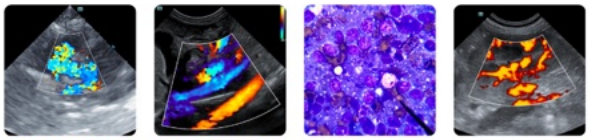




**PATIENT**

Earlgrey Boker

**SPECIES**

Feline

**BREED**

Domestic Longhair

**SEX**

Spayed female

**AGE**

5 years

**WEIGHT**

10 lbs

**INTERPRETED BY**

Dr. Alicia Angosto Guerrero

**IMAGING PERFORMED BY**

Michelle Lindemulder, DVM

**HOSPITAL NAME**

Southkent VH

**REFERRING VET**

Therese Burns, DVM

**INVOICE**

72208

**DATE**

3/4/26

## PRESENTING CLINICAL SIGNS

- Lethargy, anorexia, weight loss. Palpable abdominal mass
- CBC: non-regenerative anemia, monocytosis Chem: Increased SDMA, ALT, GGT, ALP, Tbili; decreased BUN

## 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 anechoic. The bladder neck and proximal urethra have a normal ultrasonographic appearance. No calculi are identified, and there is no evidence of inflammatory or neoplastic change.

The left kidney is normal in shape and size, measuring 3.41×2.13 cm, and the cortical thickness is 0.30 cm in the sagittal plane. The cortex is isoechoic compared with the hepatic parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler evaluation shows a normal vascular pattern.

The right kidney is normal in shape and size, measuring 3.82×2.43 cm, and the cortical thickness is 0.33 cm in the sagittal plane. The cortex is isoechoic compared with the hepatic parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler evaluation shows a normal vascular pattern.

### *Adrenal Glands*

Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.26 cm at the cranial pole and 0.24 cm at the caudal pole. The right adrenal gland was not clearly visualized.

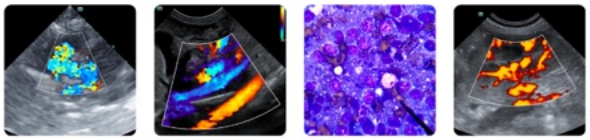
### *Spleen*

Splenic thickness is 0.70 cm. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture without focal parenchymal 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 appears uniform and isoechoic compared with 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.





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### *Gastrointestinal*

The stomach is empty and moderately distended with fluid. Gastric mural thickness measures 1.13 mm with preserved wall layering.

The jejunum measures 1.55 mm. The ileum measures 1.43 mm. A focal intestinal segment adjacent to the ileocecal junction measures up to 2.98 mm in thickness. Wall layering remains preserved. No evidence of obstruction, ileus, or intraluminal foreign material is identified.

The colon measures 0.96 mm, with formed fecal material present within the descending colon.

### *Pancreas*

The evaluated pancreatic regions do not show evidence of overt inflammatory change.

### *Peritoneal Cavity*

Small amounts of free abdominal fluid are present within the pelvic recess and the hepatic subphrenic space. Pleural effusion is also noted.

A heterogeneous hypoechoic mass with poorly defined margins, measuring approximately 6×2 cm, is identified within the mid-abdominal cavity. The mass does not demonstrate a clear organ of origin. It may arise from a small intestinal loop with predominantly extraluminal growth, although a mesenteric origin is also considered.

Multiple cranial mesenteric lymph nodes are markedly enlarged, measuring 1.24–1.79 cm, with a rounded morphology and hypoechoic appearance. The surrounding perinodal fat is hyperechoic.

Additional lymph nodes:

Splenic lymph node measures 3.34×4.04 mm.

Left gastric lymph node measures 1.27×0.70 cm.

## ULTRASONOGRAPHIC FINDINGS

- Large heterogeneous hypoechoic abdominal mass (~6×2 cm) with no clear organ of origin.
- Markedly enlarged cranial mesenteric lymph nodes rounded and hypoechoic with hyperechogenicity of perinodal mesenteric fat.
- Mild abdominal effusion and pleural effusion.
- Focal intestinal wall thickening near the ileocecal junction (2.98 mm)

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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most significant finding is a large heterogeneous hypoechoic abdominal mass without a clearly identifiable organ of origin, associated with marked enlargement of the cranial mesenteric lymph nodes and mild abdominal effusion. Given the clinical history (weight loss, anorexia, lethargy), the presence of non-regenerative anemia and monocytosis, and the imaging findings, the changes are highly suspicious for an infiltrative or neoplastic abdominal process.

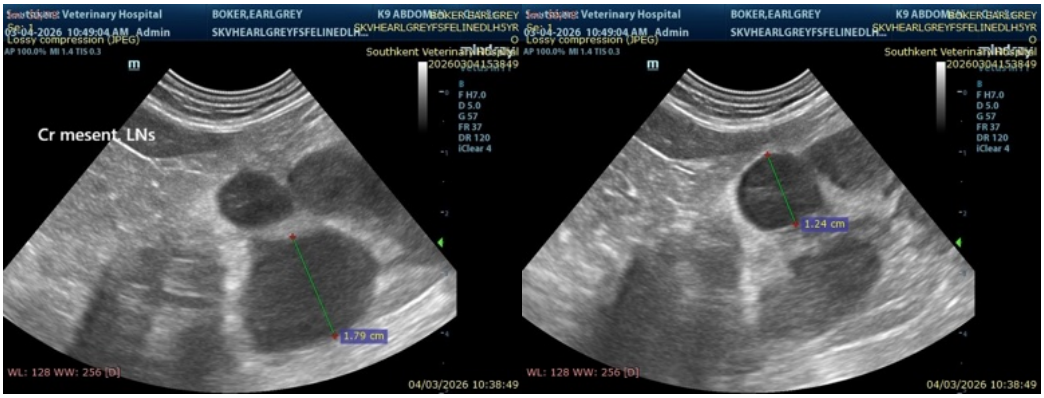
The two most likely differential diagnoses are large-cell lymphoma with mesenteric involvement and primary mesenteric or intestinal neoplasia with secondary metastatic lymphadenopathy (intestinal adenocarcinoma or mesenteric sarcoma).

The biochemical abnormalities are not explained by structural hepatobiliary abnormalities on ultrasound. These changes may represent reactive hepatopathy or early hepatic infiltration not yet producing detectable ultrasonographic changes.

The presence of pleural effusion raises suspicion for possible thoracic involvement of the disease process, including mediastinal lymphadenopathy or thoracic metastasis.

Recommendations

- Ultrasound-guided fine needle aspiration of the abdominal mass and enlarged mesenteric lymph nodes is strongly recommended as the first diagnostic step.
- If cytology is inconclusive, surgical biopsy or Tru-cut biopsy of the mass may be required to obtain a definitive diagnosis.
- Testing for FeLV and FIV is recommended given the suspicion for lymphoma and their known association with feline lymphoproliferative disease.
- 
- Thoracic imaging should be performed to evaluate the suspected pleural effusion and assess for thoracic metastasis or mediastinal lymphadenopathy.



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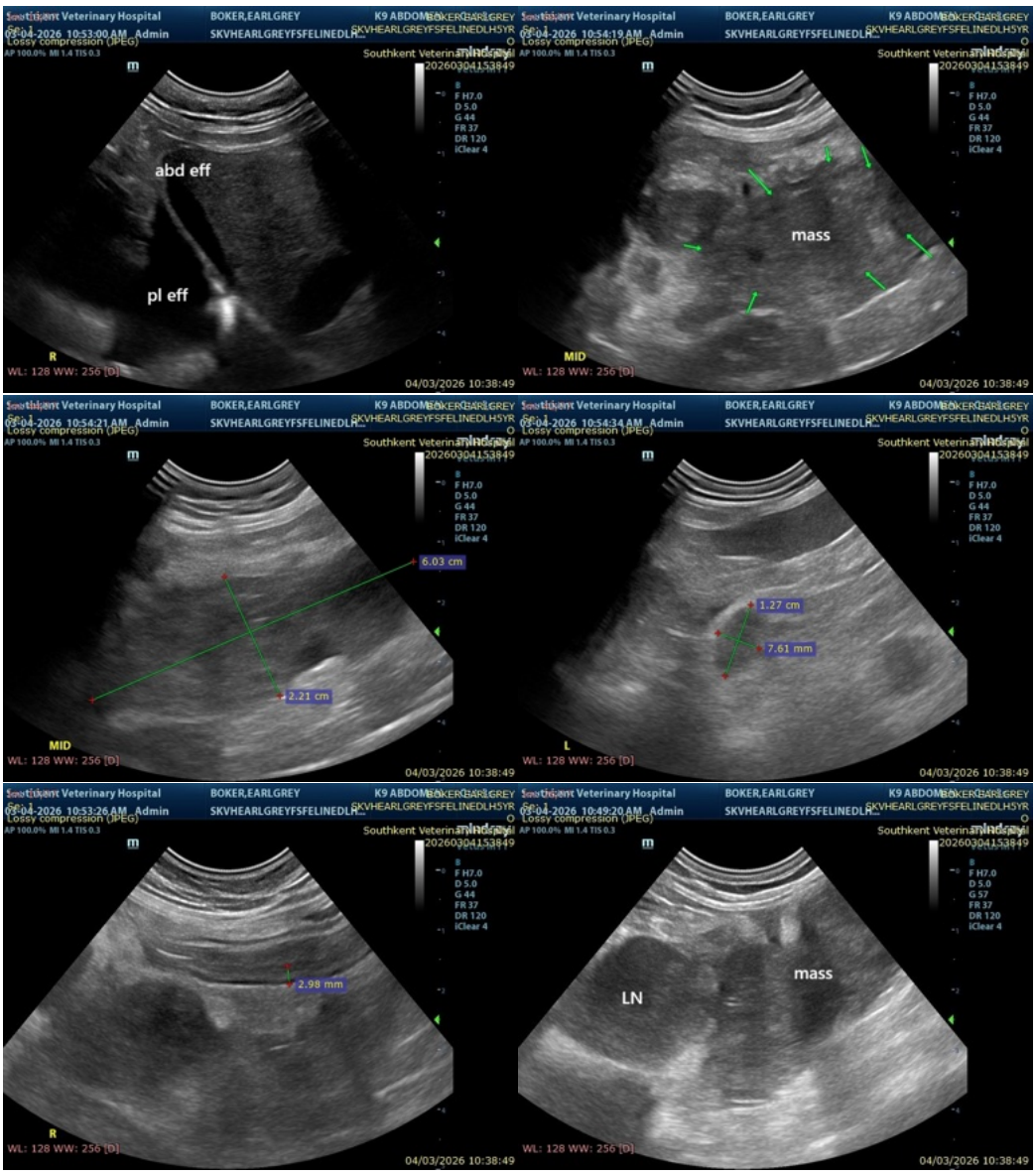


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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