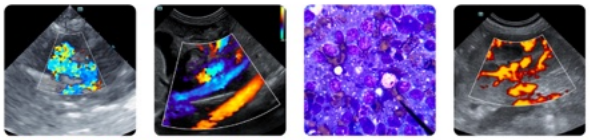


PATIENT

Feisty Sam

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

14 years

WEIGHT

8 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Coe

HOSPITAL NAME

Riverside Animal Clinic

REFERRING VET

Dr. Cline

INVOICE

69491

DATE

12/22/25

PRESENTING CLINICAL SIGNS

History: Weight loss and diarrhea first reported in 4/2025. Initial CBC/Chem/TT4 all WRI. No treatment pursued. Seen in 7/2025 due to continued weight loss, decreased grooming behaviors. BM's normal at that time. Diet Purina One at that time. CBC/Chem/TT4 all WRI again. Texas GI Panel indicated elevated TLI/PLI/Folate, and low Cobalamin. Started treatment with Prednisolone/Mirataz/Cobalaquin PO. Patient lost to follow-up...did not continue Prednisolone. Seen again in 12/2025. Weight loss continues. Reportedly improved when on Pred in 7/2025. Diarrhea. Abnormal PE/Chem/CBC/UA Results: PE most recently 12/12/25: BCS 3/9, MCS 1/3, unkempt coat with urine odor. Periodontal disease. H/L OK. CBC/Chem/TT4 12/12/25: NSF. Mild elevation BUN (40). Crea 1.9/SDMA 11. Rest WRI. Abdominal Radiographs 7/2025: NSF.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The bladder wall is thin and smooth. The urine is anechoic. The bladder neck and proximal urethra appear normal. No uroliths or ultrasonographic evidence of inflammatory or neoplastic disease are identified.

The left kidney is normal in size and shape, measuring 3.43×2.24 cm, with a cortical thickness of 0.34 cm (sagittal plane). The renal cortex is mildly hyperechoic relative to the liver. The corticomedullary ratio and corticomedullary definition are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler evaluation reveals normal renal perfusion.

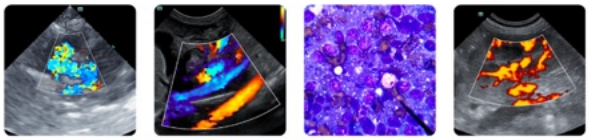
The right kidney is normal in size and shape, measuring 3.95×2.38 cm, with a cortical thickness of 0.33 cm (sagittal plane). The renal cortex is mildly hyperechoic relative to the liver. The corticomedullary ratio and definition are preserved. Mild pyelectasia is present. No nephrolithiasis or hydronephrosis is identified. Color Doppler evaluation reveals normal renal perfusion.

Adrenal Glands

Both adrenal glands are normal in size, shape, and echogenicity. The left adrenal gland measures 0.31 cm at the cranial pole and 0.33 cm at the caudal pole. The right adrenal gland measures 0.30 cm at both the cranial and caudal poles.

Spleen

The spleen measures 0.80 cm in thickness. The parenchyma has normal echogenicity and a fine, homogeneous echotexture. No focal splenic lesions are identified. The splenic capsule is smooth and regular. Splenic vasculature appears normal.



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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. No focal hepatic lesions or hepatic lymphadenopathy are identified.

The gallbladder is moderately distended with a thin wall. The lumen contains a small amount of biliary sludge. The common bile duct measures approximately 4.23 mm proximally, tapering distally to 2.75 mm and 2.33 mm, and is considered within acceptable limits for a geriatric cat.

Gastrointestinal

The stomach is empty and folded. Gastric wall thickness ranges from 1.36 to 1.63 mm, with preserved wall layering. The pylorus measures 3.86 mm. The duodenum measures 2.62 mm in wall thickness. The jejunum measures 3.08 mm, with a mucosal thickness of 1.76 mm, submucosa 0.37 mm, and muscularis propria 0.90 mm, indicating disproportionate muscularis thickening. The ileum measures 2.02 mm, with a mucosa of 0.46 mm, submucosa 0.50 mm, and muscularis propria 0.82 mm. The ileocecal junction is markedly thickened, measuring 4.49 mm, with a muscularis thickness of 3.65 mm. Immediately at the transition from ileum to colon, there is a focal, circumferential hypoechoic intestinal wall thickening with loss of normal wall layering, measuring up to 1.09 cm. Distal to this region, the colon regains normal wall layering and measures approximately 1.34 mm in thickness, with a semi-liquid colonic luminal contents. The most distal portion of the descending colon is completely empty and collapsed; therefore, the wall diameter cannot be measured.

Pancreas

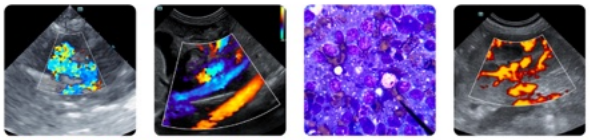
The pancreas measures approximately 7.44 mm in thickness. Pancreatic parenchyma is isoechoic to mildly hypoechoic relative to the surrounding omental fat. The pancreatic duct measures 2.68 mm. No hyperechoic peripancreatic fat or other ultrasonographic signs of acute pancreatitis are identified.

Peritoneal Cavity

A very small volume of abdominal effusion is present.

Cranial mesenteric lymph nodes measure approximately 3.60–4.05 mm, with normal shape and echogenicity.
Ileocecal lymph nodes are enlarged, rounded, and hypoechoic, consistent with regional lymphadenopathy.

The iliac trifurcation appears normal.



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ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Segmental thickening of the intestinal wall at the ileocolic junction, with loss of normal wall layering (up to ~1.09 cm).
- Marked thickening of the ileocecal junction with disproportionate muscularis layer.
- Enlarged, rounded, hypoechoic ileocecal lymph nodes.
- Jejunal wall thickening with increased muscularis layer.
- Small abdominal effusion.

SECONDARY FINDINGS

- Mild renal cortical hyperechogenicity with mild right-sided pyelectasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Oncology consultation should be considered to discuss medical management options (chlorambucil/prednisolone protocol) if lymphoma is confirmed or strongly suspected.
- GI panel re-evaluation (particularly cobalamin) may be useful for monitoring and therapeutic guidance.
- Continued clinical and ultrasonographic monitoring is recommended if a conservative or medical management approach is pursued.

The disproportionate thickening of the muscularis layer in the distal small intestine and ileocecal region, combined with loss of wall stratification at the ileocolic transition, is highly suspicious for low-grade alimentary lymphoma, particularly given the chronicity of clinical signs, progressive weight loss, and documented clinical response to prednisolone earlier in the disease course. While chronic inflammatory bowel disease can cause muscularis thickening, complete loss of layering and focal mass-like thickening at the ileocolic junction strongly favors neoplasia over inflammatory disease in this location.

The presence of rounded, hypoechoic ileocecal lymph nodes further supports an infiltrative or neoplastic process rather than reactive lymphadenopathy alone. Mild jejunal thickening with muscularis predominance may represent regional extension or concurrent inflammatory change.

Pancreatic findings are most consistent with chronic pancreatitis or pancreatic involvement as part of feline triaditis, which aligns with the previously abnormal GI panel (elevated PLI/TLI, low cobalamin).

Renal and hepatobiliary findings are mild and likely secondary or incidental.

Taken together, the ultrasonographic findings, prior GI panel abnormalities, documented response to corticosteroids, and progressive weight loss are most consistent with low-grade alimentary lymphoma involving the ileocecal/ileocolic region, with possible concurrent chronic inflammatory enteropathy and pancreatic involvement.

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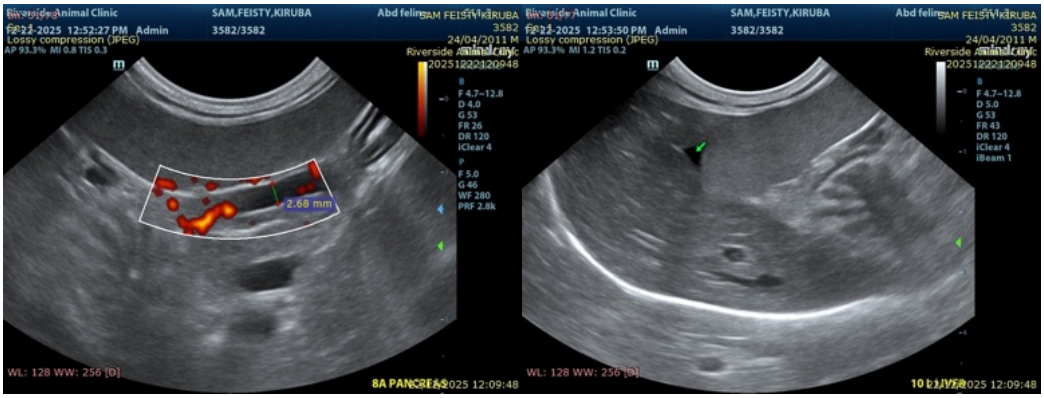
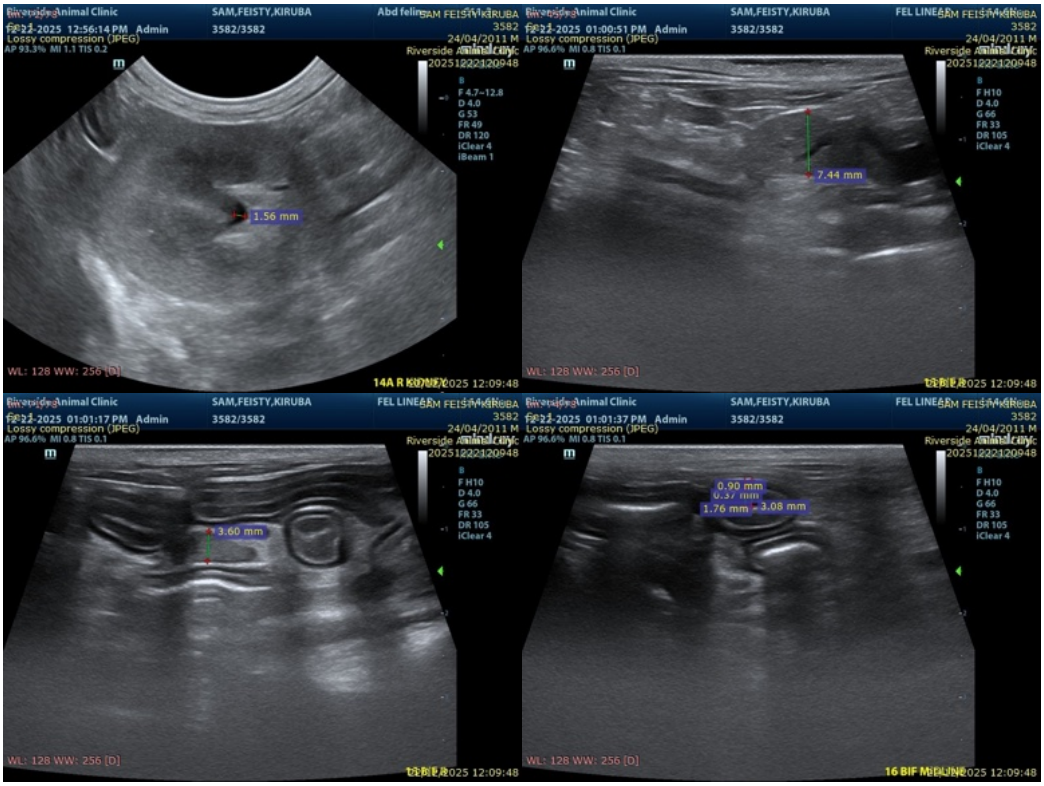
Recommendations

- Definitive diagnosis is recommended, ideally via full-thickness or endoscopic biopsies targeting the ileocecal region, with histopathology and immunohistochemistry to differentiate low-grade lymphoma from severe IBD.
- If biopsies are declined or delayed, re-initiation of prednisolone therapy with concurrent cobalamin supplementation is reasonable, acknowledging that this may mask histologic diagnosis.





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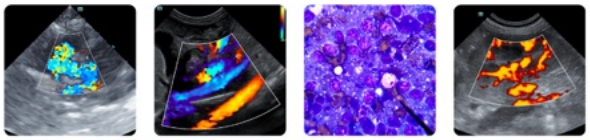

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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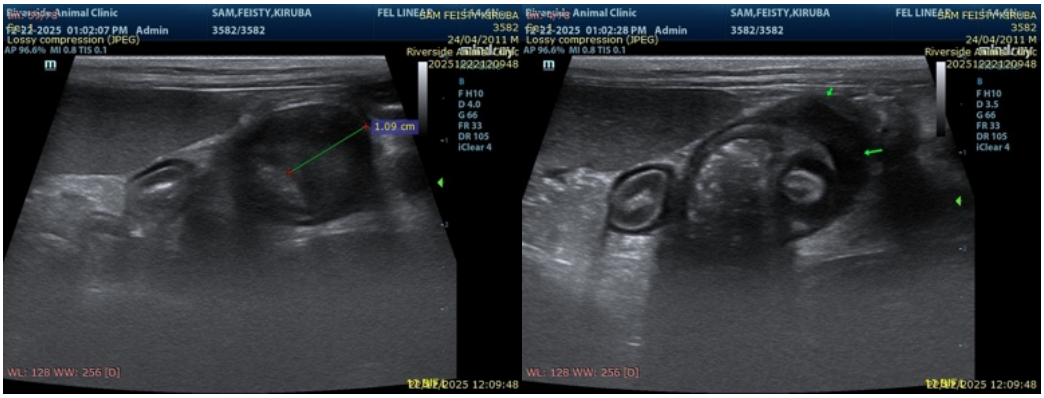

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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