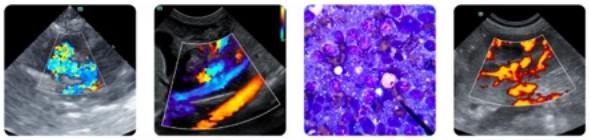


PATIENT

Panther Thomson

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

8 years

WEIGHT

13 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Danielle Shemanski DVM, MA

HOSPITAL NAME

Western New York VS

REFERRING VET

Dr. Muckenhirn

INVOICE

69435

DATE

12/18/25

PRESENTING CLINICAL SIGNS

History: RDVM REASON FOR REFERRAL: Concern for neoplasia. CLINICAL SIGNS: Brief patient history includes chronic vomiting and weight loss (2 lbs) over the past 2-3 months. Panther was seen at ARK urgent care last week where an abdominal ultrasound was recommended. He was vomiting more than just occasional hairballs starting around May. The owner stopped giving a delectable treat, thinking it might be too rich. He also vomited real turkey. He has been seen by his primary veterinarian, and had an unremarkable physical exam.. She has noticed Panther spacing out over the last couple of weeks, which was occurring prior to starting Mirtazapine. He has not been vomiting recently but on average, he has about 2 hairball events /week. MEDICATIONS: Mirtazapine transdermal. The owner has not given it for the past couple of days. It did seem to increase his appetite. *Given 0.12 mL butorphanol IM for sedation for the ultrasound.
Abnormal PE/Chem/CBC/UA Results: CBC, chem panel, and urinalysis showed no significant findings. TT4 and UA unavailable

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the bladder wall appears thin and smooth. The urine is predominantly anechoic with scant suspended echogenic material. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 4.03×2.56 cm, with a cortical thickness of 0.48 cm in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

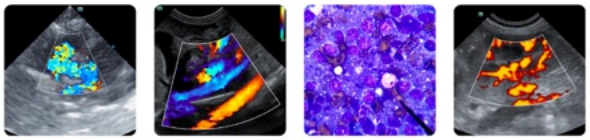
The right kidney is normal in shape and size, measuring 4.28×2.42 cm, with a cortical thickness of 0.50 cm in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

The left adrenal gland is not visualized. The right adrenal gland measures 0.35 cm at the cranial pole and 0.34 cm at the caudal pole.

Spleen

Splenic thickness measures 0.93 cm. The splenic parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.



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Liver

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

The gallbladder lumen is normally distended. The gallbladder wall is thin, and the contents are anechoic. The common bile duct measures approximately 4.40 mm proximally, tapering to 2.29–2.08 mm distally.

Gastrointestinal

The stomach is moderately distended and contains abundant ingesta producing marked acoustic shadowing, compatible with dry food, dehydrated content, and/or hairball material. Gastric mural thickness measures approximately 1.94 mm, with preserved wall layering. The pylorus measures 3.18 mm.

Duodenum measures 1.62 mm. Jejunum measures 2.66 mm, with mucosa 1.16 mm, submucosa 0.65 mm, and muscularis propria 0.45 mm. Ileum measures 2.61 mm, with mucosa 1.02 mm, submucosa 0.96 mm, and muscularis propria 0.64 mm. The ileocecal junction measures approximately 2.71 mm, with muscularis measuring 0.57 mm. Overall intestinal wall layering is preserved. No evidence of obstruction, ileus, or foreign material is identified in any intestinal segment.

The colon measures approximately 1.25 mm and contains formed fecal material in the descending segment.

Pancreas

No clear ultrasonographic evidence of pancreatitis is identified; however, pancreatic visualization is significantly limited due to marked gastric ingesta and associated acoustic shadowing.

Peritoneal Cavity

No abdominal effusion or signs of peritonitis are observed. A single ileocecal lymph node is identified, measuring approximately 5.82×4.07 mm, appearing hypoechoic and mildly enlarged. Cranial mesenteric lymph nodes measure approximately 5.83 mm in thickness, with normal shape and mildly hypoechoic echogenicity. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

- Gastric distension with abundant ingesta causing acoustic shadowing.
- Mild thickening of small intestinal segments with preserved wall layering. (Important: Intestinal wall measurements may be mildly influenced by the non-fasted state of the patient).
- Mild enlargement and hypoechogenicity of ileocecal lymph node and cranial mesenteric lymph nodes.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

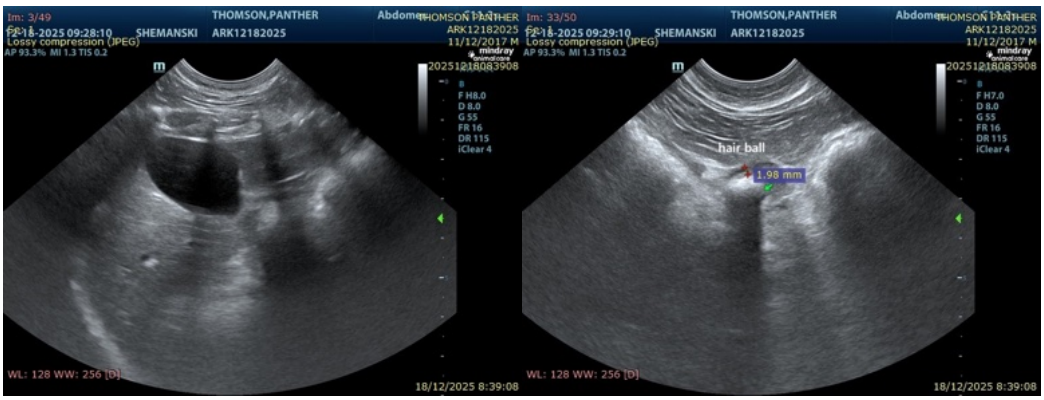
The stomach is markedly distended with ingesta, including material producing acoustic shadowing compatible with dry food and/or hairball content. While no obstructive pattern is identified, this finding supports delayed gastric emptying or impaired gastric motility, which may contribute to the patient's chronic vomiting and hairball-associated clinical signs.

While ultrasonography alone cannot definitively distinguish inflammatory bowel disease from low-grade alimentary lymphoma, the quantitative assessment of intestinal wall ratios and the overall pattern of findings at this time are more suggestive of chronic inflammatory disease. Intestinal wall layering is preserved throughout, and the degree of wall thickening is mild, with muscularis thickness remaining proportionally appropriate relative to the total wall thickness. The muscularis-to-mucosa ratios do not demonstrate the marked muscularis predominance that is more commonly associated with alimentary lymphoma. At the level of the ileocecal junction, although mild wall thickening is present, the proportional relationship between the total wall thickness and the muscularis layer remains within ranges more consistent with inflammatory enteropathy rather than neoplastic infiltration. Additionally, regional lymph nodes are mildly enlarged and hypoechoic but maintain normal shape and architecture, supporting a reactive rather than overtly neoplastic pattern.

No ultrasonographic evidence of high-grade lymphoma, intestinal obstruction, or transmural disease is identified at this time. The pancreas cannot be adequately assessed due to marked gastric content, although no secondary peripancreatic changes are evident.

Recommendations

- Given the current ultrasonographic findings and the patient's clinical stability, two diagnostic approaches may be considered. A more conservative approach would include completion of a full gastrointestinal panel, strict dietary management with a hydrolyzed or novel protein diet, cobalamin supplementation, and medical management with corticosteroids, followed by clinical and ultrasonographic reassessment over time.
- Alternatively, a more invasive diagnostic approach involving intestinal biopsies could be pursued to obtain a definitive diagnosis. However, it is important to recognize that in cases with early disease, particularly when low-grade alimentary lymphoma is a consideration, histopathologic differentiation from inflammatory bowel disease may be challenging. In such early stages, routine histology alone may be inconclusive, and advanced techniques such as immunohistochemistry or clonality testing may be required to improve diagnostic yield.



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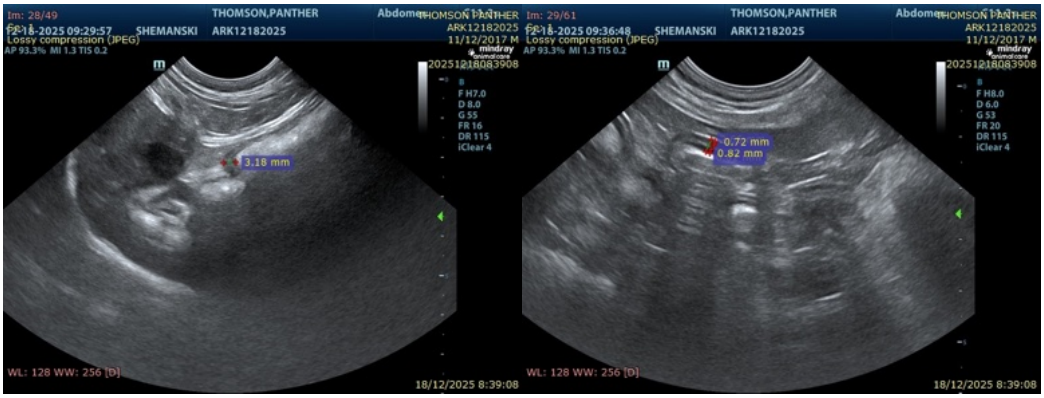

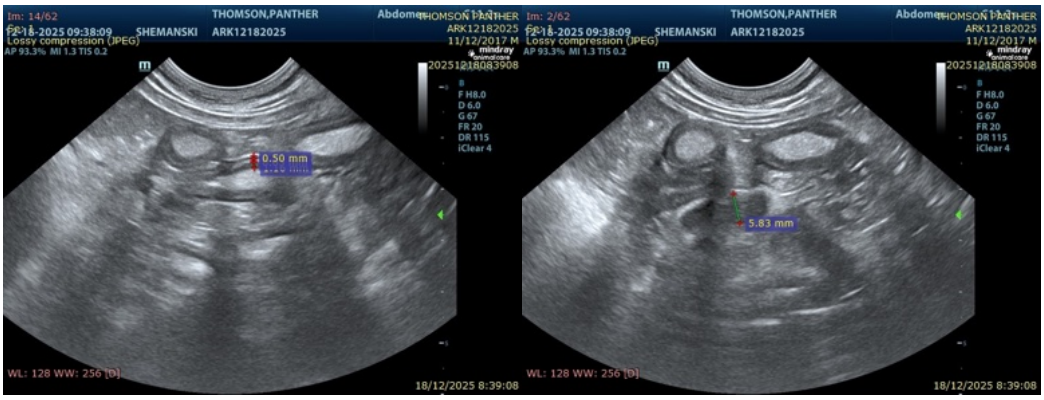

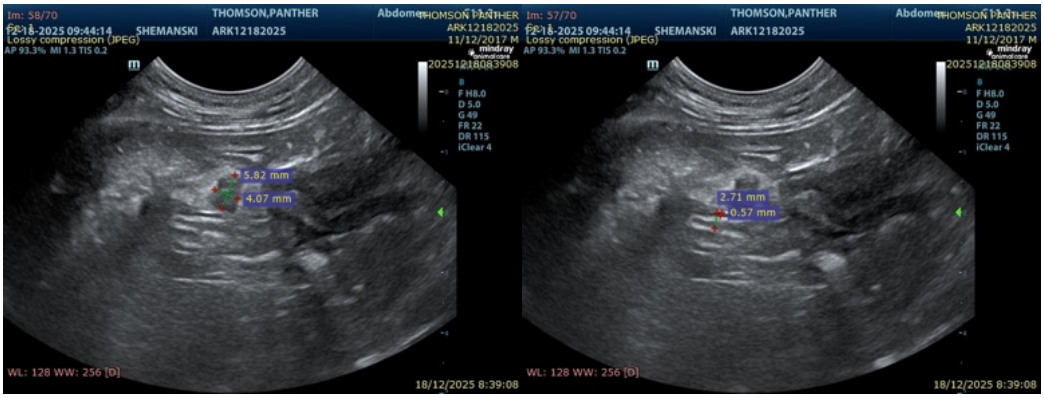

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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