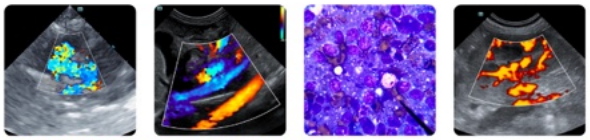


PATIENT

Nemo Kresge

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

14 years

WEIGHT

10.3 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Carney

HOSPITAL NAME

Smithfield AH

REFERRING VET

Dr. Boe

INVOICE

77658

DATE

5/18/26

PRESENTING CLINICAL SIGNS

History: Vomiting, diagnosed hyperthyroid and started methimazole. Vomiting still continuing.
Abnormal PE/Chem/CBC/UA Results: T4 WNL on Methimazole today.

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. Normal appearance of the bladder neck and proximal urethra. There are no calculi and no ultrasonographic evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.56×2.12 cm, with a cortical thickness of 0.31 cm in the sagittal plane. The renal cortex is isoechoic compared to the hepatic parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

The right kidney is not confidently visualized.

Adrenal Glands

Not visualized.

Spleen

The spleen is partially visualized. Splenic thickness measures 0.44 cm. The splenic parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture without focal abnormalities. The splenic capsule is smooth and regular.

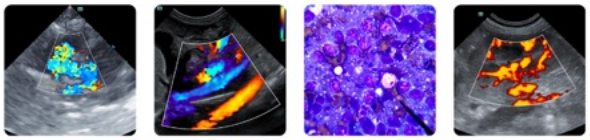
Liver

The liver is subjectively normal in size, with sharp margins and a regular contour. The hepatic parenchyma is homogeneous and isoechoic relative to the surrounding falciform fat, with a normal echotexture. No hepatic lymphadenopathy is identified.

The gallbladder is normally distended. The wall is thin and smooth. A small amount of biliary sludge is present within the lumen. No dilation of the cystic duct or common bile duct is identified.

Gastrointestinal

The stomach is empty and mildly gas distended, with preserved wall layering and a wall thickness of 1.23 mm. The duodenal wall measures 2.30 mm. The jejunal wall measures 2.45 mm, with mucosa measuring 1.56 mm, submucosa 0.40 mm, and muscularis propria 0.42 mm. The ileal wall measures 2.44 mm, with mucosa measuring 0.71 mm, submucosa 0.81 mm, and muscularis propria 0.42 mm. Wall layering is



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preserved throughout the visualized small intestine. The ileocecal junction is not confidently visualized. The descending colon measures 0.86 mm in wall thickness and contains formed fecal material.

Pancreas and Free Abdomen

Within the mid abdomen there is a poorly defined heterogeneous hypoechoic soft tissue mass-like lesion associated with marked regional peritoneal reaction. The adjacent peritoneal and mesenteric tissues appear severely thickened and irregular, with multifocal nodular-to-infiltrative appearing changes rather than simple mild inflammatory hyperechogenicity. A small volume of adjacent free abdominal fluid is present.

The exact origin of this lesion cannot be determined with confidence ultrasonographically. The lesion appears closely associated with the pancreatic region, and normal pancreatic tissue is not identified separately elsewhere during the examination, raising concern that the pancreas may be severely infiltrated and/or incorporated within the lesion. The mass does not appear convincingly associated with the gastrointestinal wall, and it also lacks the typical ultrasonographic appearance of a discrete enlarged mesenteric lymph node.

PRIMARY FINDINGS

- Poorly defined heterogeneous hypoechoic mid abdominal mass-like lesion
- Severe regional infiltrative/nodular peritoneal and mesenteric reaction
- Small volume regional free abdominal effusion

SECONDARY FINDINGS

- Mild biliary sludge
- Mild subjective muscularis prominence within portions of the small intestine with preserved layering

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The dominant ultrasonographic abnormality is a poorly defined infiltrative soft tissue lesion centered within the mid abdomen, associated with marked nodular-to-infiltrative mesenteric/peritoneal reaction and small-volume regional abdominal effusion. The precise tissue of origin cannot be determined ultrasonographically. However, because normal pancreatic tissue is not identified separately and the lesion appears centered within the pancreatic region, severe pancreatic and/or mesenteric disease remains a major concern.

The overall appearance is highly abnormal but nonspecific. Differential considerations include infiltrative neoplasia (such as pancreatic adenocarcinoma, infiltrative mesenteric neoplasia, mesenteric sarcoma/carcinomatosis, or less likely atypical invasive lymphoma), severe necrotizing pancreatitis with marked phlegmonous/inflammatory change, or less likely a chronic organized inflammatory/infectious process such as pancreatic or mesenteric abscessation. Although the infiltrative appearance, marked architectural distortion, and nodular peritoneal involvement raise concern for neoplasia, severe

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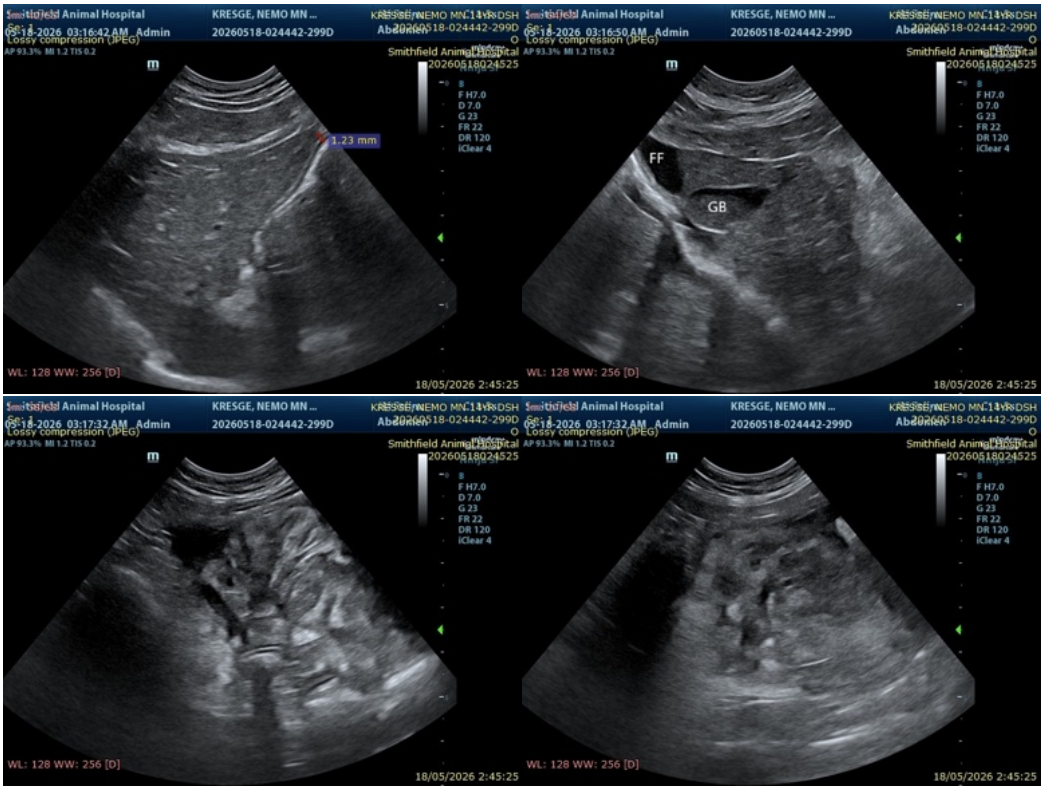
inflammatory pancreatic disease can occasionally produce a similar ultrasonographic appearance in cats.

The mild jejunal muscularis prominence remains nonspecific, and mild chronic inflammatory enteropathy or low-grade lymphoma cannot be completely excluded.

Recommendations

- Ultrasound-guided fine needle aspiration of the lesion and/or associated peritoneal changes is recommended if considered clinically appropriate and safely accessible.
- Cytologic evaluation of the regional abdominal fluid (if feasible) could also be considered.
- Correlation with pancreatic lipase testing, bilirubin, liver enzymes, appetite status, and clinical progression is recommended.
- Advanced imaging (CT) may help better define the lesion origin, extent of disease, and, if neoplastic, possible metastatic spread.

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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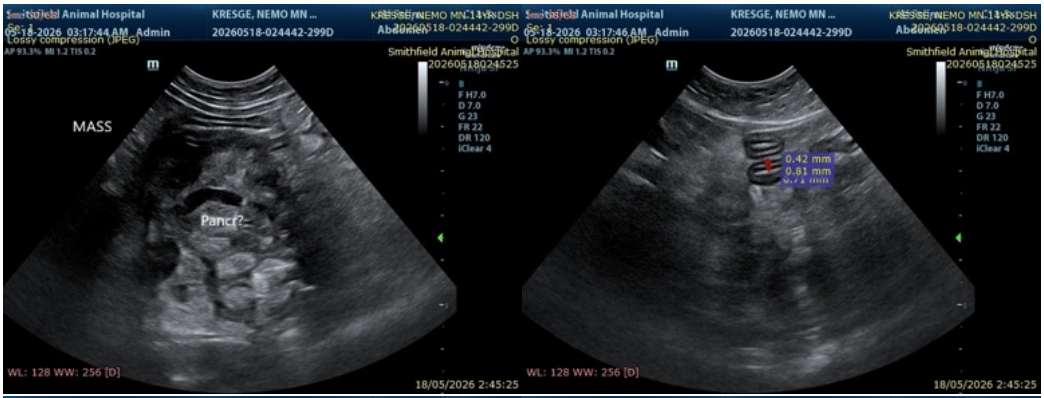

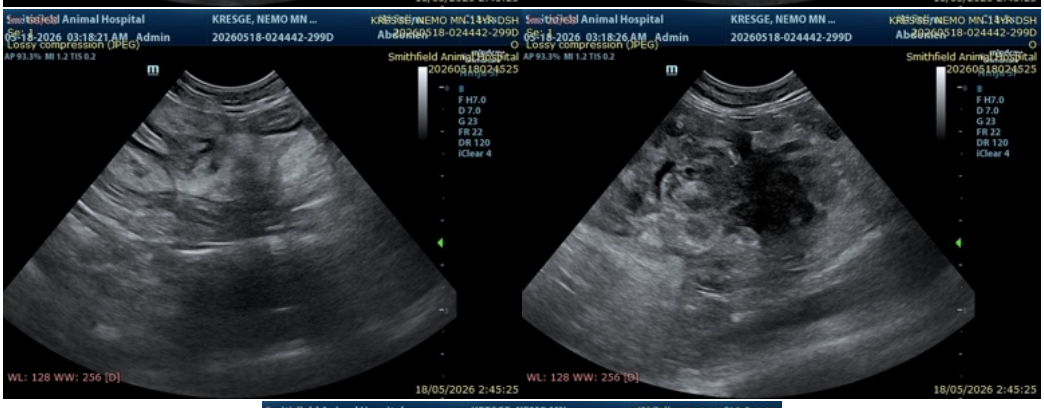

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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