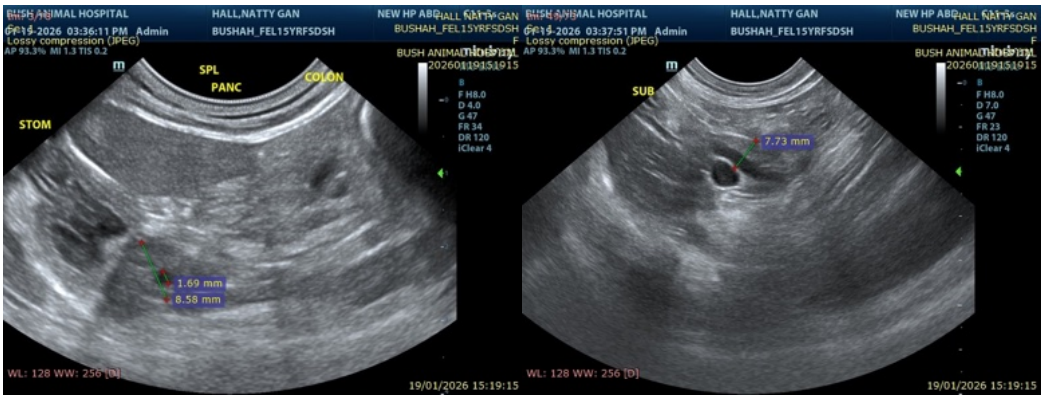

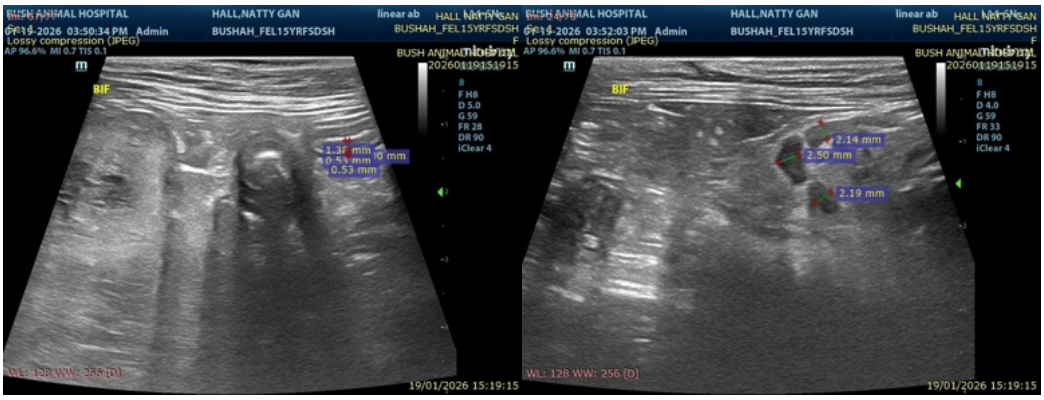

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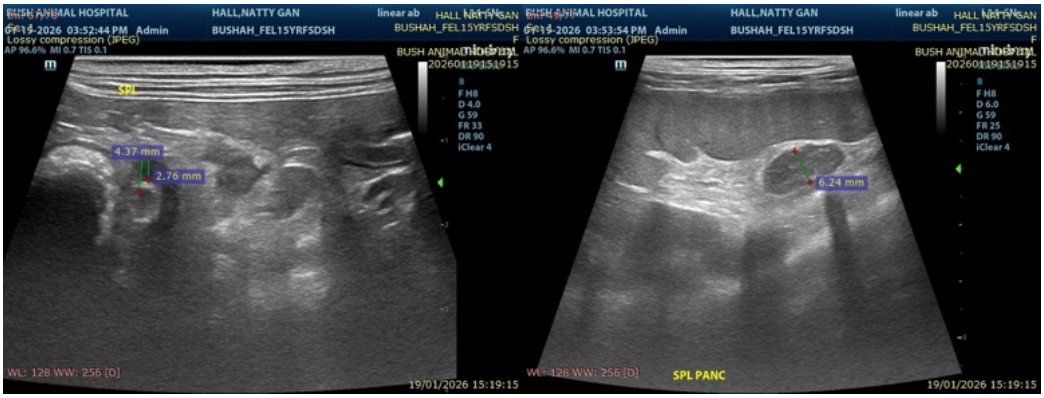

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@SonoPath.com