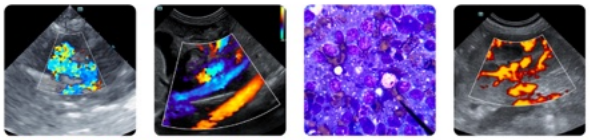


PATIENT

Bud Baca

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

9 years

WEIGHT

8.6 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Cassidy Stone

HOSPITAL NAME

Petroglyph AH

REFERRING VET

Dr. Cassidy Stone

INVOICE

75234

DATE

5/5/26

PRESENTING CLINICAL SIGNS

History: Chronic vomiting at least once daily the can be bile to undigested food. Vomiting progressed to having blood in it (regenerative anemia noted) at that time. Blood in vomit has resolved, but P still vomiting once daily. Anemia has resolved
Abnormal PE/Chem/CBC/UA Results: Elevated monocytes, basophils, eosinophils

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended. The urinary bladder wall is thin and smooth. The urine is anechoic. The bladder neck and proximal urethra are unremarkable. No cystoliths or sonographic evidence of inflammatory or neoplastic urinary bladder disease are identified.

The left kidney is normal in shape and size, measuring 3.86×2.57 cm. Cortical thickness measures 0.42 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.96×2.20 cm. Cortical thickness measures 0.40 cm in the sagittal plane. Both kidneys demonstrate mildly increased cortical echogenicity relative to the hepatic parenchyma, with mild medullary rim sign formation. Corticomedullary ratio and corticomedullary definition are preserved. No pyelectasia, hydronephrosis, or nephrolithiasis is identified. Color Doppler evaluation 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 0.31 cm at the cranial pole and 0.33 cm at the caudal pole. The right adrenal gland measures 0.32 cm at the cranial pole and 0.33 cm at the caudal pole.

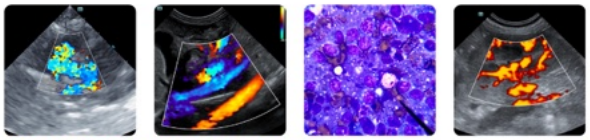
Spleen

Splenic thickness is 0.99 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 thin and the contents are primarily anechoic with a very small amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach is empty and folded. Gastric wall thickness measures 1.91 mm with preserved mural layering. The pyloric wall measures 2.81 mm. Duodenal wall thickness measures 2.69 mm. Jejunal wall thickness measures 1.50–1.59 mm with preserved mural layering. The ileum is diffusely abnormal, measuring up to 4.97 mm in wall thickness. Layer measurements include: Mucosa: 1.35 mm. Submucosa: 0.91 mm. Muscularis propria: 2.33 mm. Marked muscularis layer expansion is present with preserved mural layering in portions of the ileum. The muscularis-to-mucosa ratio is approximately 1.7, which is markedly increased relative to normal feline reference values. One segment of ileum demonstrates severe focal mural thickening up to approximately 1 cm with focal loss of normal mural stratification over an estimated length of approximately 6 cm. An additional ileal segment demonstrates mural thickening up to approximately 0.5 cm. The ileocecal junction demonstrates muscularis layer hypertrophy. No evidence of obstructive ileus or gastrointestinal foreign material is identified. Colonic wall thickness measures approximately 0.93–1.22 mm, with soft fecal material present within the lumen.

Pancreas

The evaluated pancreatic regions do not demonstrate sonographic evidence of overt pancreatitis or pancreatic mass lesions.

Free Abdomen

No abdominal effusion or sonographic evidence of peritonitis is identified.

The cranial mesenteric lymph nodes are enlarged, rounded, and hypoechoic, measuring approximately 1 cm in thickness. The ileocecal lymph nodes measure approximately 2.65–3.57 mm in thickness and retain normal shape and echogenicity.

The iliac trifurcation region is unremarkable.

PRIMARY FINDINGS

- Severe multifocal ileal mural thickening with marked muscularis layer expansion.
- Focal segmental loss of ileal mural stratification over an approximately 6 cm segment.
- Markedly increased ileal muscularis-to-mucosa ratio (~1.7).
- Muscularis hypertrophy at the ileocecal junction.
- Enlarged rounded hypoechoic cranial mesenteric lymph nodes.

SECONDARY FINDINGS

- Mild bilateral renal cortical hyperechogenicity with mild medullary rim sign formation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The severity and multifocality of the ileal lesions, including marked mural thickening, severe muscularis expansion, focal loss of mural stratification, and associated abnormal cranial mesenteric

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lymphadenopathy, are highly concerning for infiltrative intestinal neoplasia, particularly alimentary lymphoma. Although severe inflammatory enteropathy including eosinophilic enteritis cannot be completely excluded sonographically, the current ultrasonographic appearance is considered more strongly supportive of neoplastic intestinal infiltration.

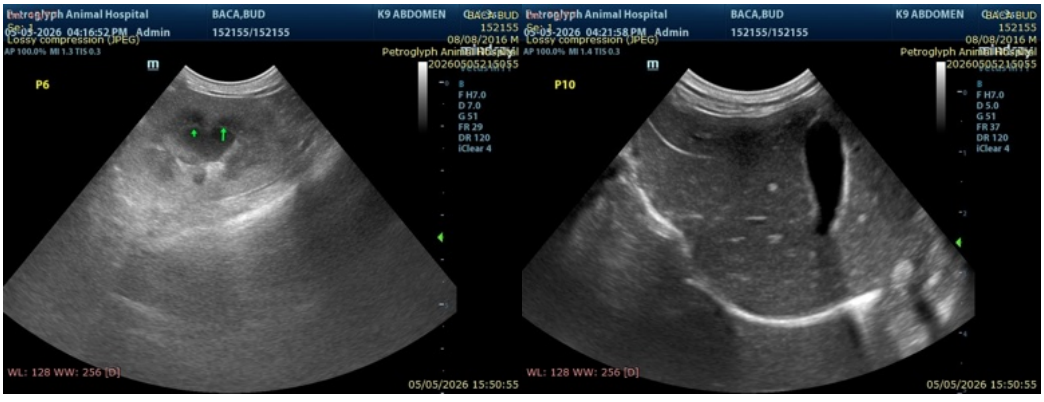
The peripheral eosinophilia and basophilia may be seen with eosinophilic or inflammatory enteropathies, however, similar hematologic abnormalities may also occur secondary to infiltrative intestinal neoplasia, particularly in the presence of mucosal ulceration and chronic intestinal inflammation. Therefore, the hematologic findings do not exclude alimentary lymphoma in this patient.

Mild bilateral renal cortical hyperechogenicity and mild medullary rim sign formation are nonspecific and may represent mild chronic renal change.

Recommendations

- Intestinal tissue sampling is recommended for definitive characterization of the ileal lesions. Surgical full-thickness biopsy would likely provide the highest diagnostic yield given the severity and transmural nature of the abnormalities.
- Fine-needle aspiration of the enlarged cranial mesenteric lymph nodes could also be considered, although cytology alone may not reliably differentiate inflammatory from lymphomatous disease.
- Correlation with serum cobalamin/folate concentrations may be clinically useful given the marked ileal involvement.

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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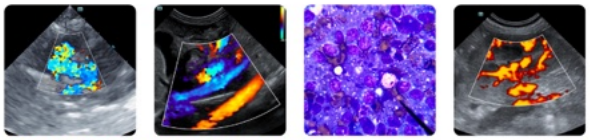

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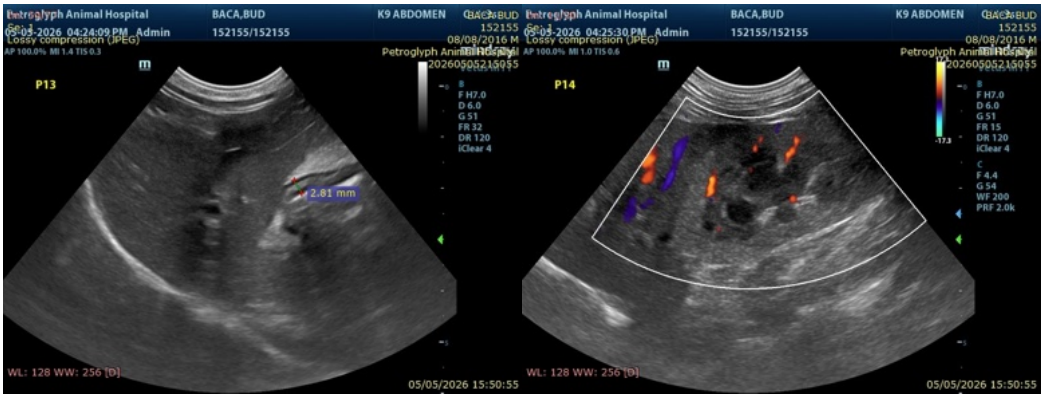

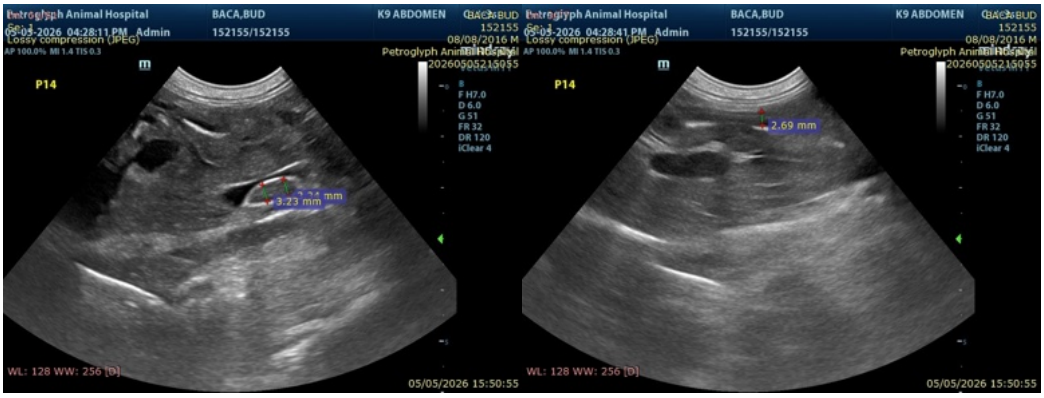

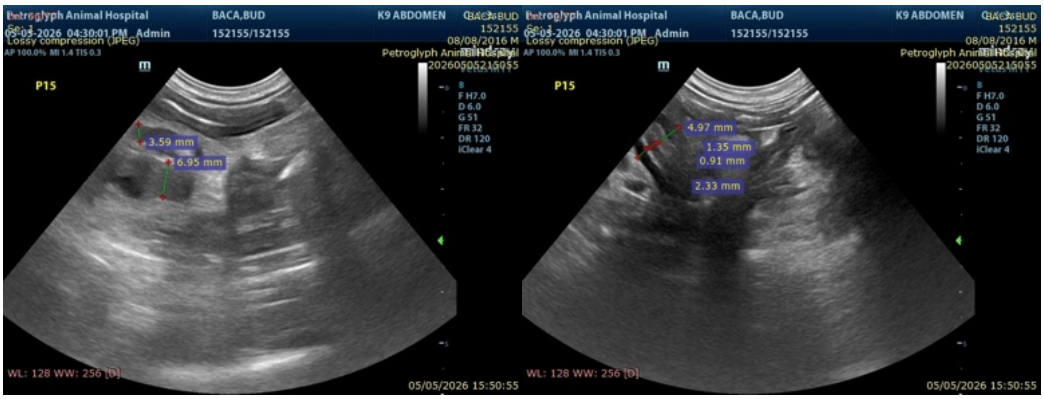

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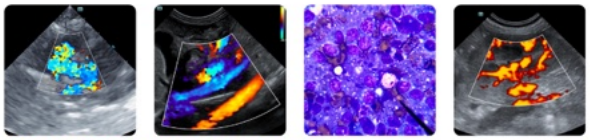

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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