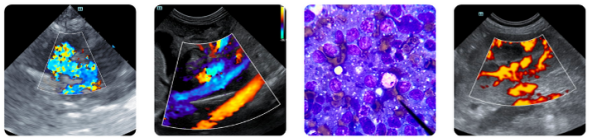


PATIENT

Geoffrey Voelinger

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Male

AGE

14 years

WEIGHT

8.5 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Danielle Shemanski, DVM, MA

HOSPITAL NAME

Western New York VS

REFERRING VET

Dr. Brenda Buck

INVOICE

70907

DATE

1/22/26

PRESENTING CLINICAL SIGNS

- RDVM REASON FOR REFERRAL: Referred for a possible bladder mass. History of UTI and urinating in the bathtub for several months. He was on Clavamox drops due to hematuria since January 2nd and has finished the course. Owner reports he is still occasionally urinating in the bathtub. Appetite is good. No vomiting reported, just an occasional hairball. No changes in defecation. Owner reports that after coming off the antibiotics (clavamox) , he has been more active again.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. There is marked focal thickening of the urinary bladder wall, measuring approximately 6.59–6.85 mm, involving the mid and caudal bladder, extending toward the bladder neck, affecting both the ventral and dorsal walls. There is no sonographic evidence of trigonal involvement. The urine is predominantly turbid, with scant suspended echogenic debris. No uroliths are identified.

The left kidney is normal in shape and size (3.68×2.37 cm). Cortical thickness measures 0.41 cm in the sagittal plane. The right kidney is normal in shape and size (3.70×2.27 cm). Cortical thickness measures 0.35 cm in the sagittal plane. In both kidneys, cortical echogenicity is normal relative to the liver. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

Both adrenal glands are normal in shape and echogenicity. The left adrenal gland measures 0.30 cm (cranial pole) and 0.31 cm (caudal pole). The right adrenal gland measures 0.22 cm (cranial pole) and 0.25 cm (caudal pole).

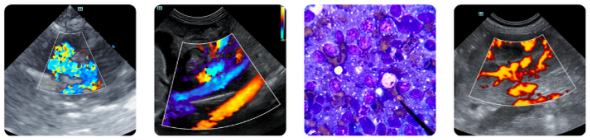
Spleen

Splenic thickness is 1.01 cm. The splenic parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal 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 uniform and isoechoic to falciform fat, with normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder is normally distended. The wall is thin, and luminal contents are anechoic. The common bile duct measures approximately 1.89–1.49 mm, within normal limits.



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Gastrointestinal

The stomach is empty and folded. Gastric wall thickness measures approximately 1.70 mm, with preserved wall layering.

The pylorus measures approximately 2.98 mm.

The jejunum measures approximately 2.10 mm, with preserved wall layering (mucosa 0.92 mm, submucosa 0.76 mm, muscularis propria 0.30 mm).

The ileum measures approximately 1.45 mm, with preserved layering (mucosa 0.88 mm, submucosa 0.72 mm, muscularis propria 0.26 mm).

The ileocecal junction measures approximately 2.29 mm, with muscularis thickness of 0.70 mm.

No sonographic evidence of mural thickening, ileus, or foreign material is identified.

The colon measures approximately 0.58 mm in wall thickness and contains formed feces within the descending segment.

Pancreas

The evaluated pancreatic regions do not demonstrate sonographic evidence of active inflammation.

Peritoneal Cavity

No abdominal effusion or evidence of peritonitis is observed.

Cranial mesenteric lymph nodes are markedly enlarged, measuring approximately 4.77×2.00 cm and 3.83×1.47 cm, with irregular margins, heterogeneous echotexture, and mixed vascular pattern on Doppler evaluation.

Ileocecal lymph nodes are not visualized.

ULTRASONOGRAPHIC FINDINGS

- Marked focal thickening of the urinary bladder wall involving mid to caudal bladder and bladder neck.
- Marked cranial mesenteric lymphadenopathy with irregular margins, heterogeneous echotexture, and abnormal vascular pattern.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The degree and focal nature of bladder wall thickening (up to ~6.8 mm) exceed what would be expected from simple diffuse cystitis alone and raise concern for significant bladder wall pathology, including infiltrative processes.

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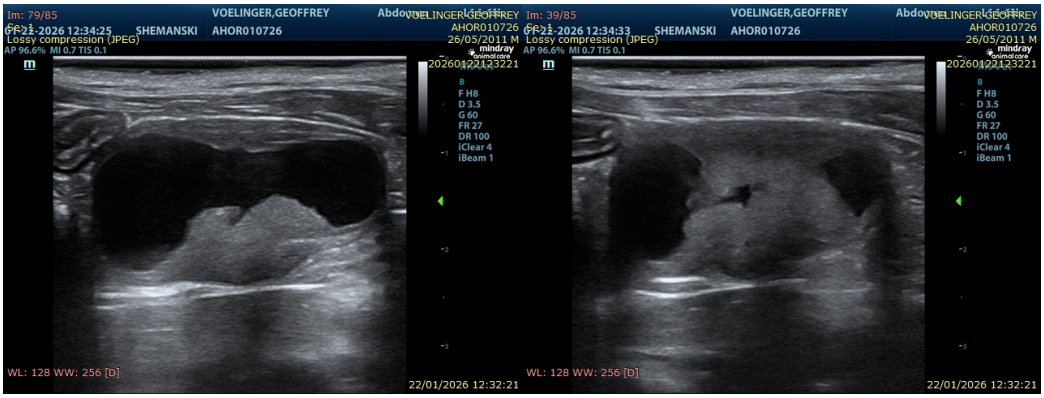
The presence of markedly enlarged, irregular, and heterogeneous cranial mesenteric lymph nodes with abnormal vascular patterns, are not typical findings of uncomplicated lower urinary tract infection and raises concern for a systemic infiltrative process. In this context, lymphoproliferative disease, including lymphoma with secondary urinary bladder involvement, represents a significant diagnostic consideration, despite its relative rarity.

No upper urinary tract abnormalities are identified, and there is no evidence of urinary obstruction, urolithiasis, or secondary hydronephrosis. The remainder of the abdominal organs do not demonstrate abnormalities that would explain the lymphadenopathy.

Recommendations

- Cytologic evaluation of the markedly enlarged cranial mesenteric lymph nodes is appropriate and represents a critical first diagnostic step. Interpretation of these results will be central to determining whether a lymphoproliferative or other infiltrative systemic process is present.
- Correlation with the urinary bladder lesion remains essential. Although lymph node cytology may establish a diagnosis of systemic disease, the presence of marked focal bladder wall thickening raises concern for concurrent bladder involvement. If lymph node cytology is inconclusive or confirms neoplasia, targeted sampling of the urinary bladder wall is recommended to determine whether the bladder changes represent direct involvement by the same process.
- Urinalysis, including sediment examination, may be supportive but is unlikely to be definitive, as exfoliation of diagnostic cells from infiltrative bladder wall disease is inconsistent.
- Further staging and treatment decisions should be guided by the combined cytologic and/or histopathologic findings, rather than imaging findings alone.



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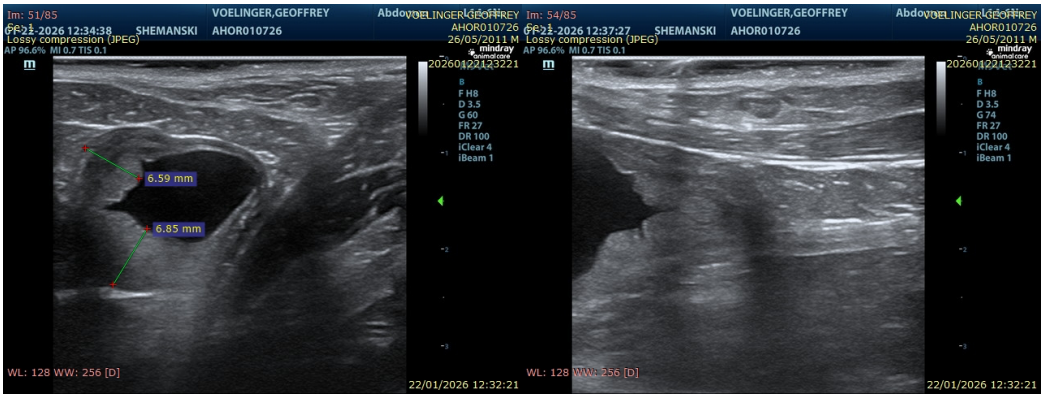

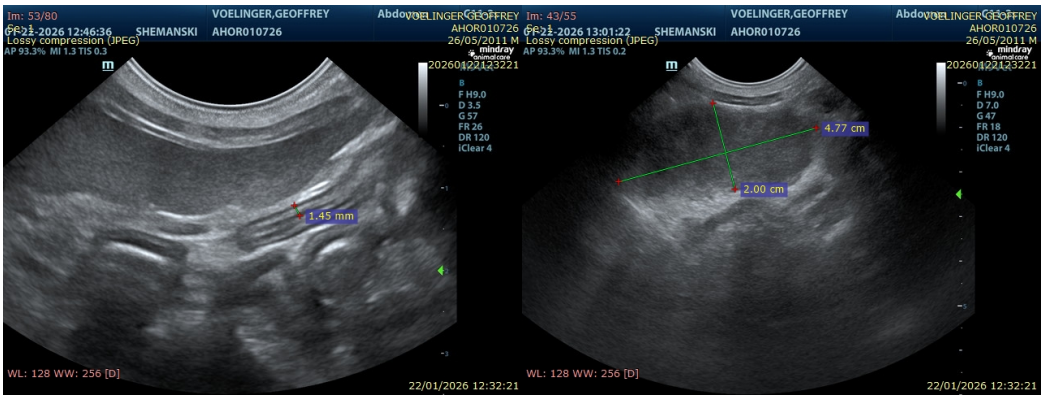

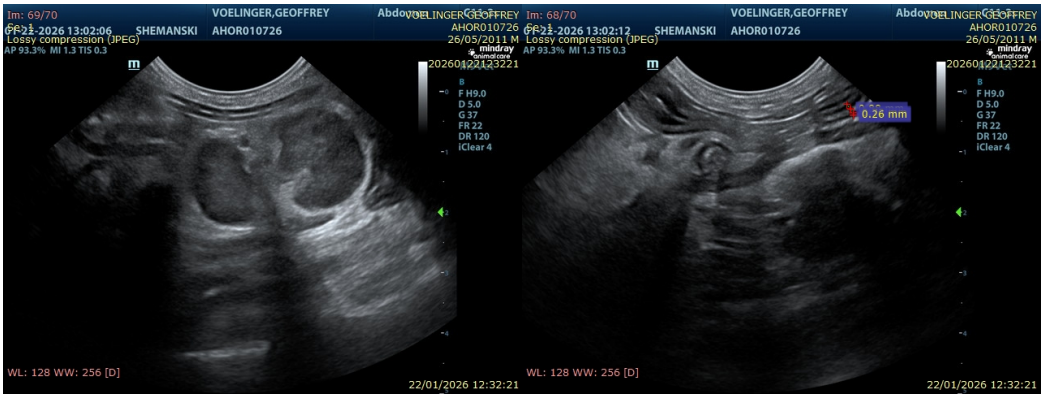

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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