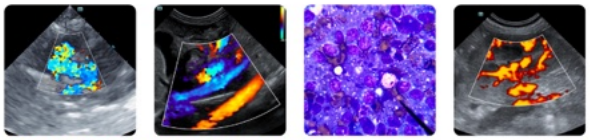


PATIENT

Lucy Baldwin

SPECIES

Feline

BREED

Domestic Medium Hair

SEX

Spayed female

AGE

9 years

WEIGHT

9.38 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Amanda Olsen, VMD

HOSPITAL NAME

Limestone VH

REFERRING VET

Katherine Williams, DVM

INVOICE

75595

DATE

5/15/26

PRESENTING CLINICAL SIGNS

History: Lucy, 9 yr FS DMH, presented for evaluation of chronic vomiting a couple months. Vomiting is random, appears to be mostly brown colored liquid. Eating well, drinking well. Vomiting about 3x/day. P has had gradual weight loss with more dramatic weight loss from March 2026 to now (10.14 lb to 9.38 lb). PE overall unremarkable, suspect feces palpated mid-abdomen. BW from 3/2026 below.
Abnormal PE/Chem/CBC/UA Results: Creatinine: 1.6 (0.6-2.4) BUN: 24 (14-36) SDMA: 9 (<15) Na/K Ratio: 44 (32-44) K+: 3.5 (3.4-5.6) Sodium: 153 (3.4-5.6) Monocytes: 798 (0-600) USG: 1.064 (1.015-1.060); Protein: 1+ UPCR: 0.1

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. The bladder neck and proximal urethra appear normal. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.42 × 1.97 cm, and the thickness of the cortex is 0.34 cm in the sagittal plane. The cortex is isoechoic compared to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

The right kidney is normal in shape and size: 3.93 × 2.15 cm, and the thickness of the cortex is 0.39 cm in the sagittal plane. The cortex is isoechoic compared to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.28 cm at the cranial pole and 0.27 cm at the caudal pole. The right adrenal gland is not confidently visualized.

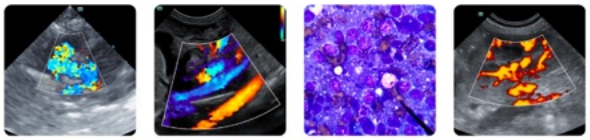
Spleen

Splenic thickness is 0.60 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 contains a small amount of residual ingesta. Gastric mural thickness measures approximately 2.47–2.76 mm with preserved wall layering.

The pylorus measures approximately 2.86 mm. The duodenum measures 1.29 mm. The jejunum measures approximately 2.16 mm, with mucosa measuring 1.27 mm, submucosa 0.51 mm, and muscularis propria 0.34 mm. The ileum measures approximately 3.11 mm, with mucosa measuring 1.14 mm, submucosa 1.14 mm, and muscularis propria 0.95 mm. The ileocecocolic junction measures approximately 4.03 mm, with muscularis propria measuring approximately 2.12 mm. Wall layering remains preserved throughout the evaluated gastrointestinal tract.

Additionally, a focally abnormal segment of small intestine, presumed most likely ileal in origin although not definitively confirmed, demonstrates mild corrugation and an adjacent irregular poorly marginated hypoechoic soft tissue lesion/mural-associated thickening extending approximately 1.8 cm extraluminally into the adjacent mesentery/peritoneal fat. The lesion does not clearly disrupt mural layering but is associated with regional hyperechoic reactive mesenteric fat change.

The colon measures approximately 0.58–0.72 mm in thickness and contains formed fecal material within the descending colon.

Pancreas

The evaluated pancreatic regions do not demonstrate ultrasonographic evidence of overt inflammation or focal neoplastic disease. No evidence of active peripancreatic fat inflammation is identified.

Free Abdomen

No abdominal effusion or generalized peritonitis is identified. Cranial mesenteric lymph nodes are enlarged, rounded, and hypoechoic, measuring approximately 0.98 × 1.23 cm. Additional rounded hypoechoic abdominal lymph nodes are identified, including a left gastric lymph node measuring approximately 6.13 × 4.89 mm and a pancreaticoduodenal lymph node measuring approximately 3.75 × 5.24 mm. The ileocecocolic lymph nodes are not confidently identified. The iliac trifurcation appears normal.

PRIMARY FINDINGS

- Marked muscularis thickening affecting the ileum and ileocecocolic junction
- Focal infiltrative-appearing small intestinal/peri-intestinal lesion with associated mesenteric fat reaction
- Regional abdominal lymphadenopathy

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

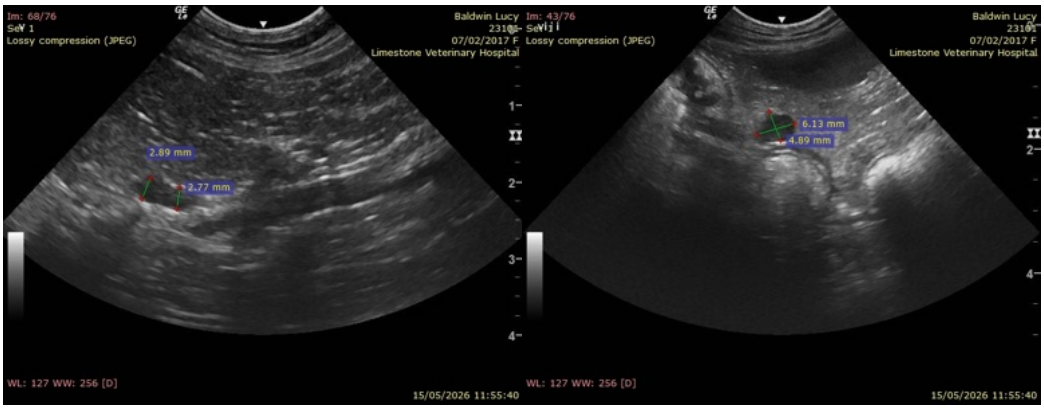
Collectively, these findings are highly concerning for infiltrative intestinal disease. Primary differential considerations include alimentary lymphoma (including focal or segmental lymphoma with associated mesenteric extension), other intestinal neoplasia, severe focal inflammatory/granulomatous enteritis, or less likely infectious infiltrative disease.
Regional reactive mesenteric/peritoneal fat change adjacent to the abnormal intestinal segment suggests localized transmural/perilesional inflammatory reaction. Although no ultrasonographic evidence of frank perforation or generalized septic peritonitis is identified at this time, mural integrity may be compromised and progression cannot be excluded.

The combination of chronic vomiting, progressive weight loss, focal infiltrative intestinal abnormality, marked ileocecocolic muscularis thickening, and rounded hypoechoic abdominal lymph nodes raises particularly strong concern for intestinal infiltrative disease.

Recommendations

- Ultrasound-guided fine needle aspiration of the enlarged mesenteric lymph node(s) is recommended if safely accessible.
- Surgical exploratory laparotomy/laparoscopy with intestinal biopsy is strongly recommended for definitive diagnosis.
- Given the probable ileal involvement and infiltrative appearance, full-thickness biopsy would likely provide substantially greater diagnostic yield than endoscopic biopsy alone.

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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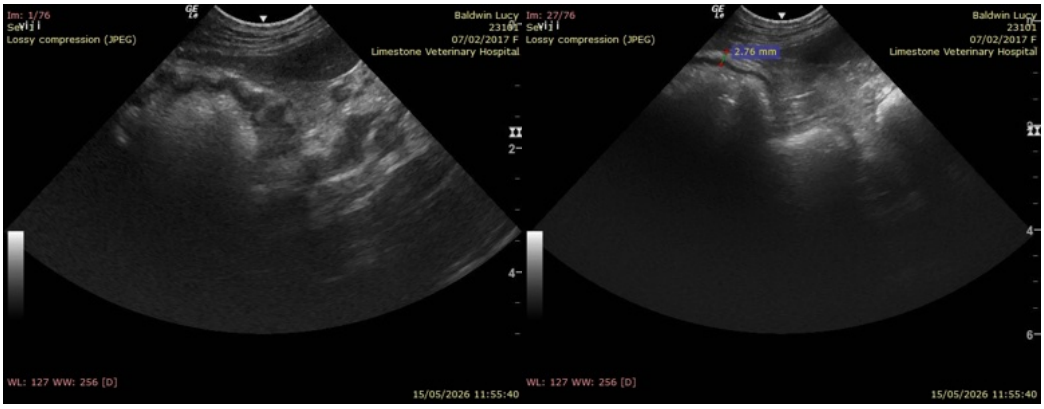

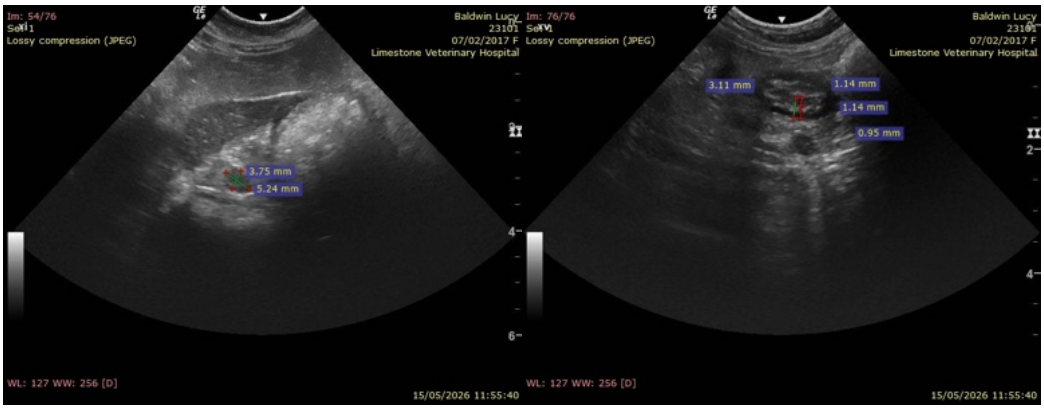

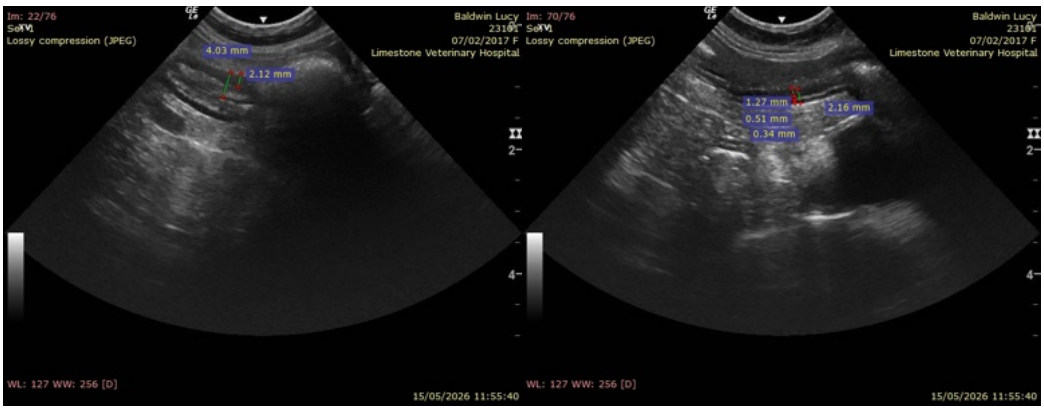

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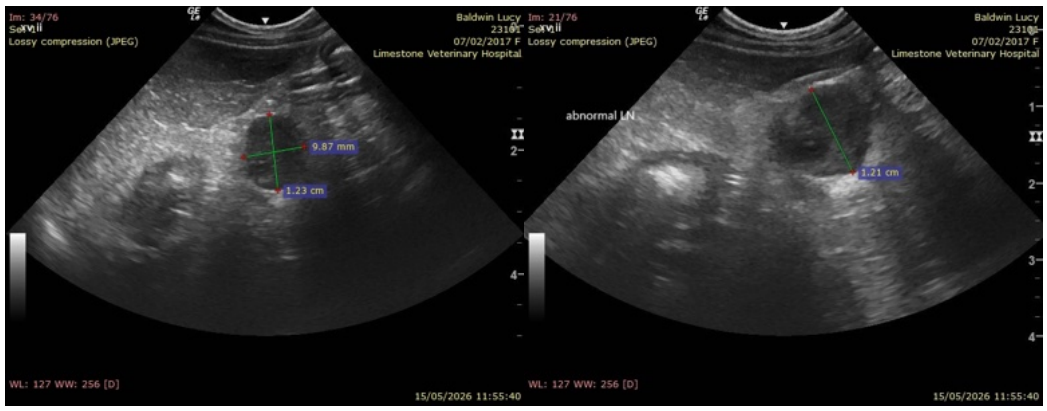

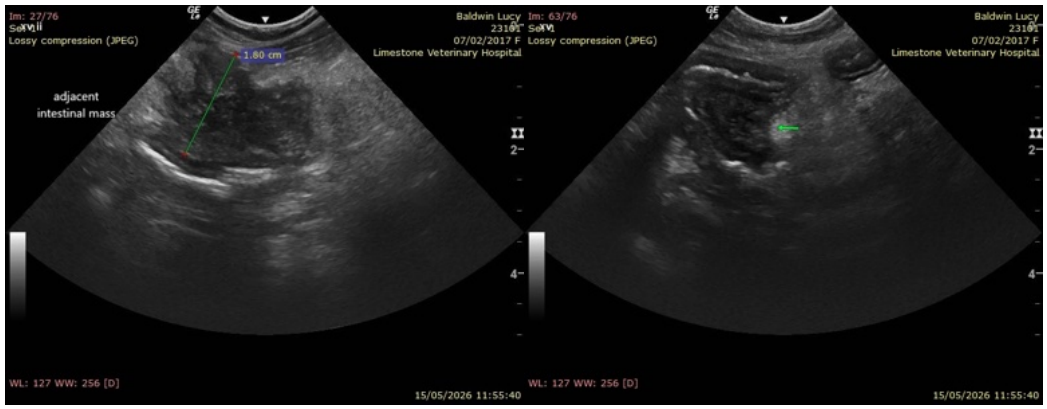

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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