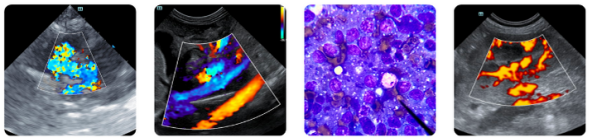


PATIENT

Selena Digenova

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

6 years

WEIGHT

4 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Nicole Carney

HOSPITAL NAME

Smithfield AH

REFERRING VET

Dr. Boe

INVOICE

75294

DATE

5/11/26

PRESENTING CLINICAL SIGNS

History: Severe weight loss, decreased appetite, intermittent diarrhea
We are second opinion from AWSOM shelter hospital - concern for GI lymphoma
Abnormal PE/Chem/CBC/UA Results: BW normal from AWSOM, T4 normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the wall appears thin and smooth. The urine is anechoic. Normal appearance of the bladder neck and proximal urethra. No calculi are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic change.

The left kidney is normal in shape and size, measuring 3.56×2.36 cm, with a cortical thickness of 0.45 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.73×2.17 cm, with a cortical thickness of 0.46 cm in the sagittal plane. Both kidneys demonstrate mildly increased cortical echogenicity compared to the hepatic parenchyma, with preserved corticomedullary definition. A mild medullary rim sign is present bilaterally. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified.

Adrenal Glands

Not visualized.

Spleen

The spleen was not identified within the available images/videos and therefore could not be evaluated.

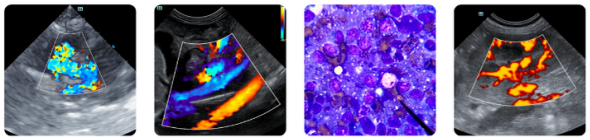
Liver

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. The common bile duct measures 2.22-3.51 mm in diameter.

Gastrointestinal Tract

The stomach is empty and folded, with preserved wall layering and mural thickness measuring 1.78 mm. The pylorus measures 2.98 mm. The duodenum measures 2.64 mm in thickness. The jejunum is diffusely thickened, measuring up to 4.24 mm, with preserved wall layering. The mucosa measures 1.48 mm, the submucosa 0.48 mm, and the muscularis propria 2.21 mm. The muscularis-to-mucosa ratio is approximately 1.5. The ileum measures 3.12 mm, with preserved wall layering. The mucosa measures



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0.83 mm, the submucosa 1.17 mm, and the muscularis propria 1.42 mm. The muscularis-to-mucosa ratio is approximately 1.7. The ileocecal junction measures 4.25 mm in thickness, with muscularis propria thickness measuring 2.06 mm. The colon measures 2.73 mm and is moderately distended with fluid content.

Pancreas

The pancreas measures 5.65 mm in thickness. The pancreatic parenchyma is isoechoic relative to the adjacent mesenteric fat. The pancreatic duct measures 0.65 mm in diameter. No ultrasonographic evidence of active peripancreatic inflammation is identified.

Free Abdomen

No abdominal effusion or evidence of peritonitis is observed. Cranial mesenteric lymph nodes measure up to 7.84 mm in thickness, and ileocecal lymph nodes measure 5.29-5.85 mm in thickness. These lymph nodes are mildly rounded and mildly hypoechoic. The iliac trifurcation region is unremarkable.

PRIMARY FINDINGS

- Diffuse jejunal thickening with marked muscularis propria thickening
- Ileal and ileocecal muscularis thickening
- Mild enlargement and hypoechogenicity of cranial mesenteric and ileocecal lymph nodes

SECONDARY FINDINGS

- Mild bilateral renal cortical hyperechogenicity with bilateral medullary rim sign

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This study demonstrates diffuse chronic enteropathy characterized predominantly by muscularis propria thickening affecting the jejunum, ileum, and ileocecal junction, with preservation of normal intestinal wall layering. The muscularis-to-mucosa ratios are abnormally increased, particularly within the jejunum and ileum, supporting infiltrative chronic intestinal disease. In cats, this ultrasonographic pattern most commonly overlaps between chronic inflammatory enteropathy/IBD and low-grade alimentary lymphoma. The preservation of wall layering and absence of focal mass lesions or transmural loss of architecture somewhat favor chronic inflammatory or low-grade infiltrative disease rather than high-grade lymphoma; however, ultrasound alone cannot reliably differentiate feline IBD from low-grade lymphoma because both entities commonly produce muscularis-predominant thickening with relatively preserved mural stratification.

The mild rounded hypoechoic mesenteric and ileocecal lymphadenopathy further supports chronic intestinal inflammatory or infiltrative disease.

Mild pancreatic enlargement and mild pancreatic duct dilation may reflect concurrent chronic pancreatitis, which commonly accompanies feline chronic enteropathy and hepatobiliary disease as part of feline triaditis-spectrum disease. Importantly, the absence of hyperechoic peripancreatic fat does not

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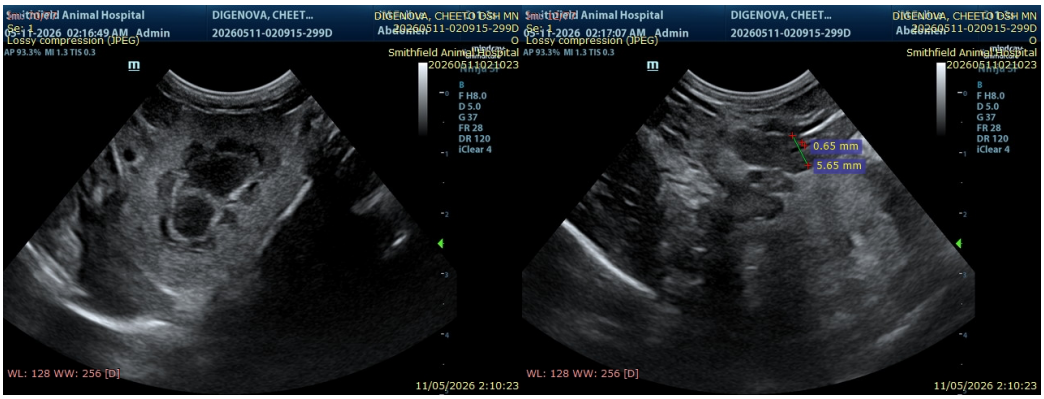
exclude chronic pancreatitis in cats.

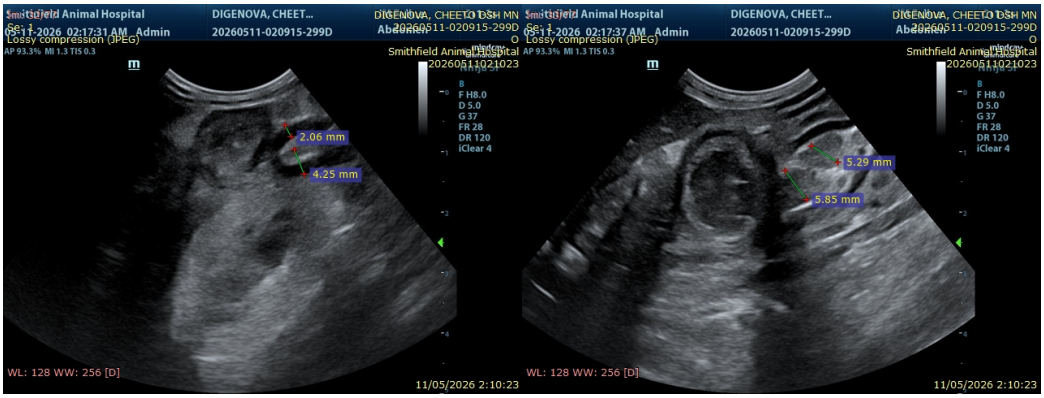
The bilateral renal cortical hyperechogenicity and medullary rim sign are nonspecific and may represent chronic incidental renal change, mineralization, previous tubular injury, or early nephropathy.

Recommendations:

- Correlation with serum cobalamin/folate, fPLI, and repeat review of CBC/chemistry is recommended.
- Cobalamin supplementation if low should be strongly considered.
- Definitive differentiation between inflammatory enteropathy and low-grade lymphoma requires intestinal biopsy with histopathology ± immunohistochemistry/PARR testing.

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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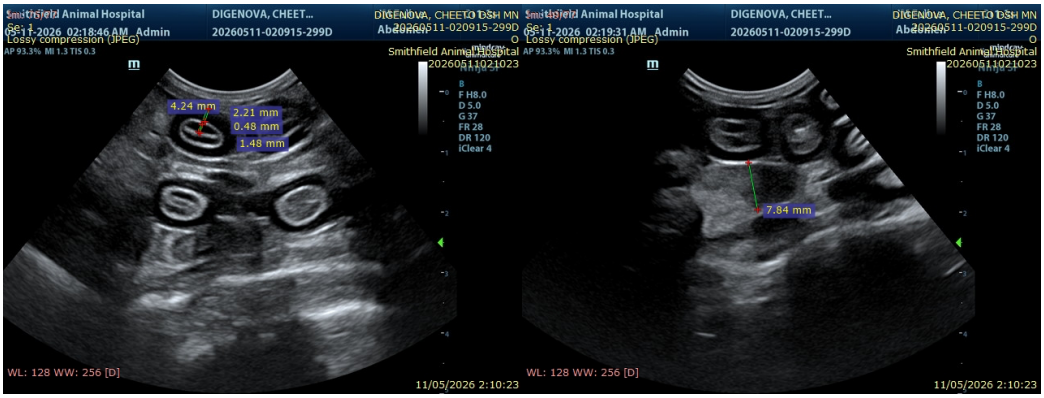

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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