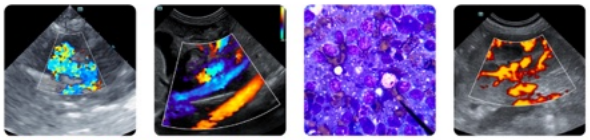


PATIENT

Nico Gonzales

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

14 ½ years

WEIGHT

10.56 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Cameron Johnson, DVM

HOSPITAL NAME

Craig Road AH

REFERRING VET

Dr. Cooper

INVOICE

77990

DATE

5/26/26

PRESENTING CLINICAL SIGNS

History: - Chronic vomiting for approximately 5 months since Christmas
- Vomiting occurs randomly on carpet or after eating
- Vomits food (sometimes whole kibble visible), grass/weeds, and occasionally hairballs
- Client concerned about weight loss - reports he looks skinny
- Eats quickly, prefers dry kibble over wet food
- Fed Blue Buffalo sensitive stomach formula since Christmas
- Occasionally given wet food with chunks in gravy
- Indoor/outdoor cat, sometimes escapes yard for up to 20 minutes
- Coughing noted before vomiting episodes (lasts 10-20 seconds)
- One episode of wheezing/shortness of breath when picked up 3 days ago
- Lives with 2 other cats
- 5 litter boxes for 3 cats
- Some loose stool noted in litter box recently (unknown which cat)
- Due for rabies, distemper, and leukemia vaccines
- No current medications

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The 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 change.

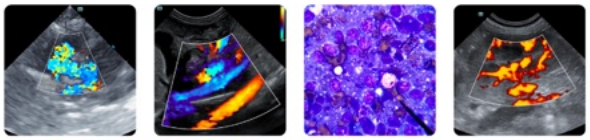
The left kidney is normal in shape and size, measuring 3.15×1.79 cm, with cortical thickness measuring 0.31 cm in the sagittal plane. The right kidney is mildly enlarged, measuring 4.23×2.10 cm. Cortical thickness could not be reliably measured in the submitted images. Both renal cortices are diffusely hyperechoic compared to the hepatic parenchyma. The corticomedullary ratio remains within normal limits and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a subjectively normal vascular pattern.

Adrenal Glands

Not visualized.

Spleen

The spleen is diffusely enlarged, with splenic thickness measuring up to 9.04 mm and mildly rounded margins. The splenic parenchyma remains relatively homogeneous without discrete focal nodular lesions identified. The splenic capsule is smooth and regular. Splenic vasculature appears normal.



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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 moderately distended. The wall remains thin and smooth, and the contents are predominantly anechoic. No convincing cystic duct or extrahepatic biliary duct dilation is identified. The common bile duct measures 3.08-2.71-2.06 mm along its visible course.

Gastrointestinal tract

The stomach is empty and mildly folded, with preserved wall layering and wall thickness measuring 1.83 mm. The pylorus measures 3.16 mm in wall thickness. The duodenum measures 4.16 mm in total thickness, with muscularis propria measuring 1.55 mm. The jejunum measures 3.94 mm in total thickness. The mucosa measures 1.64 mm, submucosa 0.92 mm, and muscularis propria 1.64 mm, resulting in a muscularis-to-mucosa ratio of approximately 1.0. The ileum measures 4.61 mm and demonstrates mild partial loss of normal mural layer definition. The ileocecal junction measures 3.82 mm, with muscularis propria measuring 2.0 mm. The colon measures 0.75 mm in wall thickness and contains a small amount of fecal material within the descending segment.

Pancreas

The pancreas measures approximately 5.35 mm in thickness. The pancreatic parenchyma is relatively isoechoic to the adjacent mesenteric fat without a clearly defined focal mass lesion. The pancreatic duct measures 1.55 mm in diameter.

Free Abdomen

A heterogeneous soft tissue structure measuring approximately 2.66×3.67 cm is identified within the region of the mesenteric root. This most likely represents a severely abnormal cranial mesenteric lymph node, although an eccentric intestinal-associated mass lesion cannot be completely excluded based on the submitted images alone.

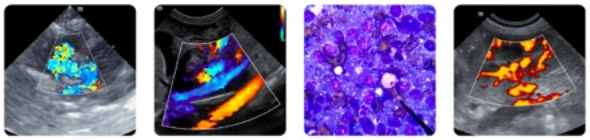
Mild-to-moderate abdominal effusion is present. There is also diffuse hyperechogenicity of the mesenteric fat consistent with regional steatitis/reactive mesenteric change.

The pancreaticoduodenal lymph node is mildly enlarged and rounded, measuring 5.22×6.70 mm, with hypoechoic echogenicity.

The iliac trifurcation lymph nodes are within normal limits.

PRIMARY FINDINGS

- Marked thickening of the small intestine, particularly muscularis propria thickening and ileocecal region involvement.



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- Mild partial loss of ileal wall layering.
- Large heterogeneous mesenteric root mass, favored to represent severely abnormal mesenteric lymphadenopathy.
- Mild-to-moderate abdominal effusion
- Diffuse reactive mesenteric steatitis

SECONDARY FINDINGS

- Mild diffuse splenomegaly
- Mild pancreaticoduodenal lymphadenopathy

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The combination of severe mesenteric lymphadenopathy/mass effect, chronic progressive vomiting, weight loss, diffuse small intestinal muscularis propria thickening with ileocecal involvement, partial loss of normal ileal wall layering, abdominal effusion, and diffuse reactive mesenteric change strongly supports alimentary lymphoma with associated mesenteric nodal involvement as the leading differential diagnosis.

Metastatic intestinal carcinoma with secondary mesenteric lymphadenopathy is considered a secondary differential consideration, particularly if the mesenteric lesion ultimately proves to represent metastatic nodal disease arising from a more focal intestinal primary lesion not fully distinguishable ultrasonographically.

The splenomegaly may represent reactive change or early infiltrative involvement.

Recommendations
- Ultrasound-guided fine needle aspiration/cytology of the mesenteric mass/lymph node and abdominal effusion is strongly recommended.
- If cytology is nondiagnostic, intestinal biopsy may ultimately be required for definitive characterization.
- Referral to oncology/internal medicine is recommended given the high index of suspicion for infiltrative gastrointestinal neoplasia.

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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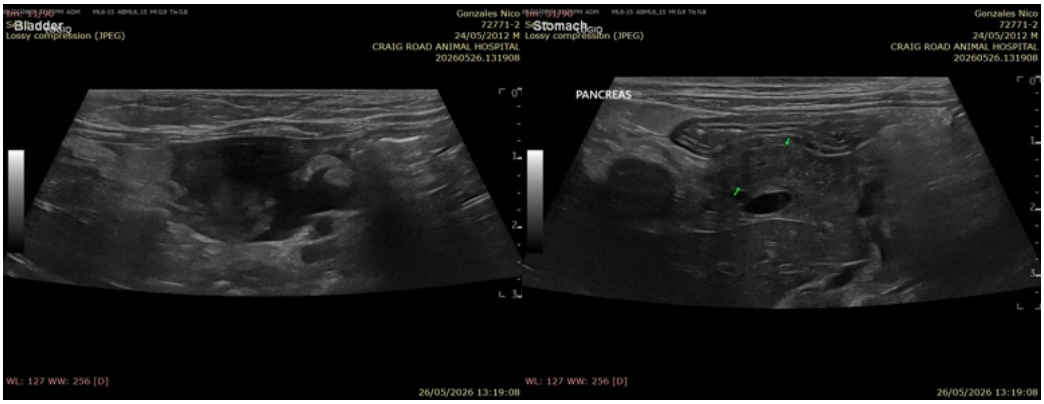

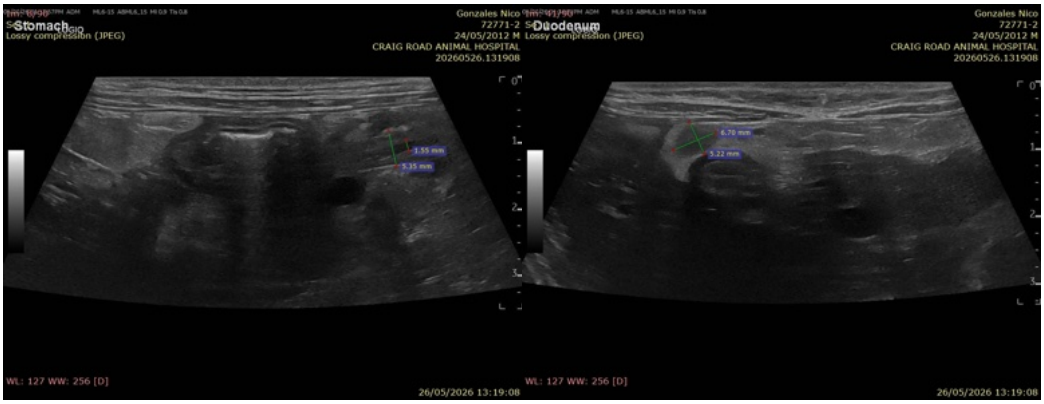

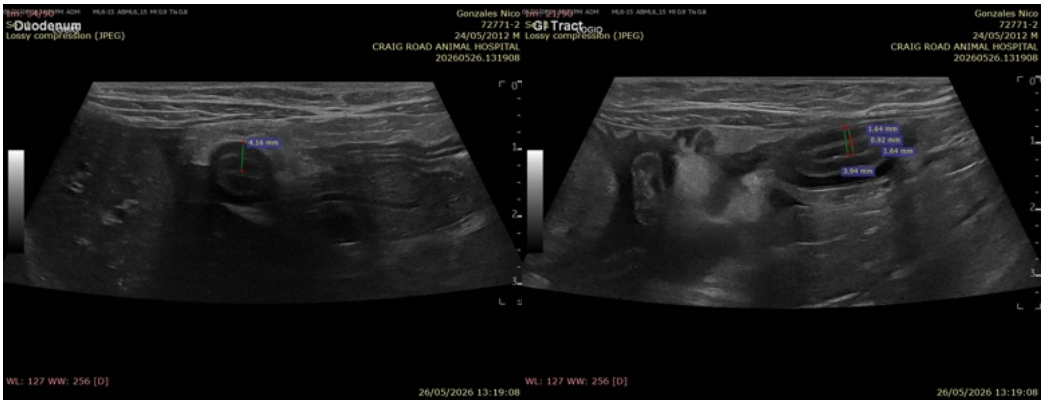

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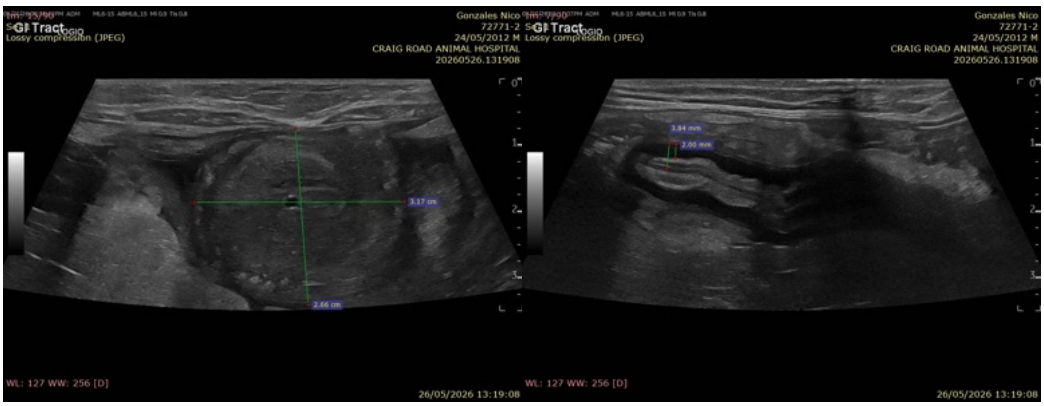

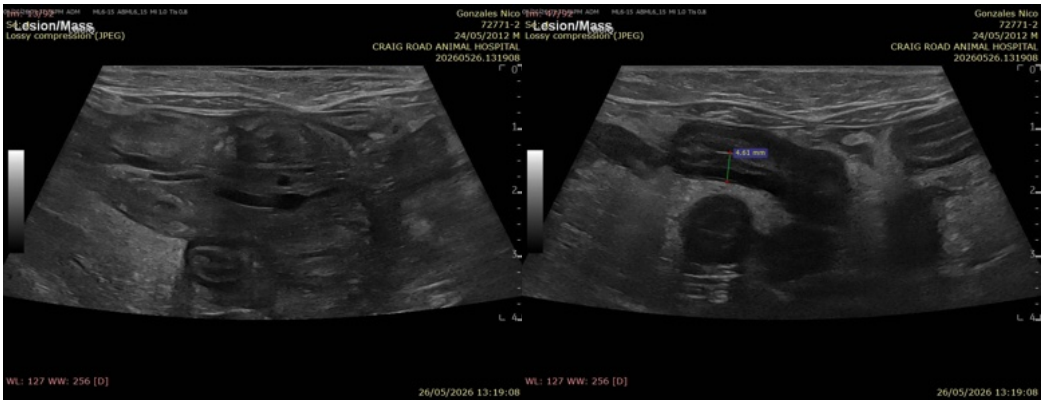

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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