



PATIENT

Alfie Chichkina

SPECIES

Feline

BREED

Domestic Medium Hair

SEX

Neutered male

AGE

14 years

WEIGHT

5 kg

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Catherine Alexander,
LVT

HOSPITAL NAME

NorthStar VS

REFERRING VET

Dr. Robinson

INVOICE

69396

DATE

12/17/25

PRESENTING CLINICAL SIGNS

History: - Abdominal mass noted on AUS at veterinarian on 12/13/25 - Inflammatory leukogram (Neuts - 15,450/uL; Monos - 950/uL) noted on BW 12/13/25 - Hypoalbuminemia (2.2 g/dL) noted on BW 12/13/25 - Weight loss
Abnormal PE/Chem/CBC/UA Results: 12/13/25 CBC WBC 23.46, Neutrophils 15.45, Monocytes 0.95, Basophils 0.31 12/13/25 Chem Albumin 2.2

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

The left kidney is normal in shape and size, measuring 4.25x2.48 cm, with a cortical thickness of 0.43 cm in the sagittal plane. The right kidney is normal in shape and size; however, measurements and cortical thickness could not be obtained in the provided images. The renal cortex is increased in echogenicity, resulting in increased corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler demonstrates a normal perfusion pattern.

Adrenal Glands

Both adrenal glands demonstrate normal shape and echogenicity. The left adrenal gland measures 0.29 cm at the cranial pole and 0.25 cm at the caudal pole. The right adrenal gland was not visualized.

Spleen

Splenic thickness is 0.57 cm. The splenic 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 edges and a regular contour. The hepatic parenchyma appears uniform and isoechoic compared to the falciform fat, with the exception of a focal hypoechoic area measuring 0.6x1 cm. 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.



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Gastrointestinal

The stomach is empty and folded, with preserved wall layering and a mural thickness of 1.75 mm. The pylorus measures 3.47 mm and contains a small amount of intraluminal fluid.

The duodenum measures 2.72 mm and contains intraluminal fluid. The jejunum measures 2.51–3.27 mm, with the following wall layer measurements: mucosa 1.37 mm, submucosa 0.68 mm, and muscularis propria 1.01 mm. The ileum measures 4.34 mm, with mucosa 2 mm, submucosa 1.35 mm, and muscularis propria 1.02 mm. Wall layering is preserved. The ileocecal junction measures 3.85 mm, with mucosa 1.13 mm and muscularis propria 1.79 mm.

The colon appears normal.

Pancreas

The pancreatic right limb measures 5.99 mm, the body 6.76 mm, and the left limb is visualized. The pancreatic margins are irregular. The pancreatic parenchyma is hypoechoic relative to the adjacent omental fat. The pancreatic duct measures 1.44 mm.

Peritoneal Cavity

No abdominal effusion or peritonitis is observed.

A cranial mesenteric lymph node measuring 3.72x1.61 mm is identified; it is markedly hypoechoic, heterogeneous, and mass-like in appearance, with marked hyperechogenicity of the surrounding perinodal fat.

Ileocecal lymph nodes measure 4.34 mm. An additional lymph node measuring 8.7x3.43 mm is identified, with normal shape and echogenicity.

The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Markedly abnormal cranial mesenteric lymph node with mass-like appearance and perinodal fat hyperechogenicity.
- Segmental thickening of the ileum and ileocecal junction. Jejunum: muscularis/mucosa \approx 0.74; Ileum: muscularis/mucosa \approx 0.51; Ileocecal junction: muscularis/mucosa \approx 1.58
- Hypoechoic pancreas with irregular margins and mildly dilated pancreatic duct.
- Focal hypoechoic hepatic lesion measuring 0.6x1 cm.
- Increased renal cortical echogenicity.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cranial mesenteric lymph node is markedly abnormal, appearing hypoechoic, heterogeneous, and mass-like, with pronounced surrounding fat hyperechogenicity. This finding is highly suspicious for clinically significant pathology, with differential diagnoses including neoplastic lymphadenopathy (most notably lymphoma) and severe inflammatory or granulomatous disease.

The ileum and ileocecal junction are thickened, with preserved wall layering and increased muscularis thickness. While layering is maintained, the degree of thickening, in combination with the abnormal mesenteric lymph node and hypoalbuminemia, raises concern for chronic infiltrative intestinal disease, including small cell or large cell lymphoma, although severe inflammatory bowel disease remains a differential.

The pancreas appears hypoechoic with irregular margins and a mildly dilated pancreatic duct, findings that are compatible with pancreatitis, which may be primary or secondary to adjacent gastrointestinal or lymph node disease.

A small focal hypoechoic hepatic lesion is identified and is nonspecific; differentials include hyperplasia, reactive change, or less likely, metastatic disease (given the broader clinical context).

The renal findings are suggestive of chronic renal parenchymal changes, although they may be incidental or age-related.

Overall, the constellation of findings is most concerning for an underlying neoplastic process, particularly intestinal lymphoma with associated lymph node involvement, although severe inflammatory disease with secondary lymphadenopathy and pancreatitis cannot be excluded based on ultrasonography alone.

Recommendations

- Ultrasound-guided fine-needle aspiration or biopsy of the cranial mesenteric lymph node is strongly recommended.
- Correlate with GI panel (including cobalamin and folate) and fPLI.
- Full-thickness intestinal biopsies are recommended if clinically feasible. Emphasis should be placed on sampling the ileum and ileocecal junction, as these regions demonstrate the most significant ultrasonographic abnormalities and are most likely to yield diagnostic information.
- Correlation with renal function parameters is recommended, including serum biochemistry (SDMA), UPC, and urine specific gravity.



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