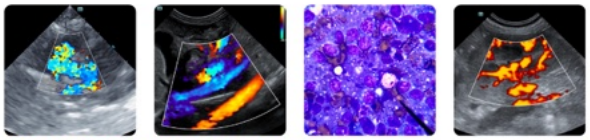


PATIENT

Peanut Marier

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

9 years

WEIGHT

9 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Anshu Gupta

HOSPITAL NAME

Liverpool Village AH

REFERRING VET

Dr. Thomas

INVOICE

69258

DATE

12/2/25

PRESENTING CLINICAL SIGNS

History: 3d history of not eating dry food, but is still eating wet food. Vomited once, not acting himself.
Abnormal PE/Chem/CBC/UA Results: BA 64 TBIL 4.8 ALT 109 Icteric on exam

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: 3.73 × 2.16 cm, and the thickness of the cortex is 0.38 cm in the sagittal plane. The right kidney is normal in shape and size: 3.92 × 2.54 cm, and the thickness of the cortex is 0.40 cm in the sagittal plane. Both kidneys have increased renal cortex in echogenicity, resulting in increased corticomedullary distinction. “Medullary rim sign” is present. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler shows a 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 0.24 cm at the caudal pole. The right adrenal gland measures 0.20 cm at the cranial pole and 0.21 cm at the caudal pole.

Spleen

Splenic thickness is 1.03 cm, with a slightly irregular contour. The parenchyma demonstrates mildly decreased echogenicity and a fine homogeneous echotexture without focal parenchymal abnormalities.

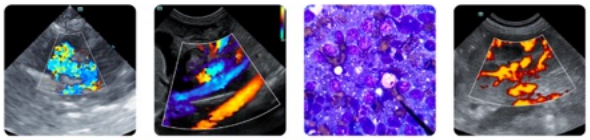
Liver

The liver is subjectively increased. The liver parenchyma looks uniform and is isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is 1.70 mm, and the contents are primarily anechoic. The common bile duct is 2.59 mm.

Gastrointestinal

The stomach is empty and folded, with mural thickness (1.53 mm) and preserved wall layering. The pylorus (2.84 mm). Duodenum: 2.66 mm. Duodenal papilla: 2.7x3.9 mm. Jejunum: 2.01 mm. Mucosa: 1.27 mm. Submucosa: 0.42 mm. Muscularis propria: 0.25 mm. Ileum: 2.19 mm. Mucosa: 1.22 mm. Submucosa: 0.67 mm. Muscularis propria: 0.45 mm. Normal wall layering. The ileocecal junction wall



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measures 3.87 mm, muscularis 1.71 mm. Several small bowel loops appear spastic or with mild corrugation. No signs of obstruction, ileus, or foreign material are identified.

Colon: 0.74 mm, with few formed feces in the descending segment.

Pancreas

Thickness 6.85 mm. The parenchyma of the pancreas appears isoechoic to the adjacent omental fat. The diameter of the pancreatic duct is 0.75 mm. No signs of active inflammation or neoplastic disease are evident.

Peritoneal Cavity

Mild abdominal effusion is observed. Cranial mesenteric lymph nodes 1.05–1.10 cm in thickness, rounded and very hypoechoic. Ileocecal lymph nodes 2.59–4.99 mm in thickness, hypoechoic. Marked hyperechogenicity of the perinodal fat. Pancreaticoduodenal lymph node: 2.63×4.80 mm, normal appearance. The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Marked cranial mesenteric and ileocecal lymphadenopathy, with rounded, markedly hypoechoic lymph nodes and pronounced perinodal fat hyperechogenicity.
- Mild abdominal effusion.
- Subjective hepatomegaly.
- Mild corrugation/spasticity of several small-bowel loops.
- Ileocecal junction wall thickening with proportionally prominent muscularis.

SECONDARY FINDINGS

- Increased renal cortical echogenicity and “medullary ring” sign.
- Mildly irregular splenic contour with slightly decreased parenchymal echogenicity.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Marked cranial mesenteric and ileocecal lymphadenopathy, characterized by rounded, markedly hypoechoic lymph nodes with pronounced perinodal fat inflammation. These findings are compatible with significant inflammatory disease, or low-grade lymphoma.

Small intestinal wall thickness and layering are within normal limits, with some mild corrugation/spasticity, which may reflect intestinal irritation or early/chronic enteropathy. The jejunal and ileal muscularis:mucosa ratios are within normal to high-normal ranges (0.20 jejunum, 0.37 ileum). The ileocecal junction wall-to-muscularis ratio (2.26; muscularis ≈44% of total thickness) is at the upper

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end of normal and may indicate mild muscular hypertrophy, a very common finding in BD and early low-grade alimentary lymphoma.

Hepatobiliary abnormalities, including subjective hepatomegaly, hyperbilirubinemia, elevated bile acids, and a mildly enlarged common bile duct, raise concern for cholangitis/cholangiohepatitis. No evidence of gallbladder wall thickening, choleliths, or rupture.

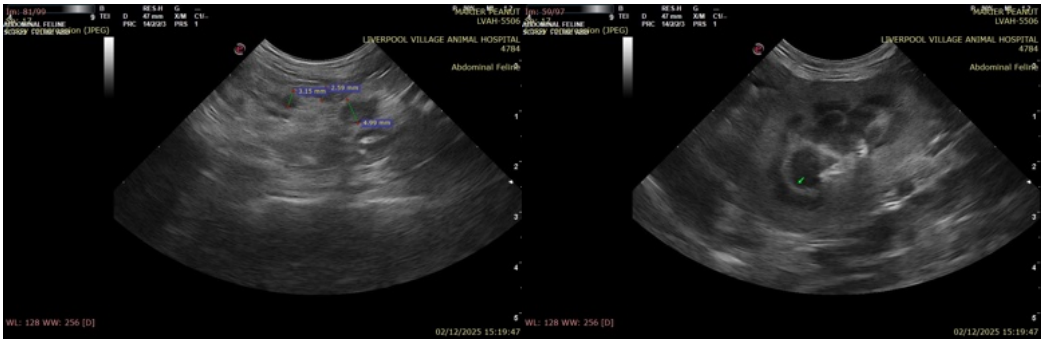
A mildly enlarged, slightly irregular, hypoechoic spleen in this context is most consistent with a reactive or congestive change secondary to systemic inflammatory/hepatobiliary disease (not the typical pattern of splenic lymphoma although it cannot be completely ruled out).

Kidneys with increased cortical echogenicity and corticomedullary "ring sign" may reflect early renal parenchymal change, systemic inflammatory/metabolic effects, or acute tubular injury.

The constellation of findings most strongly supports a cholangiohepatitis/triaditis with IBD or low-grade lymphoma.

Recommendations

- Obtain tissue samples for definitive diagnosis, ideally including:
  - Liver biopsy.
  - Mesenteric lymph node biopsy (or FNA if biopsy is not feasible).
  - Intestinal biopsies.
- Perform coagulation testing (PT/aPTT) prior to any liver sampling.
- Submit biopsies for histopathology with optional immunophenotyping if lymphoma is suspected.
- Test feline pancreatic lipase to evaluate for concurrent pancreatitis, given overlapping clinical presentations.



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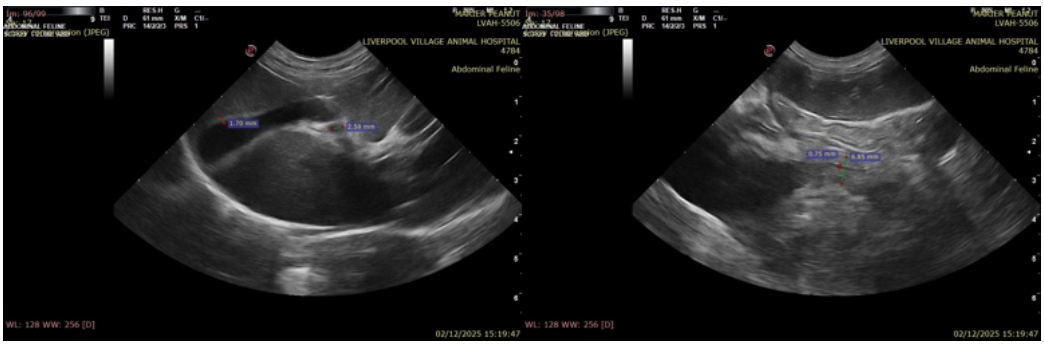

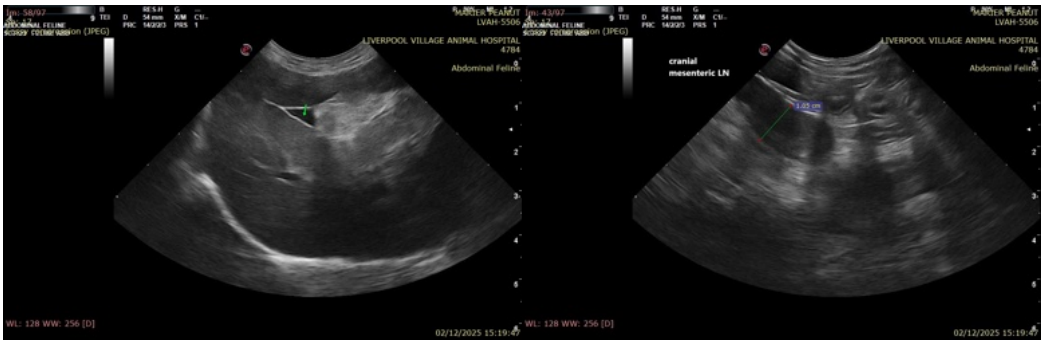

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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