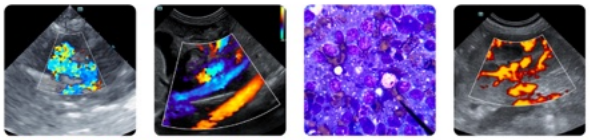


PATIENT

Lexi Furlong

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

13 years

WEIGHT

6.3 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Pascucci

HOSPITAL NAME

American AH

REFERRING VET

Dr. Stockmal

INVOICE

68531

DATE

11/10/25

PRESENTING CLINICAL SIGNS

History: - chronic vomiting - weight loss - hyporexia - palpable lymph nodes in abdomen and thickened bowel
Abnormal PE/Chem/CBC/UA Results: Jan 2025- monocytes 1.039k

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. Normal appearance of the proximal urethra and vesicoureteral junction. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.63x1.96 cm, and the thickness of the cortex is 0.35 cm, in the sagittal plane. The cortical is isoechogenic compared to liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths or hydronephrosis. Doppler color shows normal pattern.

The right kidney is normal in shape and size: 3.74x2.15 cm, and the thickness of the cortex is 0.33 cm, in the sagittal plane. The cortical is isoechogenic compared to liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths or hydronephrosis. Doppler color shows normal pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. The left adrenal gland measures 0.22 cm at the cranial pole and 0.20 cm at the caudal pole. The right adrenal gland measures 0.21 cm at the cranial pole and 0.24 cm at the caudal pole.

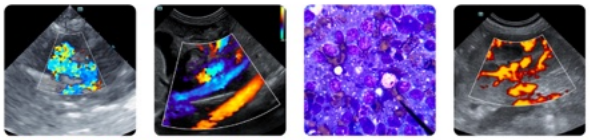
Spleen

Splenic thickness is 0.63 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

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



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Gastrointestinal

The stomach is empty and folded, with normal mural thickness (1.72 mm) and preserved wall layering. The pylorus is not clearly visualized.

Duodenum: 1.94 mm. Jejunum: 1.72 mm (mucosa 1.20 mm, submucosa 0.25 mm, muscularis 0.19 mm). Ileum: 1.54 mm (mucosa 0.73 mm, submucosa 0.37 mm, muscularis 0.25 mm). Ileocecal junction: 2.87 mm (muscularis 1.01 mm). No evidence of obstruction, ileus, or foreign material.

Colon: Ascending 0.71 mm, transverse 0.60 mm, descending 0.92 mm; contains semi-formed, soft fecal material and few undigested contents in the descending segment.

Pancreas

A well-defined structure located between the spleen, stomach, and descending colon, corresponding to the anatomical region of the left pancreatic lobe, measures up to 1.2 cm in diameter. This segment appears mildly enlarged and heterogeneous, containing a rounded anechoic to hypoechoic area (approximately 7.9×7.5 mm) with minimal posterior acoustic enhancement. No peripancreatic fat reaction, free fluid, or peritonitis is observed.

Based on its anatomic position, the finding is most compatible with the left pancreatic lobe, although definitive confirmation cannot be made from the available images.

Peritoneal Cavity

No abdominal effusion or peritonitis is observed. Cranial mesenteric and ileocecal lymph nodes are not visualized, but the surrounding regions appear unremarkable. The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Mild diffuse small intestinal thickening, more evident at the ileocecal junction, with mildly prominent muscularis layer and preserved layering.
- Focal enlargement and heterogeneity of the left pancreatic lobe region, containing a small anechoic-to-hypoechoic rounded area.

SECONDARY FINDINGS

- Descending colon with soft, semi-formed feces and undigested material.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ultrasound shows a normal small intestinal wall thickness throughout most segments, with only a focal, mild thickening at the ileocecal junction. Wall layering is preserved, and no mesenteric lymphadenopathy is detected, supporting a focal low-grade inflammatory change. Nonetheless, as the

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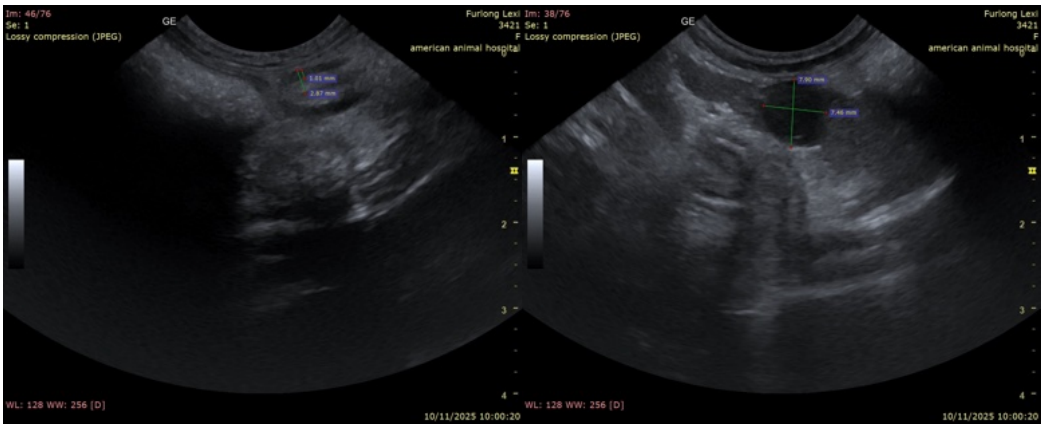
ileocecal valve represents a predilection site for alimentary lymphoma in cats, a very early neoplastic process cannot be completely ruled out at this time, even though the current imaging features are not consistent with it.

The main abnormality lies in the left pancreatic region, where a segment measuring up to 1.2 cm appears heterogeneous and mildly enlarged, containing a well-defined rounded area (7.9×7.5 mm) with anechoic-to-hypoechoic content and minimal posterior enhancement. There is no peripancreatic fat reaction, effusion, or peritonitis, suggesting a chronic rather than active process. This finding is most compatible with a focal chronic pancreatic lesion, such as a residual cystic area, pancreatic pseudocyst, pseudoabscess, or fibro-cystic scar following prior pancreatitis. However, a neoplastic process cannot be completely excluded.

Recommendations

- Perform fPLI to evaluate pancreatitis.
- Monitor the observed pancreatic lesion ultrasonographically.
- If the pancreatic lesion increases in size, becomes irregular, or develops peripancreatic reaction, consider fine-needle aspiration under ultrasound guidance for cytologic evaluation.
- CT scan with contrast is recommended if cytology is inconclusive or if the ultrasonographic appearance worsens.
- Check cobalamin (B12) and folate levels to assess absorptive and pancreatic function. Consider TLI testing if signs of maldigestion or weight loss persist.
- Medical management: Highly digestible or hydrolyzed protein diet, low in fat; antiemetics; analgesia; cobalamin supplementation if B12 is low.



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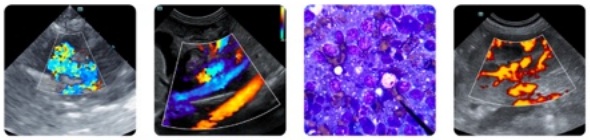

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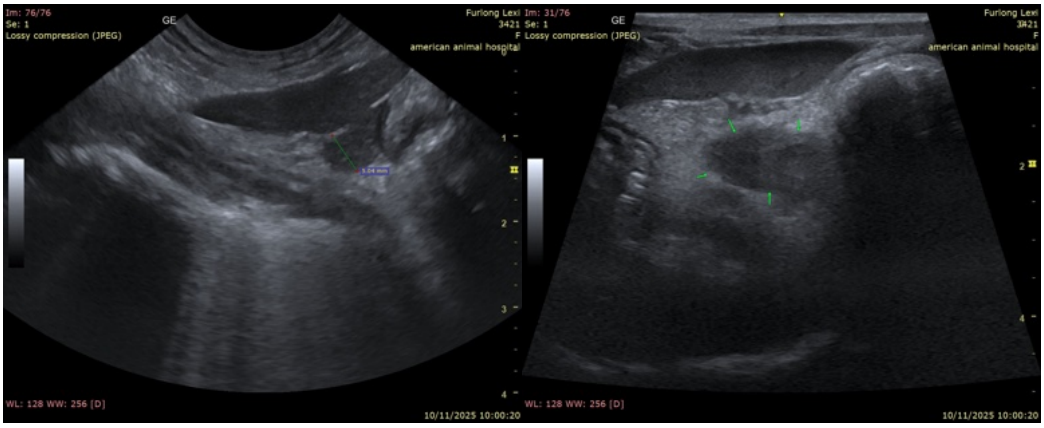

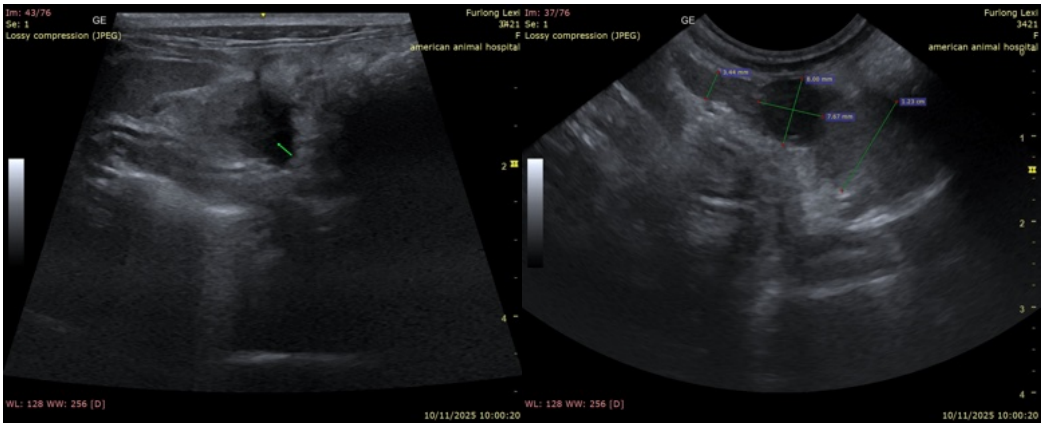

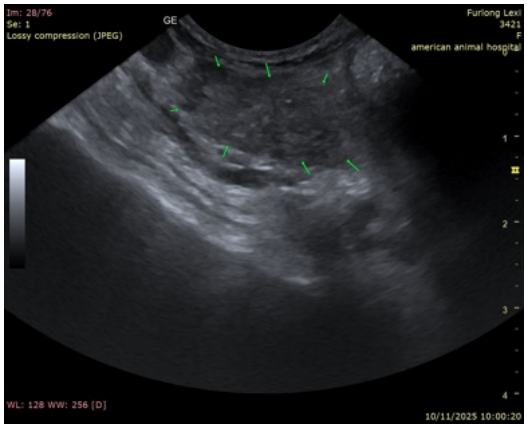

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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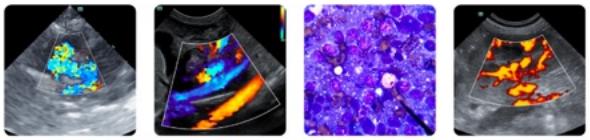

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Alicia Angosto Guerrero, DMV, PgDip, MSc.

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