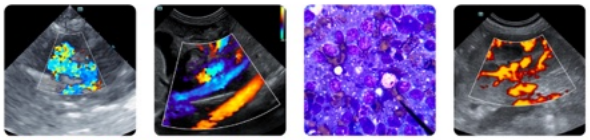

PATIENT

Jack Bowe

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

17 years

WEIGHT

9.9 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Amanda Olsen, VMD

HOSPITAL NAME

Limestone VH

REFERRING VET

Dr. Olsen

INVOICE

77977

DATE

5/26/26

PRESENTING CLINICAL SIGNS

History: 17 year old MN DSH, presents for recent weight loss despite excellent appetite. No vomiting/diarrhea and O reports other than weight loss is doing well. Has lost 7.5 lbs since last seen 4 years ago, but O thinks that weight loss is mostly recent. Incidental finding of free fluid in abdomen during ultrasound guided cystocentesis to complete bloodwork panel prompted full ultrasound. BW is still pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended, and the urinary bladder wall appears thin and smooth. The urine is anechoic. Normal appearance of the bladder neck and proximal urethra. No calculi or sonographic evidence of inflammatory or neoplastic mural changes are identified.

The left kidney is normal in shape and size, measuring 3.60×1.85 cm, with a cortical thickness of 0.31 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.75×1.73 cm, with a cortical thickness of 0.35 cm in the sagittal plane. In both kidneys, the cortex is mildly hyperechoic relative to the hepatic parenchyma. The corticomedullary ratio is preserved, and corticomedullary definition remains distinct. Mild bilateral medullary rim sign change is present. No evidence of pyelectasia, nephrolithiasis, ureteral dilation, or hydronephrosis is identified.

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Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.38 cm The right adrenal gland measures 0.38 cm

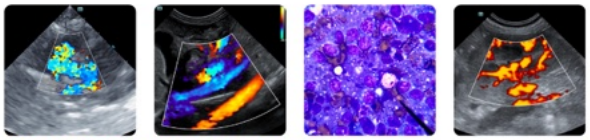
Spleen

The spleen is markedly enlarged, with thickness measuring approximately 9.67 cm. The splenic parenchyma demonstrates diffusely decreased echogenicity with a heterogeneous multinodular appearance throughout the organ.

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 is normally distended. The gallbladder wall measures approximately 1.19 mm. The luminal contents are predominantly anechoic. The common bile duct measures approximately 3.33–2.86 mm.



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Gastrointestinal tract

The stomach is empty and folded, with mural thickness measuring 1.39 mm and preserved wall layering. The duodenal wall measures 2.12 mm in thickness. Adjacent to the duodenum, a focal hypoechoic nodular structure measuring approximately 3.66×5.67 mm is identified. The jejunal wall measures 2.99 mm, with mucosa measuring 1.68 mm, submucosa 0.38 mm, and muscularis propria 0.38 mm. The ileal wall measures 2.48 mm, with mucosa measuring 0.87 mm, submucosa 1.19 mm, and muscularis propria 0.39 mm. The ileocecocolic junction measures 2.45 mm, with mucosa measuring 0.98 mm and muscularis propria 0.91 mm. Intestinal wall layering remains preserved throughout the evaluated intestinal tract. The colon measures 0.95–0.97 mm in wall thickness and contains formed fecal material within the descending colon.

Pancreas

Only a small portion of the right pancreatic lobe could be confidently identified, measuring approximately 4.52 mm in thickness. The visible pancreatic margins appear mildly irregular. The pancreatic parenchyma is mildly hypoechoic relative to the adjacent mesenteric fat. The pancreatic duct measures approximately 1.08 mm in diameter.

The region dorsal to the pylorus and expected location of the left pancreatic lobe is extensively occupied by multiple soft tissue masses/markedly enlarged hypoechoic lymph nodes, significantly limiting evaluation of the remaining pancreas.

Free Abdomen

Mild abdominal effusion is present.

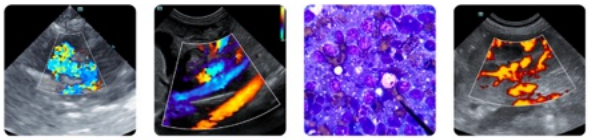
Multiple markedly enlarged, rounded, hypoechoic abdominal lymph nodes are identified, including cranial mesenteric lymph nodes measuring approximately 9.91–9.93 mm in thickness, a hepatic/gastric lymph node measuring 2.90×1.78 cm, a left gastric lymph node measuring 8.72×7.75 mm, and a pancreaticoduodenal lymph node measuring 5.26×7.29 mm.

PRIMARY FINDINGS

- Severe diffuse splenomegaly with heterogeneous multinodular infiltrative appearance.
- Marked multifocal abdominal lymphadenopathy.
- Soft tissue masses/marked lymph node enlargement surrounding the pyloric region and expected left pancreatic lobe.

SECONDARY FINDINGS

- Mild pancreatic irregularity and pancreatic ductal prominence.
- Mild bilateral renal cortical hyperechogenicity with medullary rim sign change.
- Mild muscularis prominence at the ileocecocolic junction.
- Abdominal effusion.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The dominant abnormalities on the current examination are severe diffuse infiltrative splenic disease and marked multifocal abdominal lymphadenopathy. In combination, these findings are highly concerning for systemic round cell neoplasia, with lymphoma considered the primary differential diagnosis. Metastatic histiocytic disease or less likely other disseminated neoplastic infiltrative processes remain additional considerations.

The spleen demonstrates marked enlargement with diffuse heterogeneous multinodular infiltration rather than isolated benign nodular hyperplasia. The associated abdominal lymphadenopathy is extensive and includes the cranial mesenteric, gastric/hepatic, and pancreaticoduodenal lymphocenters, supporting a disseminated biologic process rather than isolated reactive nodal enlargement.

The region dorsal to the pylorus and expected location of the left pancreatic lobe is extensively occupied by soft tissue masses/enlarged lymph nodes, significantly limiting pancreatic evaluation. Mild hypoechogenicity and irregularity of the visible right pancreatic lobe may represent secondary/reactive pancreatic involvement or concurrent chronic pancreatic remodeling. Mild pancreatic ductal prominence is also present.

Mild muscularis prominence at the ileocecocolic junction is identified, although intestinal wall layering remains preserved.

Mild abdominal effusion is present and is considered clinically significant in the context of the extensive infiltrative splenic and abdominal nodal disease. Although nonspecific, the effusion may represent reactive/neoplastic effusion secondary to disseminated abdominal neoplasia or partial lymphatic obstruction. Septic peritonitis is considered less likely based on the current ultrasonographic appearance.

Overall, the current examination is highly concerning for disseminated lymphoma with marked splenic and abdominal nodal involvement. Ultrasound-guided cytology of the spleen and/or enlarged abdominal lymph nodes is strongly recommended if clinically appropriate.

Recommendations

- Ultrasound-guided fine needle aspiration/cytology of the spleen and/or enlarged abdominal lymph nodes is strongly recommended for definitive diagnosis.
- If cytology is nondiagnostic and definitive classification would alter treatment decisions, tissue biopsy and/or flow cytometry/PARR testing may be considered.
- Thoracic imaging may be considered for additional staging if systemic neoplasia is confirmed.

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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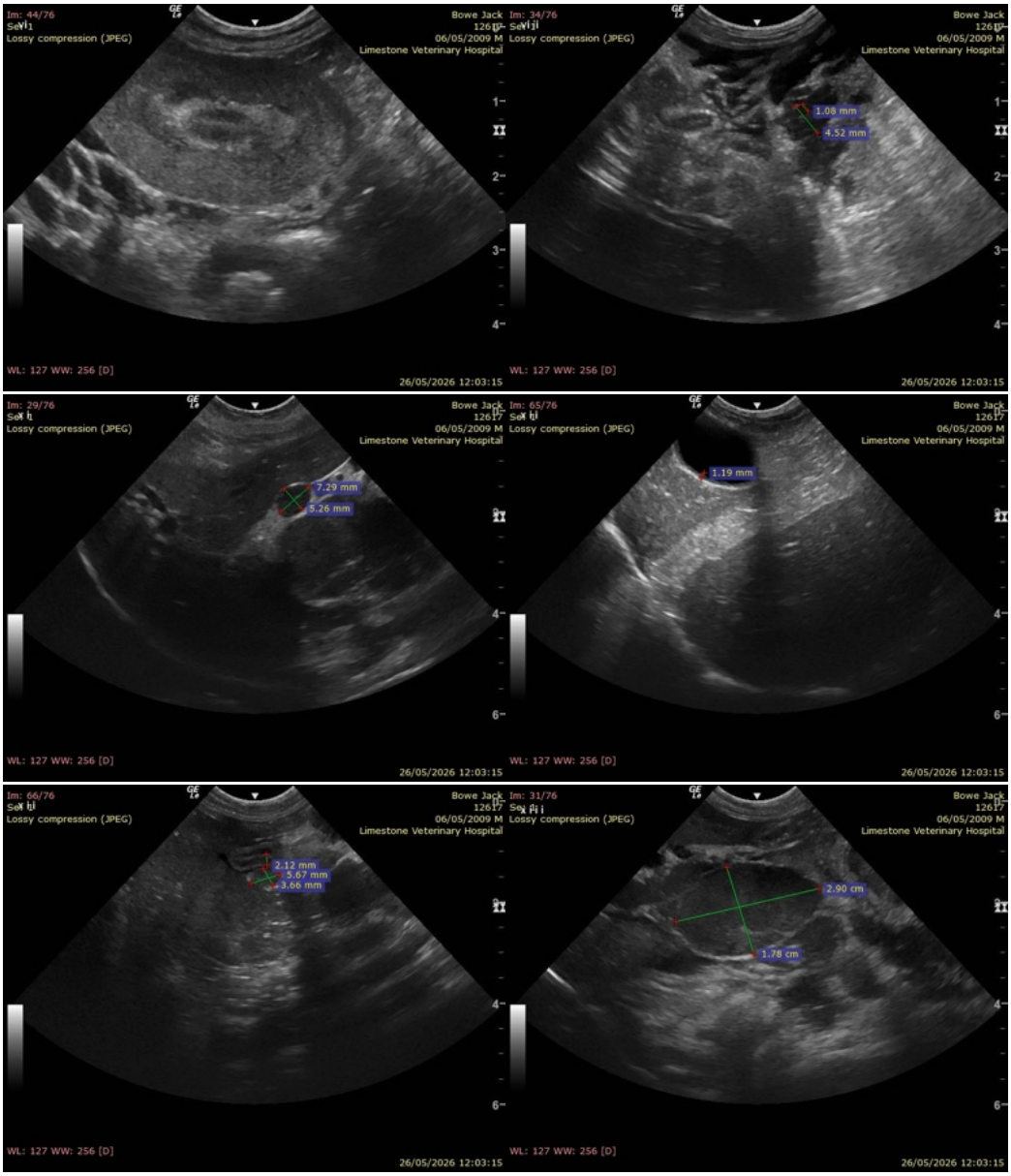

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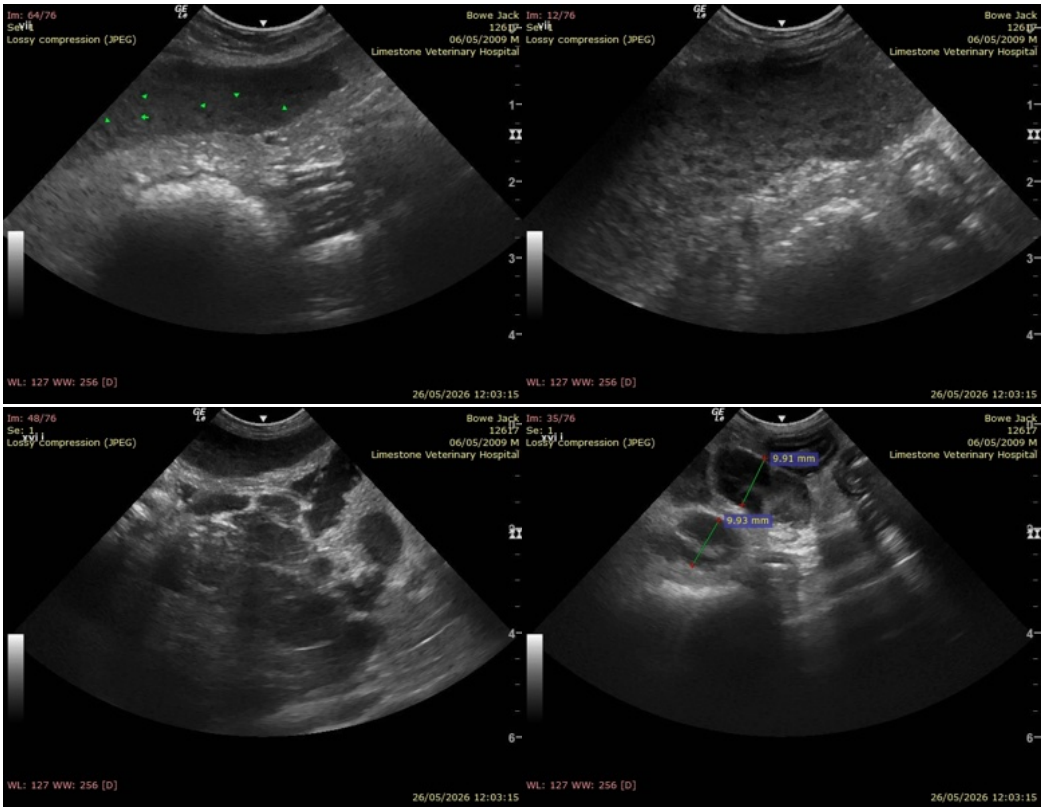

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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