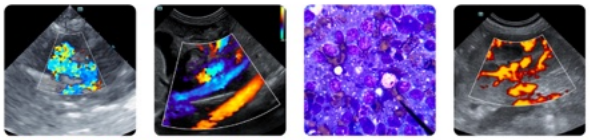


PATIENT

Natasha Verdichizzi

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

5 years

WEIGHT

6.2 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Shannon Matthies

HOSPITAL NAME

Saugerties AH

REFERRING VET

Dr. Matthies

INVOICE

69584

DATE

12/24/25

PRESENTING CLINICAL SIGNS

History: Intermittent vomiting and diarrhea for the past 2-3 months. Weight loss of 1.5 lbs in the past 2 months. Minimal response to medical management (bland diet, famotidine, Cerenia, etc.).
Abnormal PE/Chem/CBC/UA Results: PE 12/22/25 - palpated irregular mass in cranial abdomen, just able to reach the edge of it under the rib cage. CBC/Chem results in October 2025 - WNL

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. Normal appearance of the bladder neck and proximal urethra. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 3.21 × 1.83 cm, and the cortical thickness is 0.31 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. Color Doppler shows a normal pattern.

The right kidney is normal in shape and size, measuring 3.48 × 1.84 cm, and the cortical thickness is 0.39 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. Color Doppler shows a normal pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. The left adrenal gland measures 0.32 cm at the cranial pole and 0.27 cm at the caudal pole. The right adrenal gland measures 0.30 cm at the cranial pole and 0.29 cm at the caudal pole.

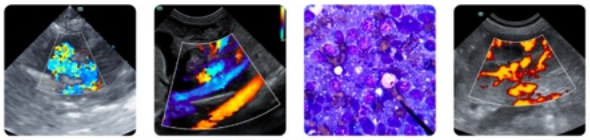
Spleen

The spleen is small, with a splenic thickness of 0.46 cm. The parenchyma demonstrates decreased echogenicity and a fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma appears uniform and isoechoic compared to the falciform fat, with a normal echotexture.

The gallbladder lumen is normally distended. The wall is thin, and the contents are primarily anechoic with a small amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach is filled with food, with a mural thickness of 1.56 mm and preserved wall layering. The pylorus demonstrates marked wall thickening measuring up to approximately 1.29 cm, with near-complete loss of normal wall layering, creating a mass effect and resulting in pyloric outflow obstruction.

Duodenum measures 1.73 mm. Jejunum measures 1.44–1.46 mm (mucosa: 0.73 mm; submucosa: 0.40 mm; muscularis propria: 0.23 mm). Ileum measures 1.98 mm (mucosa: 0.32 mm; submucosa: 0.50 mm; muscularis propria: 0.27 mm), with normal wall layering. The ileocecal junction measures 2.10 mm. The colon contains formed feces in the descending segment.

Pancreas

The right limb (7.29 mm), body (9.15 mm), and left limb (6.76 mm) appear thickened. The pancreatic parenchyma is hypoechoic compared to the adjacent omental fat. The pancreatic duct measures 1.25 mm in diameter. No signs of peripancreatic inflammation are evident.

Peritoneal Cavity

No abdominal effusion or peritonitis is observed. Cranial mesenteric lymph nodes and ileocecal lymph nodes are not visualized, and the surrounding regions appear unremarkable. A hepatic lymph node measuring 1.50 × 1.51 cm is noted, appearing rounded and hypoechoic. The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Severe pyloric wall thickening with complete loss of wall layering and mass effect, resulting in pyloric outflow obstruction.
- Enlarged hepatic lymph node, rounded and hypoechoic.

SECONDARY FINDINGS

- Diffuse pancreatic enlargement with hypoechoic parenchyma and mild pancreatic duct dilation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The ultrasonographic appearance of the pylorus is highly suspicious for an infiltrative or neoplastic process, with gastric lymphoma considered the primary differential diagnosis, followed by adenocarcinoma and other malignant gastric neoplasms.

The pancreas appears diffusely thickened and hypoechoic, with mild dilation of the pancreatic duct. While these changes may represent secondary or reactive pancreatic involvement due to adjacent gastrointestinal disease, a primary pancreatic process cannot be definitively excluded. However, the

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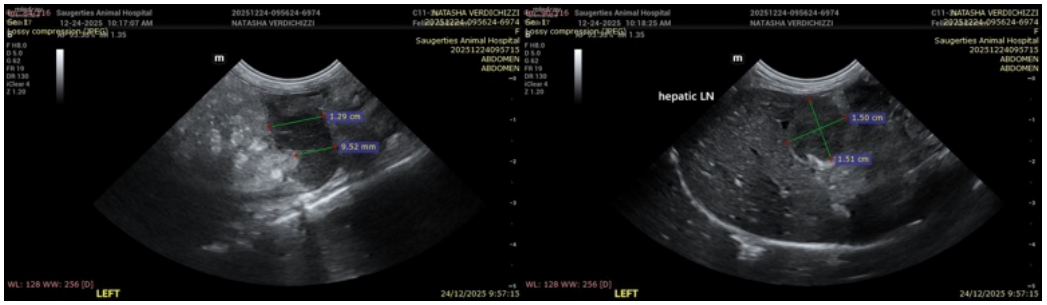
pyloric lesion remains the dominant abnormality and is most likely the primary driver of the patient's clinical signs.

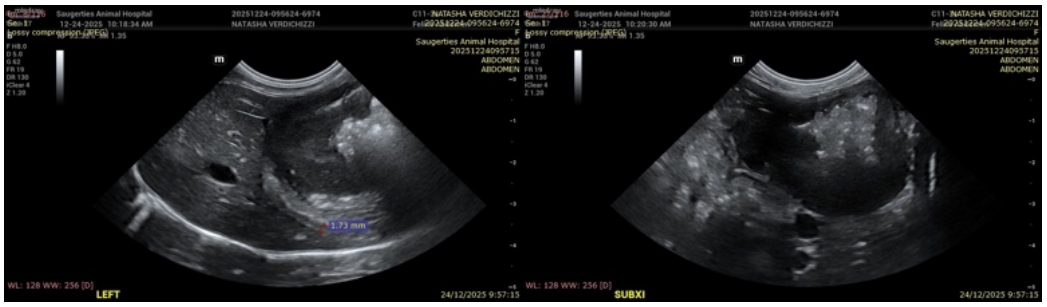
A markedly enlarged hepatic lymph node is identified, raising concern for regional lymphadenopathy. Given that this lymph node receives lymphatic drainage from the pyloric region, this finding may represent either reactive change or neoplastic metastasis associated with the adjacent pyloric mass.

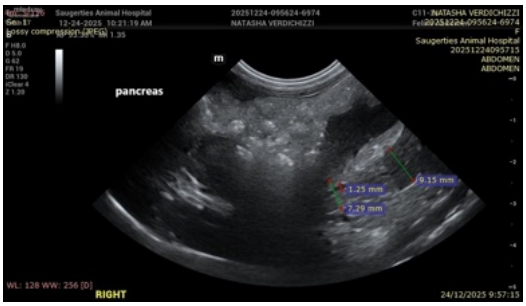
The remainder of the gastrointestinal tract demonstrates normal wall thickness and preserved layering, suggesting a focal rather than diffuse gastrointestinal disease process.

Recommendations

- Ultrasound-guided fine-needle aspiration of the pyloric mass and the enlarged hepatic lymph node is recommended as the first diagnostic step, as these structures are accessible and sampling may allow differentiation between lymphoma and carcinoma.
- Therapeutic approach will be determined based on the final diagnosis (lymphoma versus adenocarcinoma or other neoplasia).
- Thoracic imaging is recommended to rule out metastatic disease.







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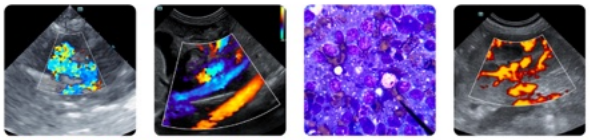

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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