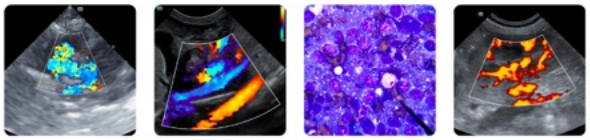


PATIENT

Utah Race

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

5 years

WEIGHT

13.4 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Amy Jagger DVM

HOSPITAL NAME

VCA Parkway AH

REFERRING VET

Dr. Jagger

INVOICE

78029

DATE

5/27/26

PRESENTING CLINICAL SIGNS

History of weight loss and chronic vomiting
Abnormal PE/Chem/CBC/UA Results: Labs WNL other than Creatinine elevation (2.6) with normal BUN/SDMA and very concentrated urine (1.072)

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 predominantly turbid with suspended echoes. 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 3.93×2.35 cm, with cortical thickness measuring 0.36 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 4.04×2.60 cm, with cortical thickness measuring 0.34 cm in the sagittal plane. The renal cortices are mildly hyperechoic relative to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition remain preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler demonstrates a subjectively normal vascular pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.21 cm at the cranial pole and 0.20 cm at the caudal pole. The right adrenal gland measures 0.19 cm at the cranial pole and 0.21 cm at the caudal pole.

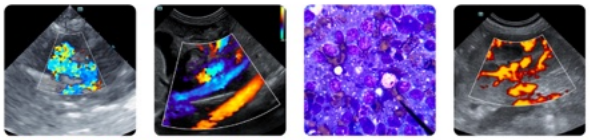
Spleen

Splenic thickness is 0.83 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 0.98 mm and the contents are primarily anechoic with a small amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal tract

The stomach stomach is slightly distended with ingesta. Gastric wall thickness measures approximately 1.01 mm in most evaluated regions with preserved wall layering. However, within the pyloric region, there is severe focal mural thickening measuring approximately 5.90-8.68 mm with marked loss of normal wall layering. Multifocal irregular luminal mucosal defects/crateriform changes are present and are highly suspicious for ulcerative mucosal disease. No convincing evidence of deep perforating ulceration is identified ultrasonographically at this time. The duodenum measures approximately 3.14 mm in wall thickness and is mildly thickened with preserved wall layering and relative muscularis prominence. The jejunum measures 2.28 mm in total wall thickness. The mucosa measures 1.36 mm, submucosa 0.57 mm, and muscularis propria 0.31 mm. Wall layering remains preserved. The ileum measures approximately 2.84 mm in total wall thickness. The mucosa measures 1.43 mm, submucosa 1.04 mm, and muscularis propria 0.19 mm. Wall layering remains preserved. The ileocecal junction measures approximately 2.86 mm in total wall thickness. The mucosa measures 0.75 mm and the muscularis propria measures 0.96 mm, resulting in muscularis prominence at the ileocecal region.

Pancreas

The pancreas measures approximately 5.16 mm in thickness. The pancreatic parenchyma is isoechoic relative to the adjacent mesenteric fat. The pancreatic duct measures approximately 0.83 mm in diameter. No convincing ultrasonographic evidence of active pancreatitis or peripancreatic inflammatory change is identified.

Free Abdomen

No abdominal effusion or generalized peritonitis is identified. Cranial mesenteric lymph nodes measure approximately 6.32 mm in thickness. Ileocecal lymph nodes measure approximately 1.90-2.86 mm in thickness and maintain relatively normal shape and echogenicity.

The pancreaticoduodenal lymph node measures approximately 1.43 × 0.58 cm and is hypoechoic. A left gastric lymph node measures approximately 0.66 × 1.13 cm and is rounded and hypoechoic. The iliac trifurcation lymph nodes are within normal limits.

PRIMARY FINDINGS

- Severe focal pyloric mural thickening with marked loss of wall layering and suspected mucosal ulceration
- Mild diffuse proximal small intestinal thickening with muscularis prominence
- Hypoechoic regional gastric/pancreaticoduodenal lymphadenopathy

SECONDARY FINDINGS

- Mild bilateral renal cortical hyperechogenicity
- Mild biliary sludge accumulation

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This examination demonstrates severe focal pyloric mural thickening with marked architectural distortion/loss of normal wall layering and multifocal crateriform mucosal defects highly suspicious for ulcerative pyloric disease. The degree of mural thickening and loss of layering are concerning for infiltrative gastric disease.

Primary differential considerations include gastric neoplasia (particularly lymphoma, or less likely adenocarcinoma or other infiltrative neoplasms). Severe chronic hypertrophic/inflammatory pyloric gastritis, or severe ulcerative inflammatory disease cannot be ruled out, but the severity of the findings and the associated regional lymphadenopathy increases concern for clinically significant infiltrative or neoplastic disease.

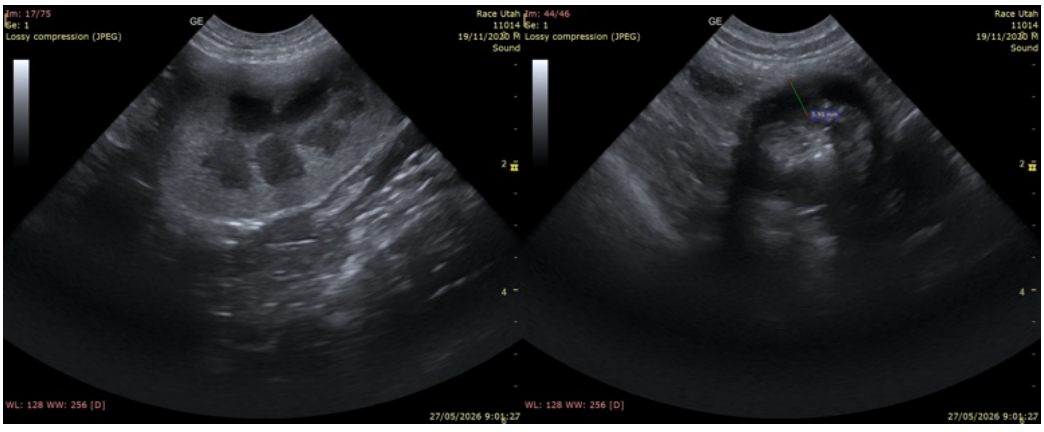
Additional mild muscularis-predominant intestinal thickening involving portions of the proximal small intestine and ileocecal junction may reflect concurrent chronic enteropathy/chronic inflammatory intestinal disease, although early low-grade infiltrative disease cannot be fully excluded ultrasonographically.

The mild renal cortical hyperechogenicity is nonspecific and may reflect mild/early chronic renal change. Given the reported concentrated urine and normal SDMA/BUN, the isolated creatinine elevation may not reflect clinically significant advanced renal dysfunction at this stage.

Recommendations

- Upper gastrointestinal endoscopy with pyloric biopsy sampling is strongly recommended for definitive characterization of the severe pyloric lesion. Surgical full-thickness biopsy may ultimately be required depending on endoscopic accessibility and histopathologic results.
- FeLV/FIV testing is also recommended if current retroviral status is unknown.

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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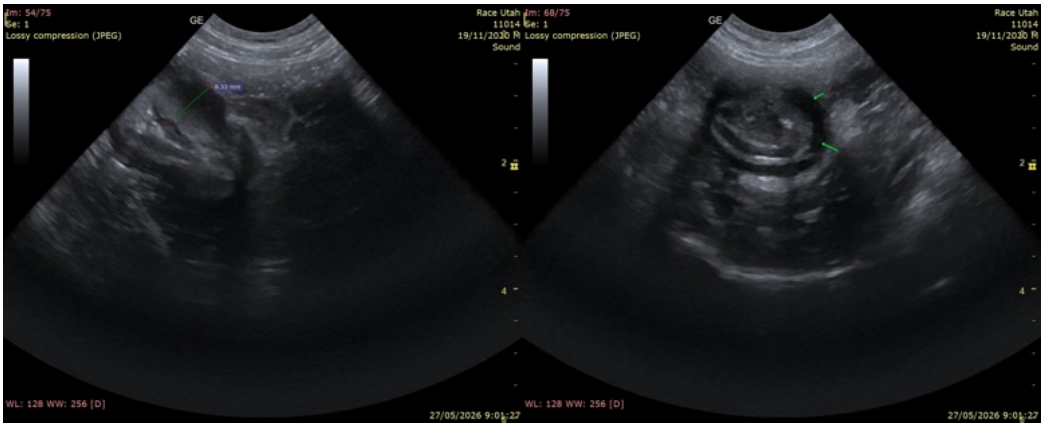

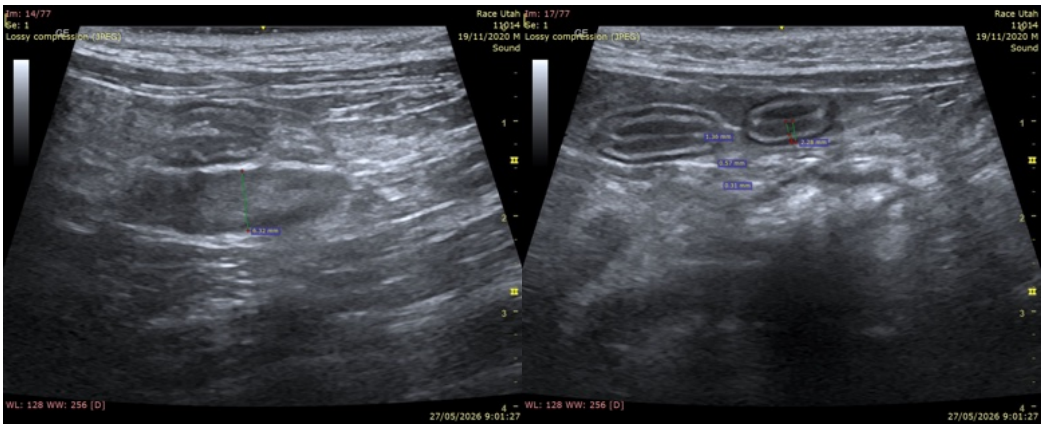

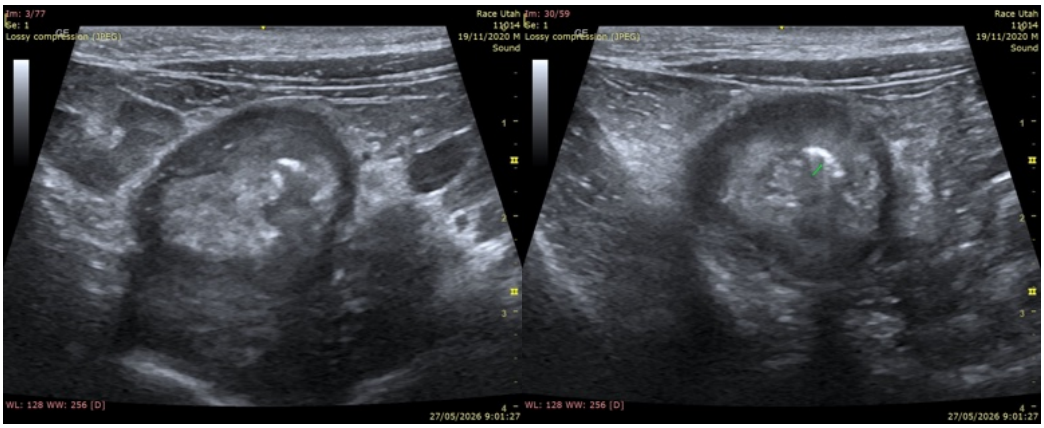

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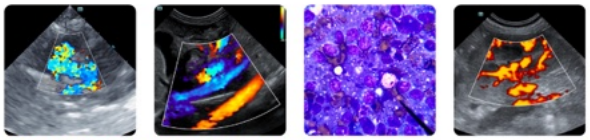

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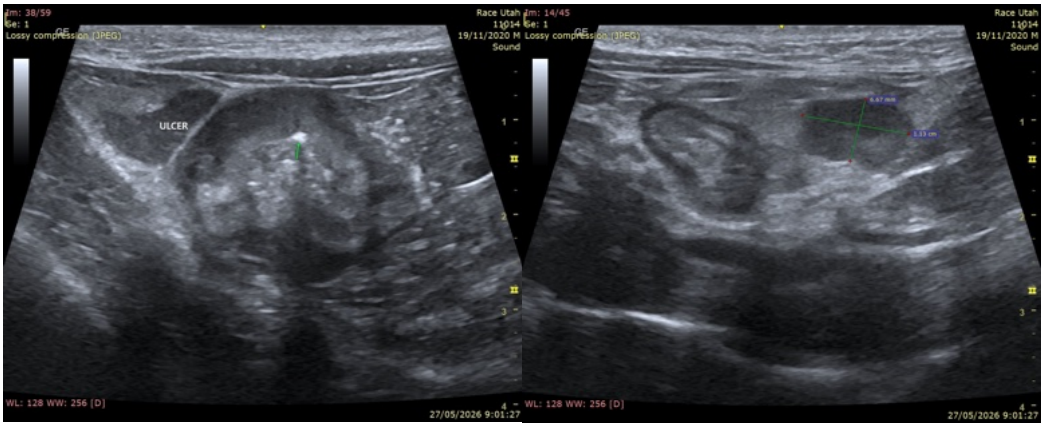

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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