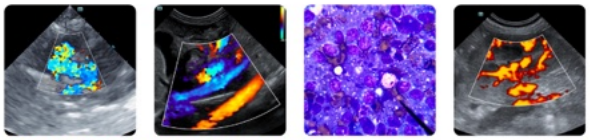


PATIENT

Pouncer Hoyt

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

16 years

WEIGHT

7.7 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Scott

HOSPITAL NAME

Wyckoff VH

REFERRING VET

Dr. Eisenberg

INVOICE

72239

DATE

3/5/26

PRESENTING CLINICAL SIGNS

- Unexplained weight loss, appetite down last few weeks. No v/d
- CBC/chem borderline azotemia USG 1.015 chest rads wnl ultrasound

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is not fully distended. The bladder wall measures 1.27 mm and appears smooth. Due to underdistension, wall measurement may be slightly overestimated. 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.

Kidneys
The left kidney is normal in shape and size, measuring 3.1×2.14 cm, with a cortical thickness of 0.34 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 3.97×2.14 cm, with a cortical thickness of 0.39 cm in the sagittal plane.

In both kidneys the renal cortex is slightly hyperechoic compared with the hepatic parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane:

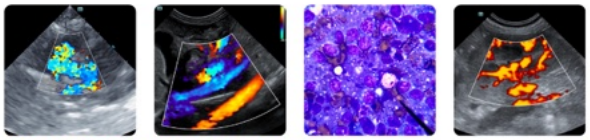
- Left adrenal gland: 0.30 cm at the cranial pole and 0.30 cm at the caudal pole
- Right adrenal gland: not reliably visualized

Spleen

Splenic thickness is 0.50 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture, except for a single markedly hypoechoic nodule measuring 4.90×4.69 mm. 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 relative to the falciform fat with normal echotexture. Several small hypoechoic and hyperechoic foci (<0.5 cm) are observed within the hepatic parenchyma, most



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compatible with nodular hyperplasia or benign parenchymal variation. No hepatic lymphadenopathy is identified.

The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic. The common bile duct measures 2.01–1.51 mm, which is within expected limits.

Gastrointestinal

The stomach is empty and folded with preserved wall layering and mural thickness measuring 1.36 mm.

However, within the distal gastric body and proximal pyloric region, there is marked focal gastric mural thickening measuring 7.35–8.47 mm, with one focal region reaching 1.15 cm in thickness. Within this area there is complete loss of normal wall layering.

The pylorus was not measured. The duodenum measures 1.86 mm. The jejunum measures 2.48 mm, with layer measurements as follows: Mucosa: 1.23 mm. Submucosa: 0.67 mm. Muscularis propria: 0.24 mm. The ileum demonstrates segmental abnormalities. Some segments appear normal (1.78 mm with preserved wall layering), while other segments measure up to 3.37 mm with alteration of wall layering. Additionally, a focal lesion arising from the muscular layer measuring 1.21×0.8 cm is identified. The ileocecal junction was not visualized. No evidence of mechanical obstruction or intraluminal foreign material is identified.

The colon measures 0.60 mm, with formed fecal material present in the descending segment.

Pancreas

Pancreatic body measures 7.56 mm, and the left pancreatic limb measures 6.17 mm in thickness. The pancreatic parenchyma appears hypoechoic relative to the surrounding omental fat. The pancreatic duct measures 1.38 mm. No surrounding fat inflammation is identified.

Peritoneal Cavity

A small amount of abdominal effusion is present.

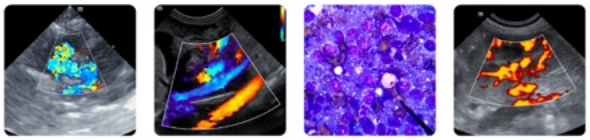
Cranial mesenteric lymph nodes are markedly enlarged, rounded, and hypoechoic, with the largest measuring 1.98×2.66 cm.

Additional lymph nodes:

- Pancreaticoduodenal lymph node: 3.73×7.17 mm
- Right gastric lymph node: 7.22×3.90 mm

Both are oval and mildly hypoechoic.

The region of the iliac trifurcation appears normal.



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ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Marked focal gastric mural thickening (7.35–11.5 mm) with loss of wall layering.
- Segmental ileal thickening with mural disruption.
- Focal ileal muscular lesion (1.21×0.8 cm).
- Markedly enlarged cranial mesenteric lymph nodes (up to 1.98×2.66 cm).
- Small volume abdominal effusion.
- Hypoechoic splenic nodule (4.9 mm).

SECONDARY FINDINGS

- Mild renal cortical hyperechogenicity.
- Small hepatic nodular changes (<0.5 cm).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The combination of focal gastric mural thickening with loss of wall layering, segmental ileal involvement, and marked enlargement of the cranial mesenteric lymph nodes is most consistent with infiltrative gastrointestinal neoplasia. In cats, the primary differential diagnoses include alimentary lymphoma and gastric or intestinal adenocarcinoma with nodal metastasis, with alimentary lymphoma considered most likely in this case given the multifocal gastrointestinal involvement and the lymph node appearance.

Pancreatic findings may reflect chronic pancreatitis.

Small hepatic nodules are present and were also described in the previous study; these are most compatible with nodular hyperplasia associated with chronic hepatopathy.

A small hypoechoic splenic nodule is also identified and remains indeterminate. In the context of suspected gastrointestinal neoplasia, metastatic disease cannot be excluded, although benign nodular change remains possible.

Recommendations

- Ultrasound-guided fine-needle aspiration of the enlarged mesenteric lymph nodes is recommended to obtain cytologic diagnosis.
- If feasible, cytologic sampling of the gastric or intestinal lesions may also be considered.
- If lymphoma is confirmed or strongly suspected, oncologic consultation may be beneficial for staging and treatment planning.
- Additional staging tests such as thoracic imaging and CBC/biochemistry review may be considered.
- Final diagnostic and therapeutic decisions should be made by the attending veterinarian, integrating these imaging findings with the complete clinical picture.

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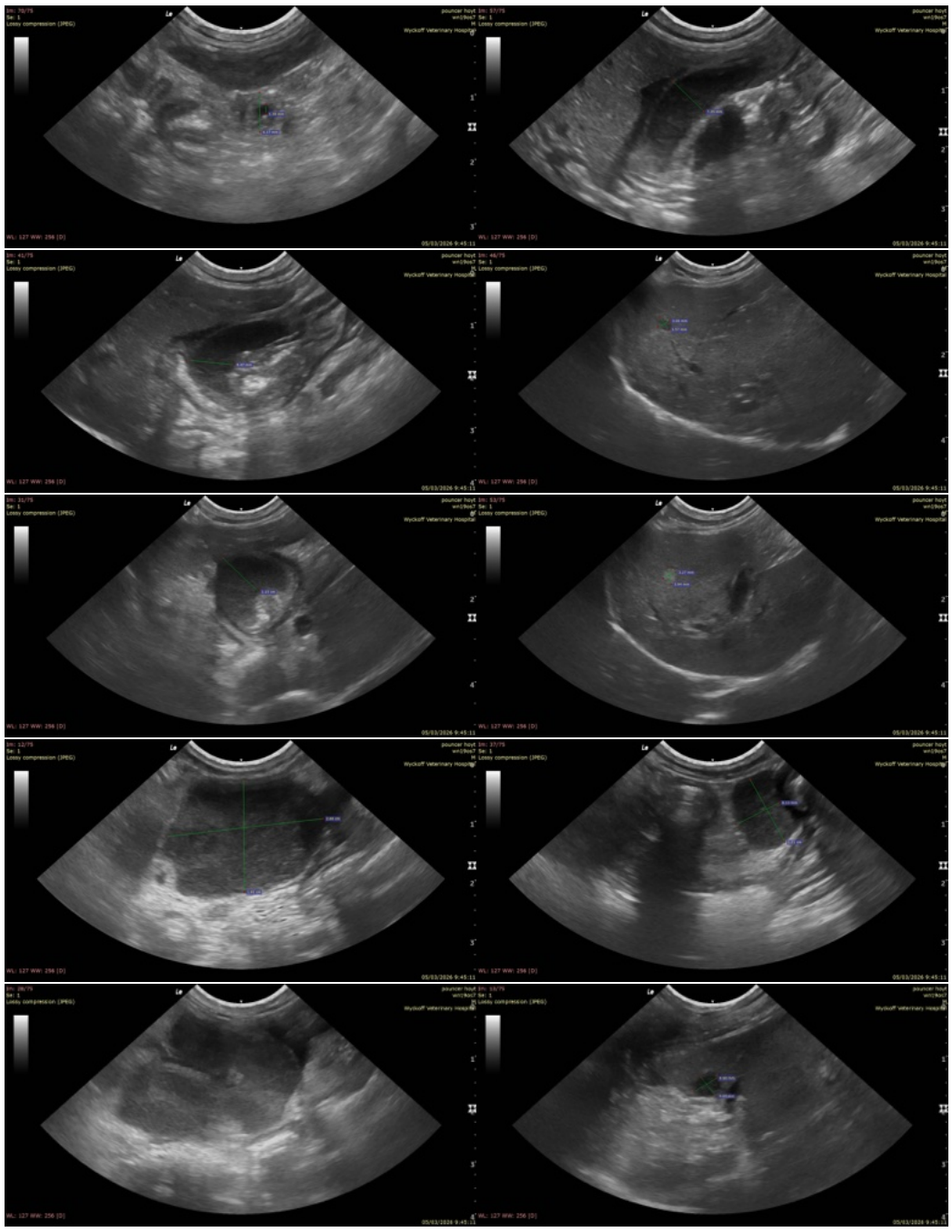

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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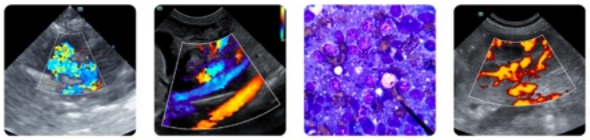

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

info@SonoPath.com