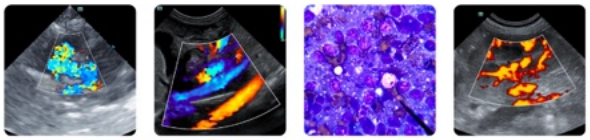


PATIENT

Sawyer Schleede

SPECIES

Feline

BREED

Domestic Longhair

SEX

Male

AGE

8 years

WEIGHT

11.4 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Danielle Shemanski, DVM, MA

HOSPITAL NAME

Wester New York VS

REFERRING VET

Dr. Delucia

INVOICE

69886

DATE

1/6/26

PRESENTING CLINICAL SIGNS

RDVM REASON FOR REFERRAL: Patient has intermittent vomiting and ileus for 1-1.5 years, but recently has had decreased to no appetite, bilious vomit, plus a 2 lb weight loss in the last two months. MEDICATIONS: Rxd today Onsior 6mg 1 PO SID x 2d(?) Mirtazapine transdermal 1 1/2 strip SID WBC: 26.55 K/uL - Neutrophils: 23.76 K/uL - Lymphocytes: Within normal range - Monocytes: 0.69 K/uL - ALT: Low - AST: Not measured - ALP: 29 U/L - Total T4: 2.1 ug/dL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the urinary bladder wall appears thin and smooth. The urine is markedly turbid with abundant suspended echoes. Normal appearance of the bladder neck and proximal urethra. No uroliths or sonographic evidence of inflammatory or neoplastic changes.

Left kidney: Normal in shape and size (4.03×2.23 cm). Cortical thickness 0.36 cm. Right kidney: Normal in shape and size (3.81×2.04 cm). Cortical thickness 0.38 cm. Both kidneys show mildly increased cortical echogenicity with mildly increased corticomedullary distinction. Corticomedullary ratio and definition are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis identified. Color Doppler demonstrates normal perfusion.

Adrenal Glands

Both adrenal glands are normal in size, shape, and echogenicity. Left: 0.39 cm (cranial pole), 0.31 cm (caudal pole). Right: 0.34 cm (cranial pole), 0.37 cm (caudal pole).

Spleen

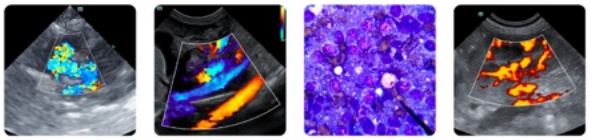
Splenic thickness is 0.64 cm. The parenchyma is homogeneous with normal echogenicity. The splenic capsule and vasculature appear normal.

Liver

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

The gallbladder is normally distended. The wall is thin. A small amount of biliary sludge is present. No dilation of the cystic duct or common bile duct is observed.

Gastrointestinal



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The stomach is partially fluid-filled and folded. General mural thickness is approximately 2.7 mm with preserved wall layering in most regions. However, a focal gastric segment shows marked wall thickening up to approximately 6 mm, with hypoechoic appearance and loss of normal wall layering. An irregular hypoechoic intraluminal gastric mass measuring approximately 2.01×2.86 cm is identified, corresponding to one of the sampled (aspirated) regions. Duodenum: 1.52 mm. Jejunum: 1.80–2.13 mm. Ileum: 1.38 mm No evidence of intestinal obstruction, ileus, or foreign material. Colon measures approximately 0.96 mm and contains a small amount of fecal material.

Pancreas

No sonographic abnormalities identified in the pancreatic regions evaluated.

Peritoneal Cavity

No abdominal effusion is present.

Mild focal hyperechogenicity and thickening of the perigastric fat is noted ventral to the stomach, adjacent to the affected gastric region.

- Left gastric lymph node: 3.75x5.19 mm
- Right gastric lymph node: 1.19x0.66 mm

Both lymph nodes maintain normal shape and echogenicity. Cranial mesenteric and ileocecal lymph nodes are not visualized.

The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Marked focal gastric wall thickening with loss of normal wall layering and focal hypoechogenicity.
- Irregular hypoechoic intraluminal gastric mass measuring approximately 2.0×2.9 cm, corresponding to the region sampled by fine-needle aspiration.
- Mild adjacent perigastric fat hyperechogenicity.
- Mildly enlarged gastric lymph nodes with preserved shape and echogenicity.

SECONDARY FINDINGS

- Urinary bladder contains markedly turbid urine with abundant suspended echoes, most consistent with sediment or debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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The ultrasonographic findings are most consistent with a focal infiltrative gastric disease, characterized by marked, localized gastric wall thickening (up to approximately 6 mm), loss of normal wall layering, and the presence of an irregular intraluminal gastric mass.

This pattern is suspicious for a primary gastric neoplasm, with gastric lymphoma and gastric carcinoma considered most likely in this species and age group. Gastric mast cell tumor is also possible.

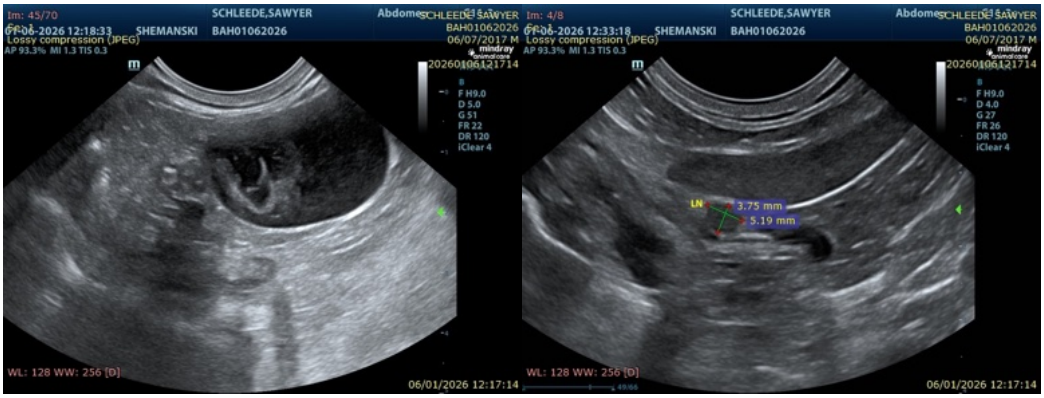
The preserved size and echogenicity of the gastric lymph nodes and the absence of abdominal effusion do not exclude malignancy, as early or localized gastric neoplasia may occur without overt metastatic disease or nodal enlargement.

No sonographic evidence of primary intestinal, hepatic, pancreatic, or splenic disease is identified that would better explain the patient's chronic gastrointestinal signs. The mild perigastric fat changes are interpreted as reactive, likely secondary to the adjacent gastric lesion.

The markedly turbid urine is considered an incidental finding and is unlikely to be related to the current gastrointestinal presentation.

Recommendations

- Correlation with cytologic results from the gastric wall aspirates is strongly recommended, as this will be critical for definitive diagnosis and differentiation among neoplastic etiologies.
- If cytology is nondiagnostic or equivocal, gastric biopsy should be considered, based on patient stability and clinician judgment.
- Following diagnostic confirmation, further staging (including thoracic imaging and reassessment of regional lymph nodes) may be considered to evaluate for metastatic disease.
- Supportive medical management may be pursued as clinically indicated while awaiting definitive diagnostic results.



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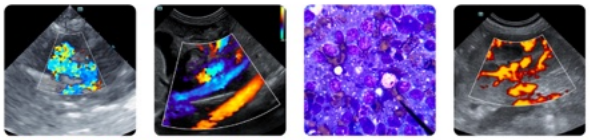

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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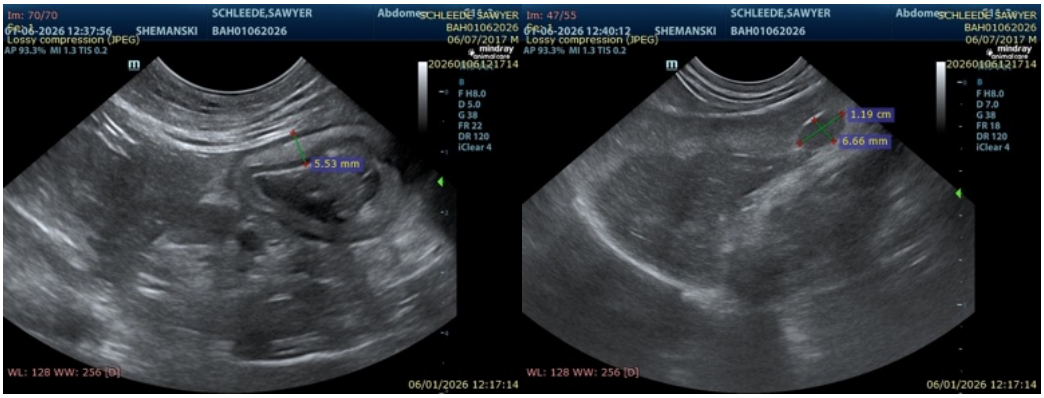

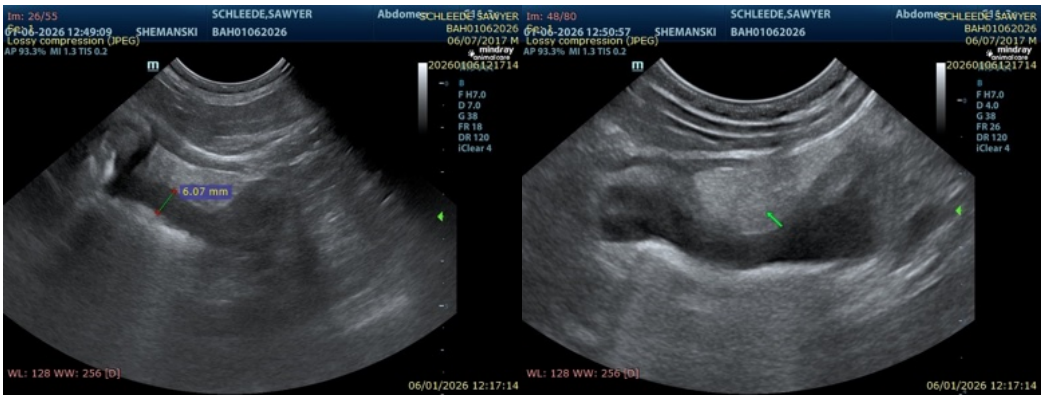

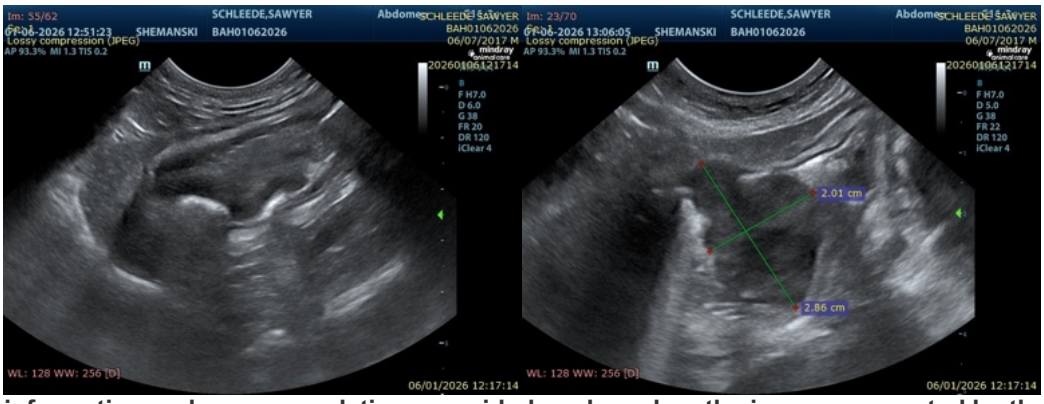

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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