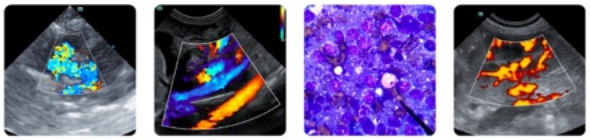


PATIENT

Maverick Adam

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

11 years

WEIGHT

9.7 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Arms

HOSPITAL NAME

Gilbertsville VH

REFERRING VET

Dr. Yiannis

INVOICE

74726

DATE

4/22/26

PRESENTING CLINICAL SIGNS

History: chronic vomit
AXR with thickened stomach concerns for inflammatory or infiltrative radiologist recomended AUS, CXR, gastric sampling.
Abnormal PE/Chem/CBC/UA Results: lab work from 2/2026 WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended. The wall is thin, smooth, and regular. The urine is anechoic. The bladder neck and proximal urethra appear unremarkable. No uroliths are identified, and there is no ultrasonographic evidence of cystitis or neoplasia.

The left kidney is normal in shape and size, measuring 4.24×2.29 cm, with a cortical thickness of 0.44 cm in the sagittal plane.
The right kidney is normal in shape and size, measuring 4.38×2.16 cm, with a cortical thickness of 0.41 cm in the sagittal plane.

Both kidneys: The cortex is mildly hyperechoic relative to the hepatic parenchyma. The corticomedullary ratio is normal and corticomedullary distinction is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.31 cm at the cranial pole and 0.30 cm at the caudal pole. The right adrenal gland measures 0.32 cm at the cranial pole and 0.33 cm at the caudal pole.

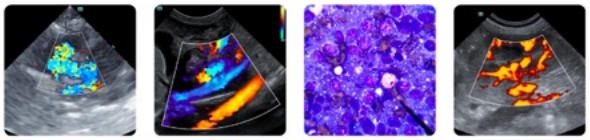
Spleen

Splenic thickness is 0.54 cm. The parenchyma demonstrates normal echogenicity and 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 liver parenchyma looks 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 evident dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach is predominantly empty and folded. At the level of the gastric body, mural thickness measures 1.87 mm, which is within normal limits for a feline patient (reference approximately 2–3 mm), with preserved wall layering and normal rugal folds.

In contrast, the remaining gastric regions demonstrate marked mural thickening ranging from 0.67–1.2 cm, with complete loss of normal wall layering, focal mass effect, and associated hyperechoic reaction of the adjacent omentum. The pylorus is not clearly delineated due to the extent of the gastric alteration.

Small intestines: Duodenum: 2.38 mm, Jejunum: 2.19–2.35 mm, Ileum: 1.76 mm. These measurements are within normal limits for a cat (generally ≤2.5–3 mm depending on segment), with preserved wall layering throughout. Muscularis-to-mucosa ratios cannot be meaningfully assessed as no mural thickening is present.

The ileocecal junction was not visualized. No evidence of ileus, obstruction, or intraluminal foreign material is identified.

Colon: wall thickness measures 0.70 mm, within normal limits.

Pancreas

The pancreas measures 0.71 cm in thickness, which is within normal limits for a cat (typically up to approximately 0.8–1.0 cm depending on body size). The parenchyma is mildly hypoechoic relative to the surrounding fat. The pancreatic duct is not dilated. No peripancreatic fat hyperechogenicity or fluid is observed.

Free Abdomen

No free abdominal fluid is identified.

A right gastric lymph node measures 0.88×0.94 cm, is rounded, and hypoechoic. Additional regional lymph nodes measure 0.47 cm and 0.7 cm in thickness. The iliac trifurcation region appears normal.

PRIMARY FINDINGS

- Marked, segmental-to-diffuse gastric mural thickening (0.67–1.2 cm) with complete loss of wall layering and mass effect.
- Associated hyperechoic perigastric omental reaction.
- Enlarged, rounded, hypoechoic gastric lymph nodes.

SECONDARY FINDINGS

- Mildly hyperechoic renal cortices relative to liver.
- Mild pancreatic hypoechogenicity without peripancreatic changes.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Severe, segmental-to-diffuse gastric mural thickening (up to 1.2 cm) with complete loss of wall layering, mass effect, and regional lymphadenopathy is most consistent with an infiltrative gastric process, with neoplasia strongly favored. Gastric lymphoma is the primary differential, with carcinoma considered less likely but not excluded.

Small intestinal segments are within normal limits in thickness and layering, with no ultrasonographic evidence of concurrent diffuse enteropathy.

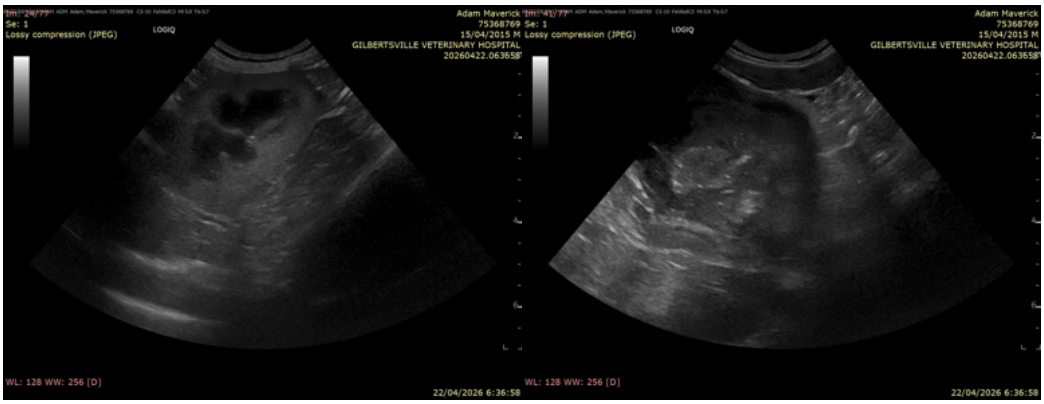
Mild pancreatic hypoechogenicity is noted. In cats, the absence of peripancreatic fat changes does not exclude pancreatitis; however, given the normal pancreatic size and lack of additional supportive findings, this change remains nonspecific. A reactive pancreatopathy secondary to adjacent gastric disease is possible.

Mild renal cortical hyperechogenicity with preserved architecture is a nonspecific finding, commonly associated with early or subclinical renal change.

Recommendations

- Gastric tissue sampling is recommended for definitive diagnosis:
  - Endoscopic biopsies may be considered initially.
  - Full-thickness biopsy should be considered if endoscopic samples are nondiagnostic.
- Fine-needle aspiration of the enlarged gastric lymph node is recommended.
- Thoracic imaging for staging.

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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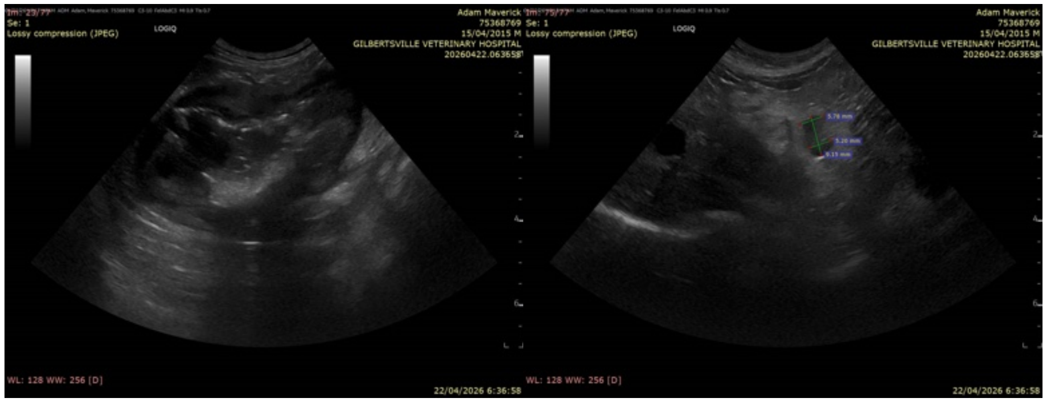

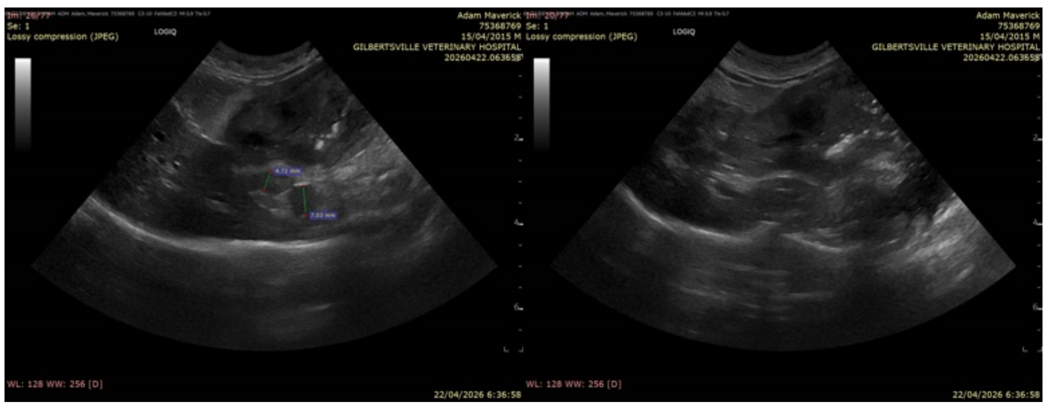

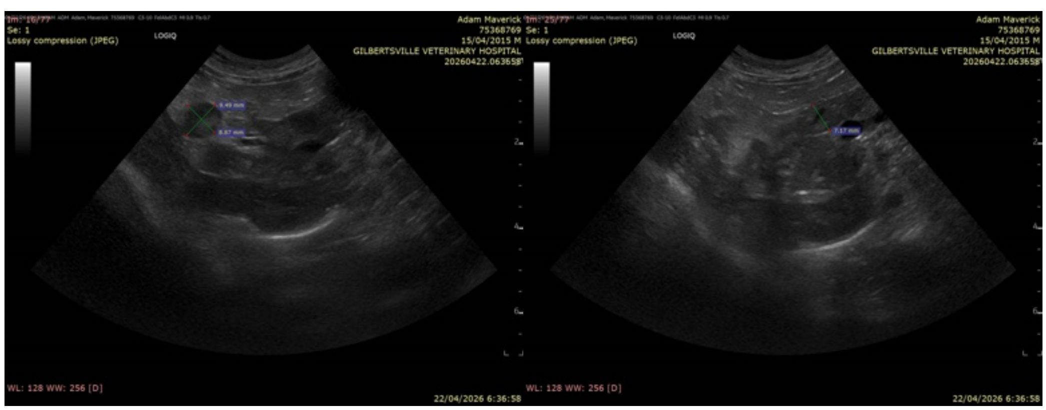

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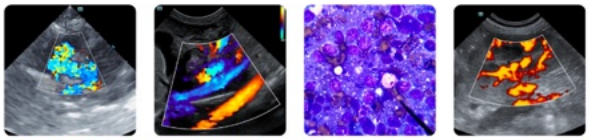

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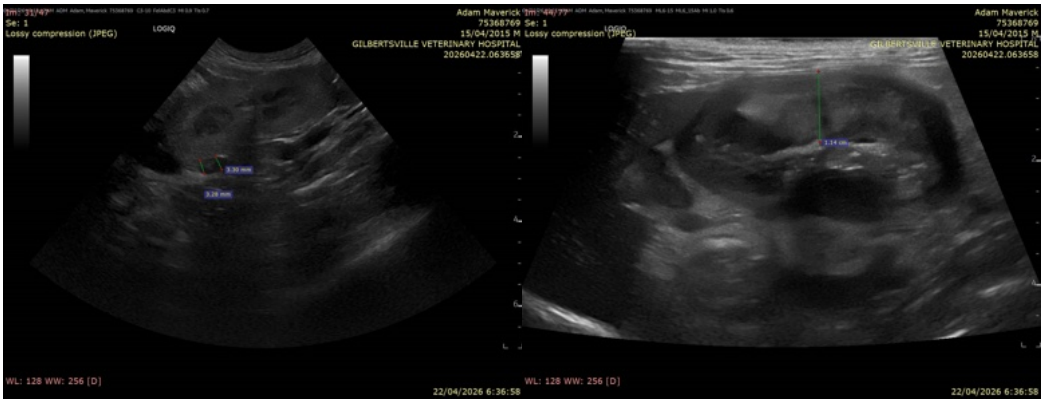

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com