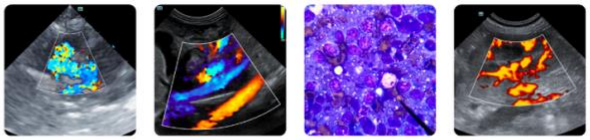


PATIENT

Sadie Klingler

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

18 Years

WEIGHT

10 Pounds

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Amanda Hockenbrock

HOSPITAL NAME

Lewisburg VH

REFERRING VET

Dr. Lindsay Huepenbecker

INVOICE

35908

DATE

2/20/26

PRESENTING CLINICAL SIGNS

- Chronic vomiting since Mid December 2025
- Client worries that patient vomits bits of foreign material frequently
- Abnormal PE/Chem/CBC/UA Results: increase proBNP Mild azotemia Radiographs: normal cardiac silhouette, empty stomach, formed stool in colon, intestines subjectively thickened

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

The left kidney measures 3.35 x 2.27 cm in the sagittal plane. Cortical thickness measures 0.39 cm. 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, nephrolithiasis, or hydronephrosis.

The right kidney measures 3.58 x 2.14 cm in the sagittal plane. Cortical thickness measures 0.37 cm. 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, nephrolithiasis, or hydronephrosis.

Adrenal Glands

Both adrenal glands have normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.29 cm at the cranial pole and 0.30 cm at the caudal pole. The right adrenal gland measures 0.33 cm at the cranial pole and 0.31 cm at the caudal pole.

Spleen

Splenic thickness is 0.60 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal abnormalities. The splenic capsule is smooth and regular.

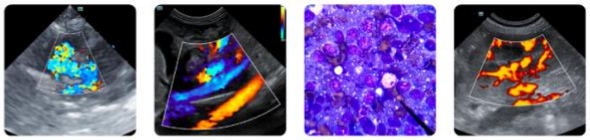
Liver

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

Gastrointestinal

The stomach is empty and folded, with mural thickness measuring 1.52 mm and preserved wall layering. The pylorus measures 3.01 mm.



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Duodenum: 2.24 mm.
Jejunum: 2.89 mm. Layer measurements: Mucosa: 1.49 mm. Submucosa: 0.54 mm. Muscularis propria: 0.59 mm.
Ileum: 3.15 mm. Layer measurements: Mucosa: 0.61 mm. Submucosa: 0.50 mm. Muscularis propria: 2.00 mm.

The ileocecal junction measures 4.49 mm in total thickness, with muscularis measuring 2.25 mm.
Colon: 1.05 mm, with formed feces in the lumen.

Pancreas

The pancreas measures 7.81–8.11 mm in thickness. The pancreatic parenchyma is mildly hypoechoic relative to adjacent omental fat. The pancreatic duct measures 1.28 mm in diameter. No peripancreatic fat hyperechogenicity or free fluid is identified.

Free Abdomen

No abdominal effusion or peritonitis is observed. Cranial mesenteric lymph nodes measure 1.07 cm and 2.22 cm in thickness. Ileocecal lymph nodes measure 0.64 cm and 0.75 cm in thickness. These lymph nodes are rounded, markedly hypoechoic, and associated with increased echogenicity of the surrounding fat. The iliac trifurcation appears normal.

PRIMARY FINDINGS

- Marked ileal wall thickening with severe muscularis hypertrophy
- Thickened ileocecal junction with muscularis expansion
- Mild jejunal muscularis layer prominence
- Marked cranial mesenteric lymphadenomegaly

SECONDARY FINDINGS

- Mild pancreatic hypoechogenicity with mild ductal prominence

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Marked ileal wall thickening is present, characterized by severe muscularis expansion resulting in a muscularis-to-mucosa ratio of approximately 3.3, which is markedly increased beyond accepted feline reference values. The ileocecal junction is similarly thickened. Mild jejunal muscularis prominence is also noted. The degree and character of the mesenteric lymphadenopathy significantly increase concern for intestinal lymphoma rather than reactive inflammatory enteropathy.

In an 18-year-old cat with chronic vomiting, the combination of pronounced ileal muscularis expansion and significant mesenteric lymphadenopathy is highly suspicious for infiltrative intestinal disease, with small-cell lymphoma considered the primary differential diagnosis. Severe inflammatory bowel disease remains a differential consideration; however, the degree of muscularis thickening and nodal changes favors a neoplastic process.

Mild pancreatic hypoechogenicity without peripancreatic fat reaction is noted and may represent age-related change or mild concurrent pancreatitis; this is considered secondary to the primary intestinal findings.

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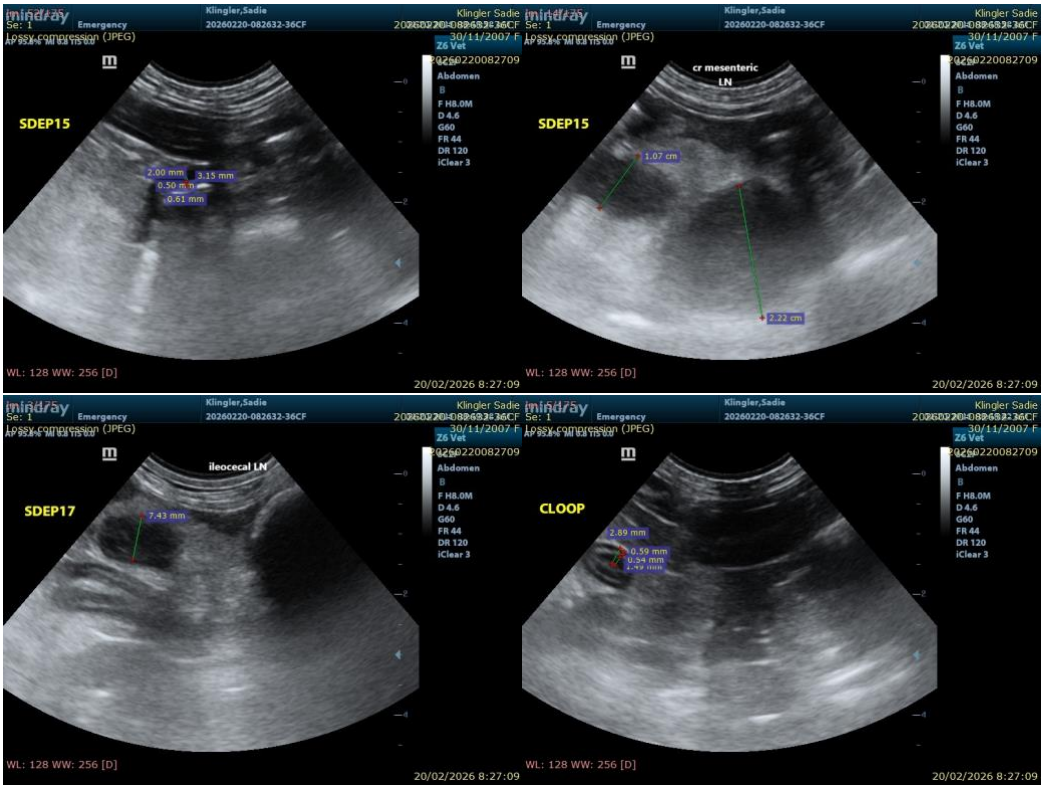
Definitive differentiation between inflammatory enteropathy and lymphoma requires histopathology; however, imaging findings in this case are strongly suggestive of intestinal lymphoma.

Recommendations:

- Fine-needle aspiration of the enlarged mesenteric lymph nodes is recommended as a minimally invasive initial diagnostic step.
- Although histopathologic confirmation remains the method of choice for definitive diagnosis, the patient's advanced age may justify consideration of a presumptive therapeutic approach (prednisolone ± chlorambucil) at the discretion of the attending clinician.
- Serum cobalamin assessment is recommended.
- fPLI testing may be considered if there is clinical suspicion for concurrent pancreatitis.



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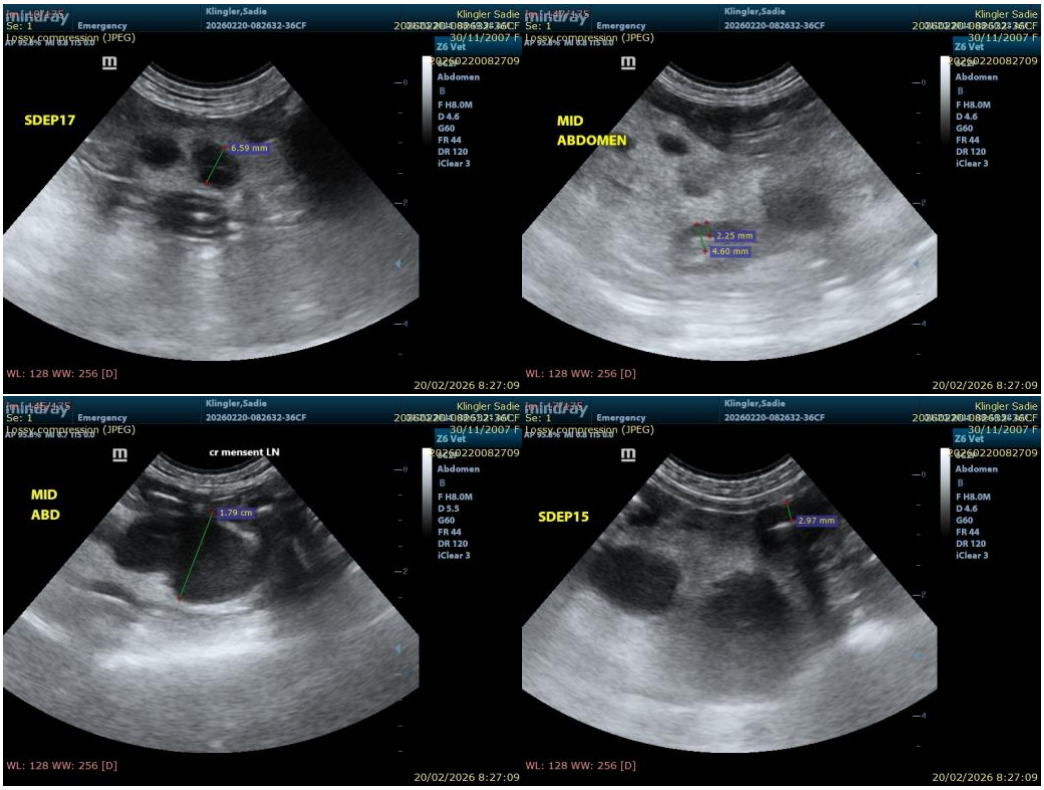

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com