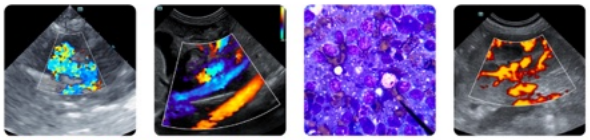


PATIENT

Madison Kraeutler

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

10 years

WEIGHT

5.4 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dana Kraeutler, CVT

HOSPITAL NAME

Pocono Peak VC

REFERRING VET

Dr. Thompson

INVOICE

69493

DATE

12/10/25

PRESENTING CLINICAL SIGNS

History: 1 week history of diarrhea, vomiting, weight loss, and intermittent appetite. Cranial abdomen felt irregular at physical exam.
Abnormal PE/Chem/CBC/UA Results: Bloodwork and FNA of spleen pending.

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 (3.58 × 2.34 cm), with a cortical thickness of 0.26 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis.

The right kidney is normal in shape and size (3.84 × 2.45 cm), with a cortical thickness of 0.25 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis.

Adrenal Glands

The images provided and labeled as adrenal glands show the following measurements: Left adrenal gland: 0.42 cm (cranial pole) and 0.46 cm (caudal pole). Right adrenal gland: 0.30 cm (cranial pole) and 0.36 cm (caudal pole).

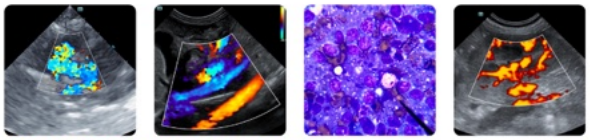
Spleen

The spleen was not visualized in any of the videos provided. The images labeled as spleen correspond to the stomach.

Liver

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

The gallbladder is moderately distended and contains a small amount of biliary sludge. The gallbladder wall is mildly thickened (1.44 mm), hyperechoic. The common bile duct is dilated and tortuous, measuring up to 5.4 mm.



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Gastrointestinal

The stomach is empty with a fluid pattern. The gastric wall is markedly abnormal, measuring approximately 1 cm in thickness, with complete loss of normal mural layering.

Duodenum: 1.83 mm. Jejunum: 1.54 mm. Ileum: 1.06–1.82 mm. These small intestinal segments show normal wall layering. The ileocecal junction was not visualized. No signs of obstruction, ileus, or foreign material are identified.

Colon: 0.84 mm, mostly empty.

Pancreas

The pancreas could not be clearly visualized.

Peritoneal Cavity

No abdominal effusion or peritonitis is observed. Cranial mesenteric and ileocecal lymph nodes are not visualized. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Severe diffuse gastric wall thickening with complete loss of layering.

SECONDARY FINDINGS

- Dilated, tortuous common bile duct (5.4 mm).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most significant abnormality identified is a severe, diffuse thickening of the gastric wall, with complete loss of normal wall layering throughout the examined segments. This pattern is highly consistent with an infiltrative gastric process, and the ultrasonographic appearance is most suggestive of gastric lymphoma. Although severe chronic inflammatory gastritis or other infiltrative conditions remain possible, the degree of transmural thickening and the complete effacement of wall layers make neoplasia the leading differential diagnosis.

The small intestine (duodenum, jejunum, and ileum) maintains normal wall thickness and preserves all mural layers, with no evidence of segmental thickening, masses, or loss of definition. These findings support localization of the primary disease process to the stomach rather than the small intestine.

The common bile duct is moderately dilated and tortuous, measuring up to 5.4 mm. No obstructive lesion is visualized within the hepatoduodenal region, and the liver and gallbladder otherwise appear normal. The degree of dilation may reflect functional cholestasis secondary to the severe gastric

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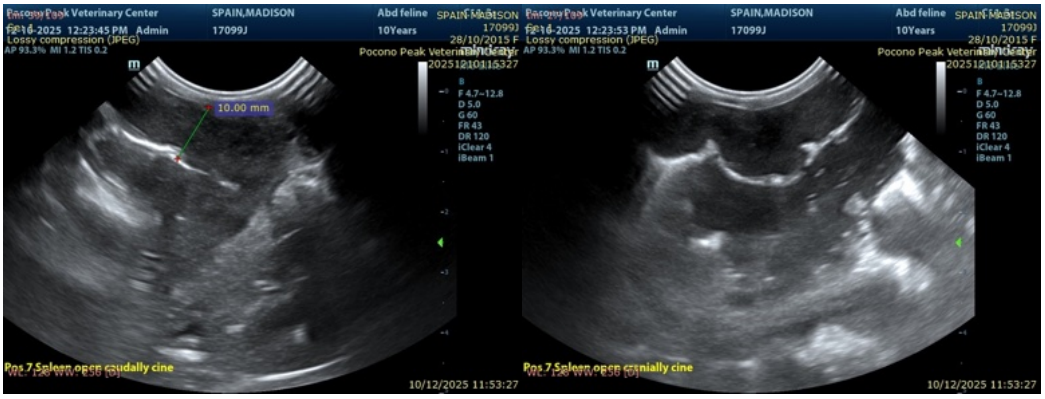
pathology or less likely early extrahepatic biliary obstruction not fully characterized due to incomplete visualization of the pancreas.

The hepatic parenchyma remains uniform; however, the slightly increased echogenicity relative to the falciform fat raises the possibility of early hepatic lipidosis.

Overall, the ultrasonographic findings indicate a severe infiltrative gastric process most compatible with gastric lymphoma, with secondary or functional biliary duct dilation possible. Further diagnostic evaluation is required for definitive characterization.

Recommendations

- Await cytology results: The sample obtained appears most consistent with gastric tissue, given the severe mural thickening and loss of layering in the region visualized. Cytology may provide preliminary classification (lymphoma vs. inflammatory infiltrate), although histopathology will be required for definitive diagnosis.
- Upper GI endoscopy with targeted gastric biopsies: essential to distinguish lymphoma from chronic inflammatory infiltrative disease and to determine the extent of gastric involvement.
- CT of the abdomen and thorax (contrast-enhanced): A complete CT study would markedly improve assessment of: full gastric wall involvement, regional and distant lymph nodes, the pancreas and hepatobiliary tract, including confirmation of whether biliary duct dilation is functional or obstructive, and possible thoracic spread, if neoplasia is confirmed.



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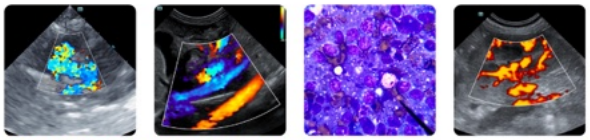

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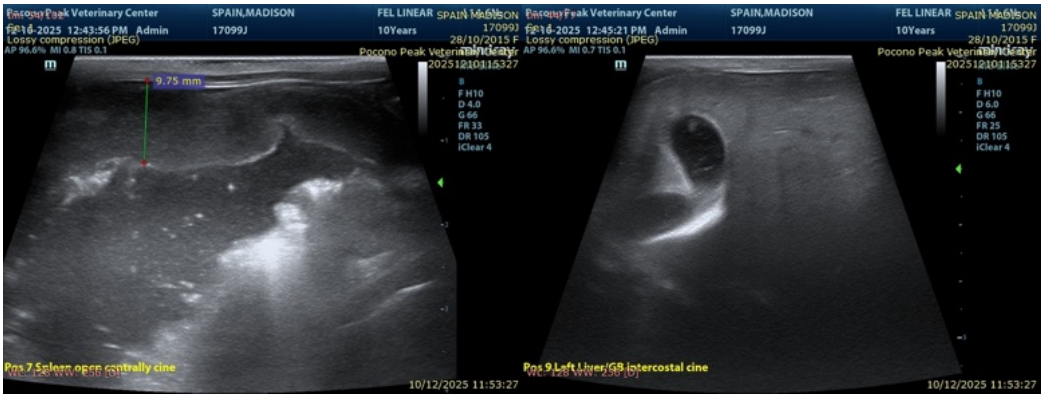

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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