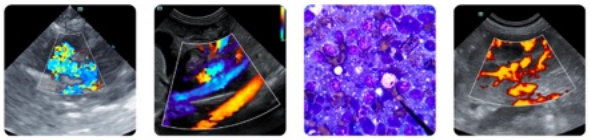


PATIENT

Echo DeFeo

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

15 years

WEIGHT

2.67 kg

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Michelle DeMelo, RVT

HOSPITAL NAME

Woodstock VH

REFERRING VET

Dr. Norris

INVOICE

74490

DATE

4/15/26

PRESENTING CLINICAL SIGNS

History: 15yo MN DSH with recurrent UTI/FIC. Previously had CaOx uroliths which were removed surgically. More recently (2025/2026), diagnosed with CKD (high end IRIS stage II). New patient to clinic in March 2026, and was examined for weight loss (over ~1 month) of 1.8 kg (despite normal appetite), was lethargic, losing hair. Blood showed azotemia, hypercalcemia, low-normal TT4; UTI noted on urine with dilute urine; suspected renal involvement given systemic clinical signs. Treated with 3 weeks of Veraflox. Patient did well while on antibiotics clinically, but since stopping, has become lethargic again. Has continued to lose weight throughout this period and is now 2.6 kg (total of 2.5 kg lost since July 2025). No vomiting/diarrhea. Has reportedly normal appetite but is only eating wet food (unknown amount); no longer eating dry food. PU/PD.
Ddx nephrolith? pyelonephritis? neoplasia (renal or elsewhere causing significant weight loss?)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, with a thin and smooth wall. The urine is anechoic. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 3.14×2.36 cm in the sagittal plane. Cortical thickness is not specified. The right kidney is normal in shape and size, measuring 2.12×2.14 cm in the sagittal plane. Cortical thickness is not specified. Both kidneys show increased cortical echogenicity compared to the liver parenchyma. The medulla is diffusely and markedly hyperechoic, with multiple mineral foci located within the calyceal and pelvic regions, consistent with nephroliths/nephrocalcinosis. No pyelectasia or hydronephrosis is observed.

Adrenal Glands

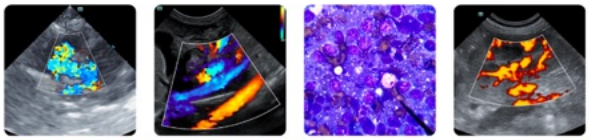
Not confidently visualized.

Spleen

The spleen is subjectively small, with a thickness of 0.31 cm. The parenchyma is mildly hypoechoic with a fine, homogeneous echotexture. The splenic capsule is smooth and regular. No focal lesions are identified

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma looks slightly hyperechoic compared to the falciform fat, with a normal echotexture. A focal cystic lesion measuring 0.94×1 cm is identified.



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The gallbladder lumen is moderately 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.

Gastrointestinal

The stomach is empty and folded, with a mural thickness of 1.50 mm. Arising from the gastric wall, there is a large, heterogeneous, predominantly hypoechoic mass with areas of mineralization. The mass has markedly irregular and invasive margins, extending toward the region of the major vessels. It appears to involve or closely contact a sublumbar/aortic lymph node (not apparently adrenal); however, due to its marked heterogeneity and infiltrative nature, it is not possible to definitively distinguish between nodal involvement and direct extension of the primary mass. The pylorus measures 3.08 mm. Duodenum: 1.66 mm. Jejunum: 1.52 mm. Ileum: 1.45 mm. Layering is preserved throughout these segments. Ileocecal junction: 2.51 mm, with a muscularis thickness of 0.76 mm. Colon: 0.83 mm, containing poorly formed fecal material.

Pancreas

The pancreas measures 0.99 cm in thickness, with irregular margins. The parenchyma is hypoechoic relative to the adjacent omental fat. The pancreatic duct measures 1.1 mm in diameter.

Free Abdomen

No abdominal effusion or peritonitis is observed.

PRIMARY FINDINGS

- Large, irregular, invasive gastric mass with mineralization and suspected regional extension/lymph node involvement
- Pancreatic hypoechogenicity with irregular margins and mildly dilated pancreatic duct (1.1 mm)

SECONDARY FINDINGS

- Bilateral renal cortical hyperechogenicity, with markedly hyperechoic renal medulla with multiple calyceal/pelvic mineral foci (nephrolithiasis/nephrocalcinosis).
- Focal hepatic cystic lesion (incidental).
- Mild increased muscularis thickness at the ileocecal junction (0.76 mm; increased relative to mucosa).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The dominant finding is a large, invasive gastric mass with mineralization and suspected regional extension, highly concerning for malignant neoplasia, most consistent with lymphoma or gastric adenocarcinoma.

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The apparent involvement of adjacent sublumbar/aortic structures raises concern for locoregional metastatic or infiltrative disease. This lesion most plausibly explains the patient's marked, progressive weight loss despite reported appetite.
The remainder of the intestinal tract is largely unremarkable. A mild, focal increase in muscularis thickness at the ileocecal junction is noted; however, given its limited extent and preserved layering, it is of uncertain clinical significance and insufficient to explain clinical signs.

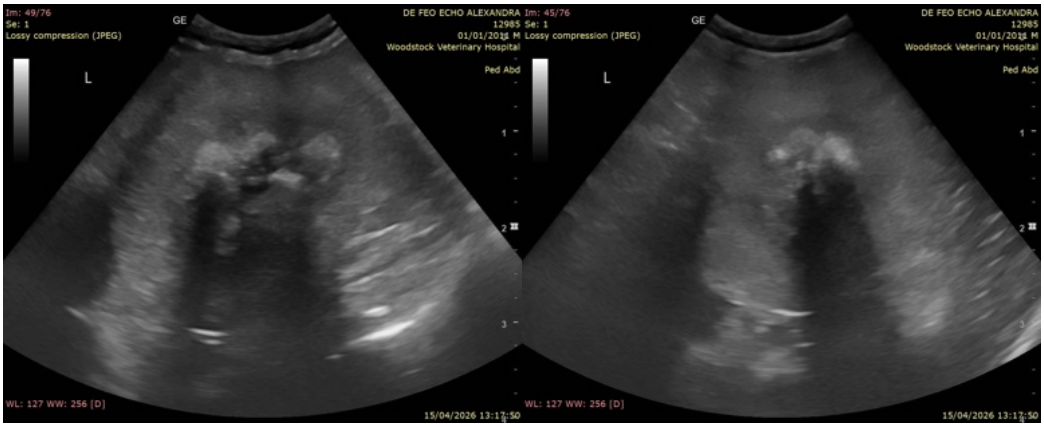
Renal changes are consistent with chronic kidney disease, with concurrent medullary mineralization/nephrolithiasis, likely exacerbated by the documented hypercalcemia. No evidence of obstruction or pyelonephritis is identified ultrasonographically.

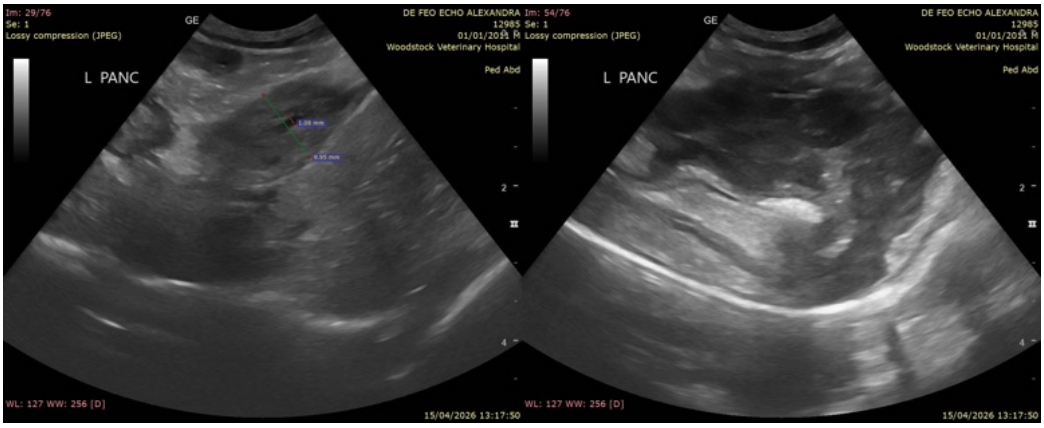
Pancreatic changes may be compatible with concurrent pancreatitis.

Recommendations

- Cytologic/tissue sampling of the gastric mass is recommended (endoscopic or surgical) for definitive diagnosis.
- Regional and thoracic staging (lymph node assessment ± thoracic imaging) is advised.
- Continue CKD management and monitoring.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.





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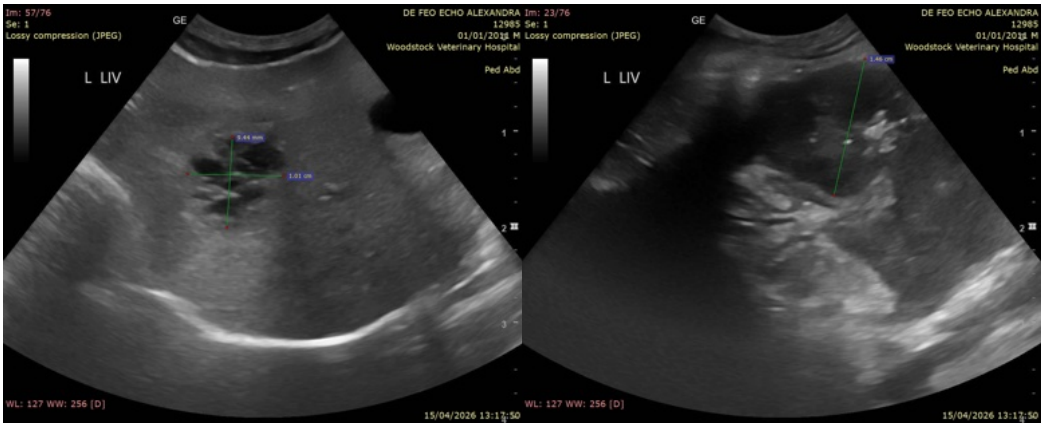

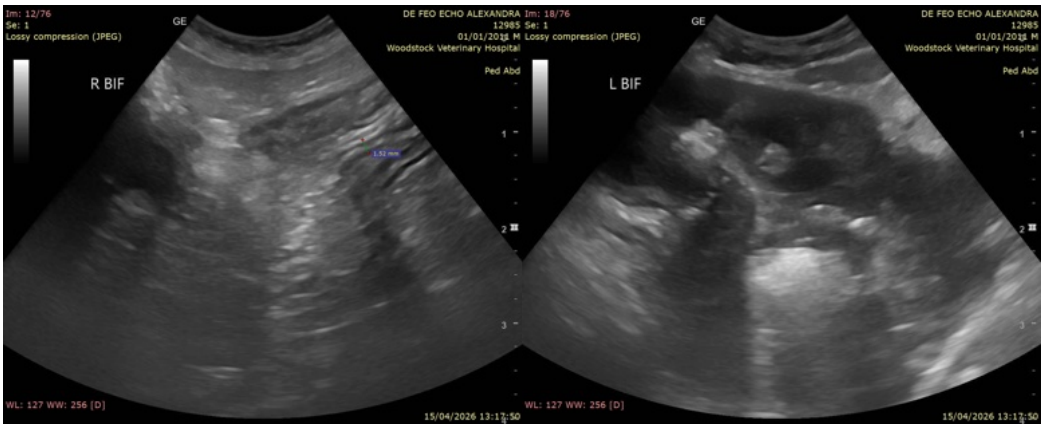

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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