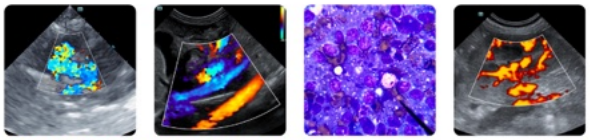


PATIENT

Minx Dannible

SPECIES

Feline

BREED

Domestic Medium Hair

SEX

Spayed female

AGE

16 years

WEIGHT

5.7 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Anshu Gupta

HOSPITAL NAME

Liverpool Village AH

REFERRING VET

Dr. Pinneo

INVOICE

78115

DATE

5/29/26

PRESENTING CLINICAL SIGNS

History: Long history of inappropriate defecation in home
Abdominal mass palpated on physical exam
1lb of weight loss in last ~8 months
Abnormal PE/Chem/CBC/UA Results: CBC/Chem last year NSF

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth, with a small 3.5 mm polypoid lesion arising from the wall. The urine is anechoic. Normal appearance of the bladder neck and proximal urethra. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.14x1.68 cm, and the thickness of the cortex is 0.25 cm, in the sagittal plane. The right kidney is normal in shape and size: 3.38x1.92 cm, and the thickness of the cortex is 0.30 cm, in the sagittal plane. Both: The cortex is slightly hyperechoic compared to the liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.30 cm at the cranial pole and 0.31 cm at the caudal pole. The right adrenal gland measures 0.33 cm at the cranial pole and 0.35 cm at the caudal pole.

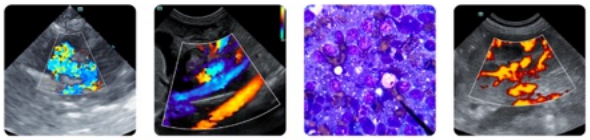
Spleen

Splenic thickness is 0.78 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

A cystic lesion measuring 3.0 x 3.5 cm is identified within the liver. The lesion has a thin wall and contains suspended internal echoes.

The gallbladder lumen is moderately distended. The wall is thin and the contents are primarily anechoic. No evident dilation of the cystic duct is observed. The common bile duct measures 4.12-3.52-1.94-1.24 mm.



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Gastrointestinal tract

The stomach is empty and folded, with mural thickness (1.63 mm) and preserved wall layering. The pylorus (3.98 mm). Duodenum: 2.52 mm. Jejunum: 3.04 mm. Mucosa: 1.37 mm. Submucosa: 0.58 mm. Muscularis propria: 0.98 mm. Ileum: 4.21 mm. Mucosa: 0.97 mm. Submucosa: 1.14 mm. Muscularis propria: 1.52 mm. Normal wall layering. The ileocecal junction measures 5.27 mm, with the muscularis measuring 2.63 mm. Colon: 0.96 mm, with scant fecal material.

Pancreas

Not confidently visualized.

Free Abdomen

No abdominal effusion or peritonitis is observed. Large masses are identified at the root of the mesentery on both sides of the cranial mesenteric artery, measuring at least 3 cm and 5 cm. These structures are heterogeneous with irregular margins and are considered most consistent with severely enlarged and markedly abnormal cranial mesenteric lymph nodes.

Marked spontaneous echogenic swirling ("smoke") is identified within the caudal vena cava, together with findings concerning for developing thrombus formation.

PRIMARY FINDINGS

- Marked thickening of the ileum and ileocecocolic junction, predominantly involving the muscularis layer.
- Severe mesenteric lymphadenopathy involving the cranial mesenteric lymph nodes (mass-like lesions).

SECONDARY FINDINGS

- Small polypoid lesion arising from the urinary bladder wall (3.5 mm).
- Mild bilateral renal cortical hyperechogenicity.
- Hepatic cystic lesion measuring approximately 3.0 x 3.5 cm with thin walls and suspended internal echoes.
- Marked spontaneous echogenic swirling ("smoke") within the caudal vena cava with suspected developing thrombus formation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Severe mesenteric lymphadenopathy associated with marked muscularis-predominant thickening of the ileum and ileocecocolic junction is highly concerning for alimentary neoplasia, with intestinal lymphoma considered the primary differential diagnosis. Metastatic involvement of the regional mesenteric lymph nodes is strongly suspected.

The marked echogenic swirling identified within the caudal vena cava, together with suspected

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thrombus formation, raises concern for a developing hypercoagulable state. In the context of suspected neoplasia, paraneoplastic thrombosis is a significant consideration.

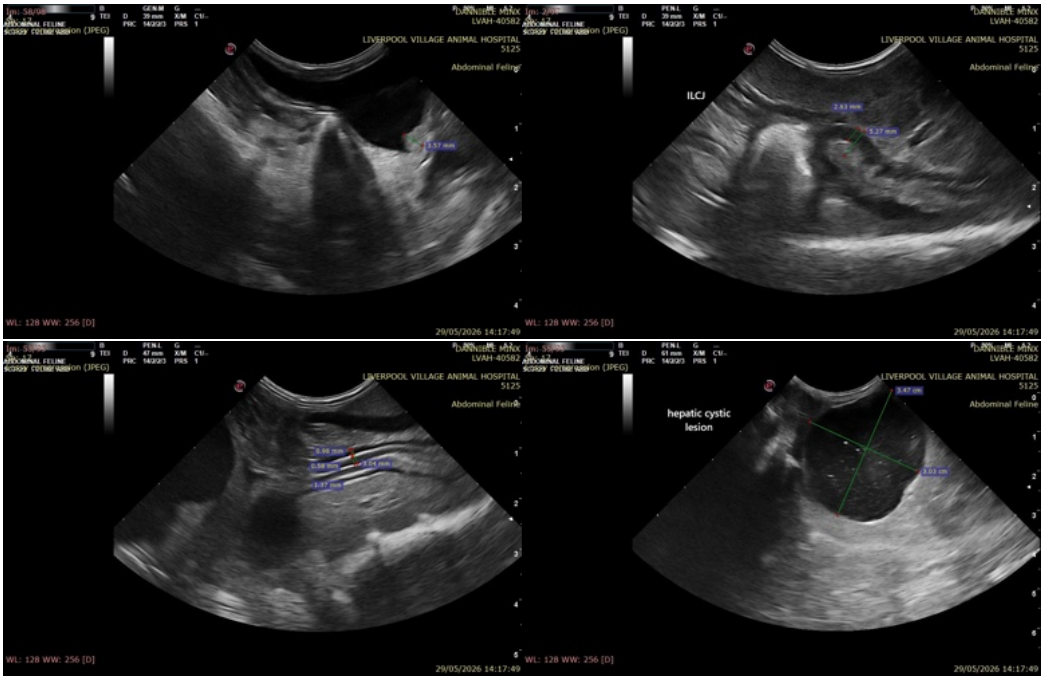
The hepatic cystic lesion is considered an incidental finding and may represent a benign hepatic cyst or chronic cavitary lesion containing proteinaceous or cellular debris. This lesion is not considered likely to explain the patient's clinical presentation.

The small urinary bladder polypoid lesion is of uncertain clinical significance and is considered an incidental finding relative to the major abdominal abnormalities.

Recommendations

- Fine-needle aspiration of the markedly enlarged mesenteric lymph nodes is likely to provide the highest-yield diagnostic sample.
- Careful assessment of the suspected caval thrombus is recommended. Antithrombotic therapy may be considered at the discretion of the attending clinician if thrombus formation is confirmed.
- Thoracic imaging may be considered for staging purposes if neoplasia is confirmed or strongly suspected.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status, the owner's goals of care, quality-of-life considerations, and willingness to pursue definitive diagnosis and treatment.



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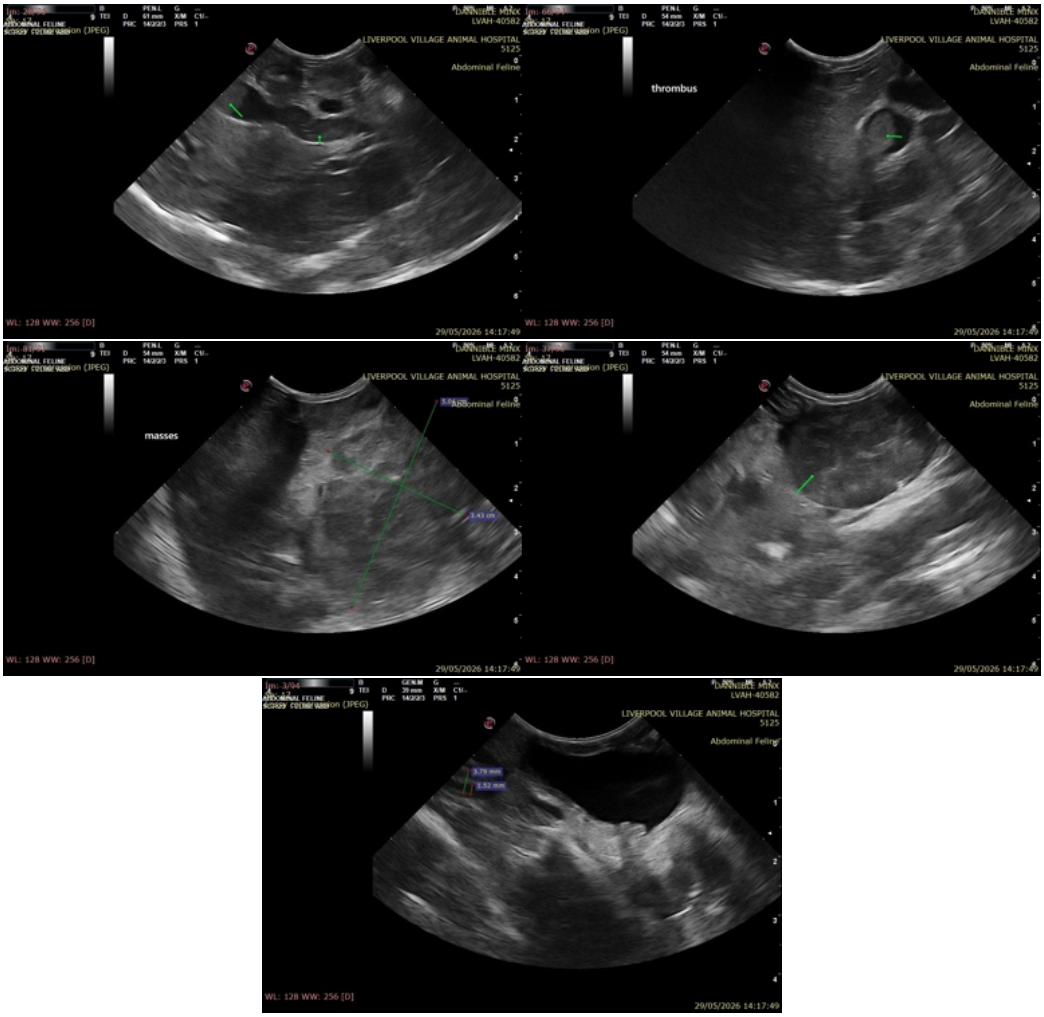

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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