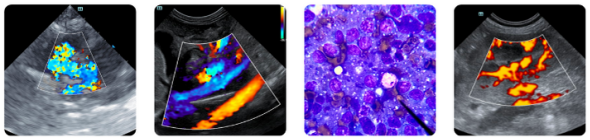


PATIENT

Roma Childers

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed Female

AGE

14 years 6 months

WEIGHT

4.84 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Carly Pate

HOSPITAL NAME

VCA McKenzie Animal Hospital

REFERRING VET

Dr. FitzClemen

INVOICE

10745

DATE

11/13/2025

PRESENTING CLINICAL SIGNS

Vomited 10x in the last 24 hrs, lethargic, interest in food but not able to keep food down. Last meal ~24 hours ago. Weight loss. Hx of IBD/chronic enteropathy, P is on Prednisolone 3mg SID, Solensia, Fluoxetine, RC GI Fiber diet.

Abnormal PE/Chem/CBC/UA Results: IH CBC/Chem/UA ALT 108, BUN 35, CA 12.5, GLU 255, K+ 3.6. WBC 22.67, LYM 0.64, NEU 20.63, MON 1.26, RBC 7.48 USG 1041.

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 anechoic. Normal appearance of the proximal urethra and vesicoureteral junction. No calculi or evidence of inflammatory or neoplastic changes are identified.
The left kidney is normal in shape and size (2.68×1.93 cm), with a cortical thickness of 0.32 cm in the sagittal plane.
The right kidney is normal in shape and size (2.71×1.84 cm), with a cortical thickness of 0.34 cm in the sagittal plane.
The renal cortex is slightly increased in echogenicity, resulting in increased corticomedullary distinction. No pyelectasia, nephroliths, or hydronephrosis are present. Basic color Doppler shows a normal vascular pattern.

Adrenal Glands

The left adrenal gland measures 0.30 cm at the cranial pole and 0.29 cm at the caudal pole.
(Right adrenal gland not visualized in videos provided.)

Spleen

Splenic thickness is 0.53 cm. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

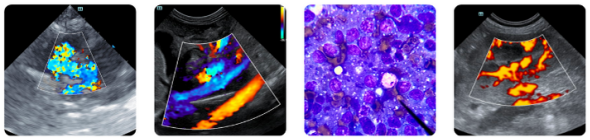
Liver

The liver is subjectively normal in size, with sharp margins and a regular contour. The hepatic parenchyma is uniform and isoechoic relative 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 dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and folded, with mural thickness of 2.10 mm and preserved wall layering.
The pylorus measures 2.50 mm.
Jejunum measures 1.96 mm (mucosa 0.85 mm, submucosa 0.75 mm, muscularis propria 0.29 mm).
Ileum measures 1.85 mm (mucosa 0.61 mm, submucosa 0.59 mm, muscularis propria 0.42 mm), with normal wall layering.
The ileocecal junction measures 2.37 mm (muscularis 0.99 mm).



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Adjacent to the ileum, there is a fluid-containing structure with turbid content, measuring 3.18 × 2.05 cm, arising from or abutting the ileal wall. It does not appear to invade or completely disrupt the intestinal layers.
Nearby lymph nodes are markedly enlarged, rounded, and severely hypoechoic.

Colon wall thickness is 0.85 mm, with formed feces in the descending colon.

Pancreas

The pancreatic regions evaluated show no evidence of inflammation.

Free Abdomen

No evidence of abdominal effusion or peritonitis is observed.

PRIMARY FINDINGS

- 3 cm fluid-filled, turbid cystic structure arising from or adjacent to the ileum.
- Markedly enlarged, rounded, severely hypoechoic lymph nodes near the ileum.

SECONDARY FINDINGS

- Mildly increased renal cortical echogenicity bilaterally.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ultrasound identifies a 3.2x2.0 cm fluid-filled structure with turbid content closely associated with the ileal serosal surface, while the adjacent ileal wall maintains normal thickness and layering, without evidence of invasion or disruption. There are markedly enlarged, rounded, severely hypoechoic mesenteric lymph nodes immediately adjacent to the lesion, compatible with significant reactive or suppurative lymphadenopathy.

Considering the patient's acute vomiting, lethargy, leukocytosis/neutrophilia, hypokalemia, weight loss, and chronic enteropathy on prednisolone, the findings are most consistent with a localized infectious/inflammatory process such as:

Most likely differentials:

- Mesenteric or mural abscess (most likely)
- Inflamed Meckel-like diverticulum (rare)
- Cavitated lymph node abscess (suppurative lymphadenitis) (less likely for the main structure but possible for the adjacent lymph nodes).
- Neoplasia with cystic degeneration (lymphoma/adenocarcinoma) – not impossible but unlikely.

Overall, the lesion behaves more like an abscess or cavitated lymph node than a primary tumor, given its fluid-dominant nature and preserved ileal wall architecture.

Mild renal cortical hyperechogenicity suggests early chronic change.

Recommendations

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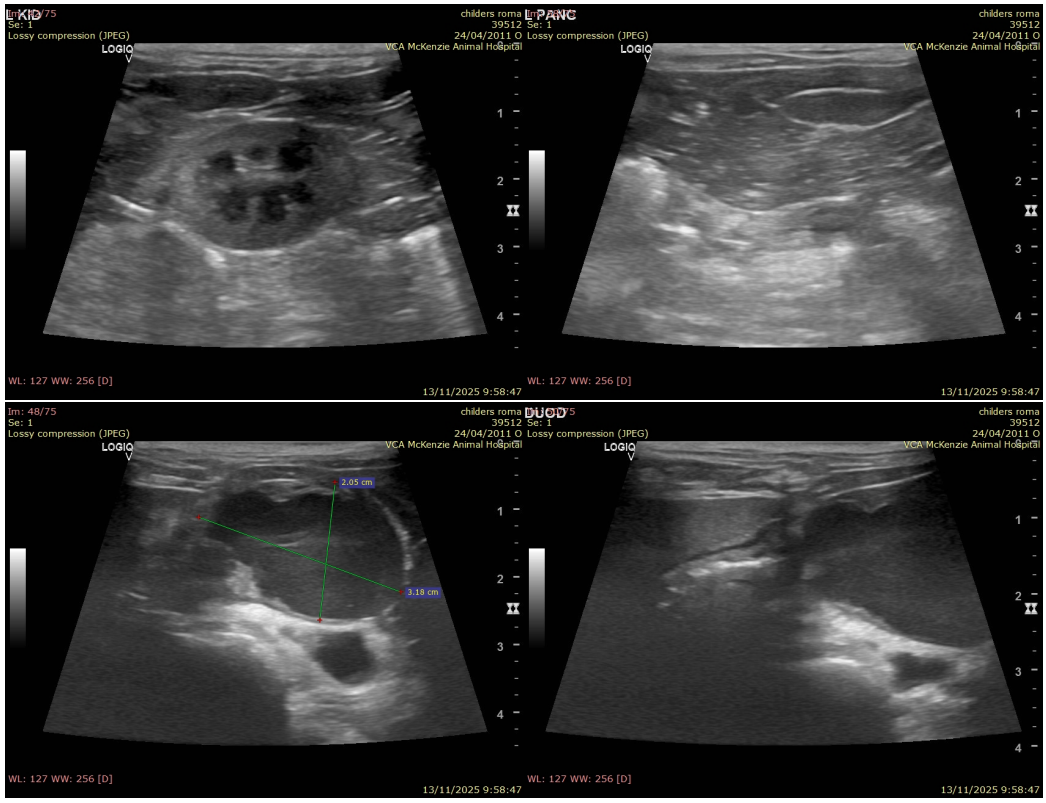
- Strongly recommend surgical exploration.
- Do not perform FNA due to high risk of rupture or peritonitis.
- Submit surgical samples (lesion + mesenteric lymph nodes ± ileal biopsy) for histopathology and bacterial culture.
- Start broad-spectrum IV antibiotics, plus standard supportive care.
- CT may be helpful, but it should not delay surgery if the patient is clinically unstable.



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.

info@SonoPath.com