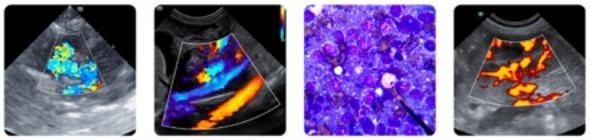

PATIENT

Bert Workman

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

12 years

WEIGHT

9.3 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Amanda Olsen, VMD

HOSPITAL NAME

Limestone VH

REFERRING VET

Dr. Olsen

INVOICE

75275

DATE

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PRESENTING CLINICAL SIGNS

History: Presented to pDVM 4/8/26 for a 4 day history of lethargy and anorexia and questionable PU/PD. Work up at that time was normal (see below) and patient was given Cerenia, SQ fluids, and Vitamin B12 injections. She was sent home with transdermal mirtazepine, prednisolone, and Clavamox. O reports patient improved until finishing the Clavamox (timeline of finishing clavamox coincides with 3 days after dropping pred dose from 5 mg/day to 2.5 mg/day). Now owner reports patient is lethargic, decreased appetite, decreased thirst, decreased urination/defecation. Finished pred 3 days ago. Vomited several times last night. Has lost 3.5 lbs in past 5 months.
Abnormal PE/Chem/CBC/UA Results: 4/8/26: Normal CBC/Chem/T4/UA. Urine well concentrated at 1.060 with quiet sediment. Abdominal radiographs: No foreign material, obstructive pattern, or obvious masses noted. 5/7/26: Blood pressure: 160/154/160 mmHg

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 predominantly turbid with mineral suspended echoes. 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 3.45×2.22 cm. Cortical thickness measures 0.31 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. Corticomedullary ratio and corticomedullary distinction are preserved. No pyelectasia, hydronephrosis, or nephrolithiasis is identified.

The right kidney is normal in shape and size, measuring 3.58×2.20 cm. Cortical thickness measures 0.30 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. Corticomedullary ratio and corticomedullary distinction are preserved. No pyelectasia, hydronephrosis, or nephrolithiasis is identified.

Adrenal Glands

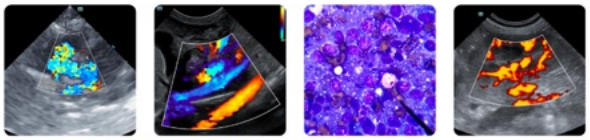
Not confidently visualized.

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

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.



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The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal Tract

The stomach is empty and folded, with mural thickness measuring approximately 1.83 mm and preserved mural layering throughout most evaluated regions. However, there is a markedly thickened gastric segment measuring approximately 6.40–7.0 mm in thickness. Although mural layering appears at least partially preserved throughout much of this region, there are more focal areas in which mural layer definition becomes poorly distinguishable. Mild surrounding perigastric fat reactivity is also identified.

Additionally, a severely thickened gastric outflow region/pyloric region is identified, with mural thickness measuring approximately 0.91–1.25 cm. It cannot be determined with confidence whether these findings represent multifocal gastric involvement affecting both the pyloric and adjacent gastric body/fundic regions, but they seem connected.

Duodenal wall thickness measures approximately 1.96 mm. Jejunal wall thickness measures approximately 2.27 mm, with mucosa measuring 1.65 mm, submucosa 0.62 mm, and muscularis propria 0.29 mm. Ileal wall thickness measures approximately 1.91 mm, with mucosa measuring 0.78 mm, submucosa 0.98 mm, and muscularis propria 0.41 mm. Preserved mural layering is identified throughout the small intestinal tract.

The ileocecal junction is not confidently visualized.

Colonic wall thickness measures approximately 0.42–0.93 mm, with small amounts of formed fecal material present within the descending colon.

Pancreas

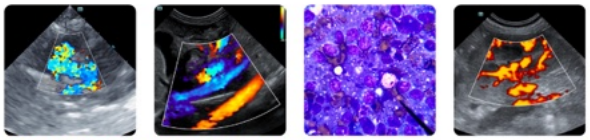
The evaluated pancreatic regions do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

No abdominal effusion peritonitis is identified. Cranial mesenteric and ileocecal lymph nodes are not confidently visualized, although the surrounding mesenteric regions appear unremarkable. A rounded hypoechoic gastric lymph node measuring approximately 0.63×0.73 cm is identified. The iliac trifurcation region is unremarkable.

PRIMARY FINDINGS

- Marked focal-to-segmental gastric mural thickening with multifocal loss/reduction of mural layer definition.
- Severe thickening of the pyloric/gastric outflow region.
- Mild perigastric fat reactivity.
- Enlarged rounded hypoechoic gastric lymph node.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Marked focal-to-segmental gastric mural thickening is present, including severe involvement of the pyloric/gastric outflow region, together with focal reduction/loss of mural layer definition, mild perigastric inflammatory reactivity, and regional gastric lymphadenopathy.
Overall, the findings are highly concerning for infiltrative gastric disease. Primary differential considerations include gastric neoplasia (particularly lymphoma or adenocarcinoma) versus severe focal granulomatous/inflammatory gastritis. The degree of mural thickening and focal architectural disruption are more severe than would typically be expected with mild nonspecific gastritis alone.

No sonographic evidence of intestinal obstruction, diffuse small intestinal infiltrative disease, pancreatitis, or metastatic abdominal disease is identified on the current examination.

Given the patient's history of weight loss, anorexia, vomiting, and temporary clinical response to corticosteroid therapy, infiltrative inflammatory disease and alimentary lymphoma remain important differential considerations.

Recommendations

- Endoscopic evaluation with gastric biopsies is strongly recommended if clinically feasible.
- If endoscopic biopsies are nondiagnostic and clinical concern remains high, full-thickness surgical biopsies may ultimately be required for definitive characterization.
- Cytologic sampling of the regional gastric lymph node is likely to be technically challenging due to its small size and deep location and may therefore have limited diagnostic utility compared with gastric biopsy.
- Supportive management for nausea, gastric inflammation/ulceration, and nutritional support is recommended pending definitive diagnosis.

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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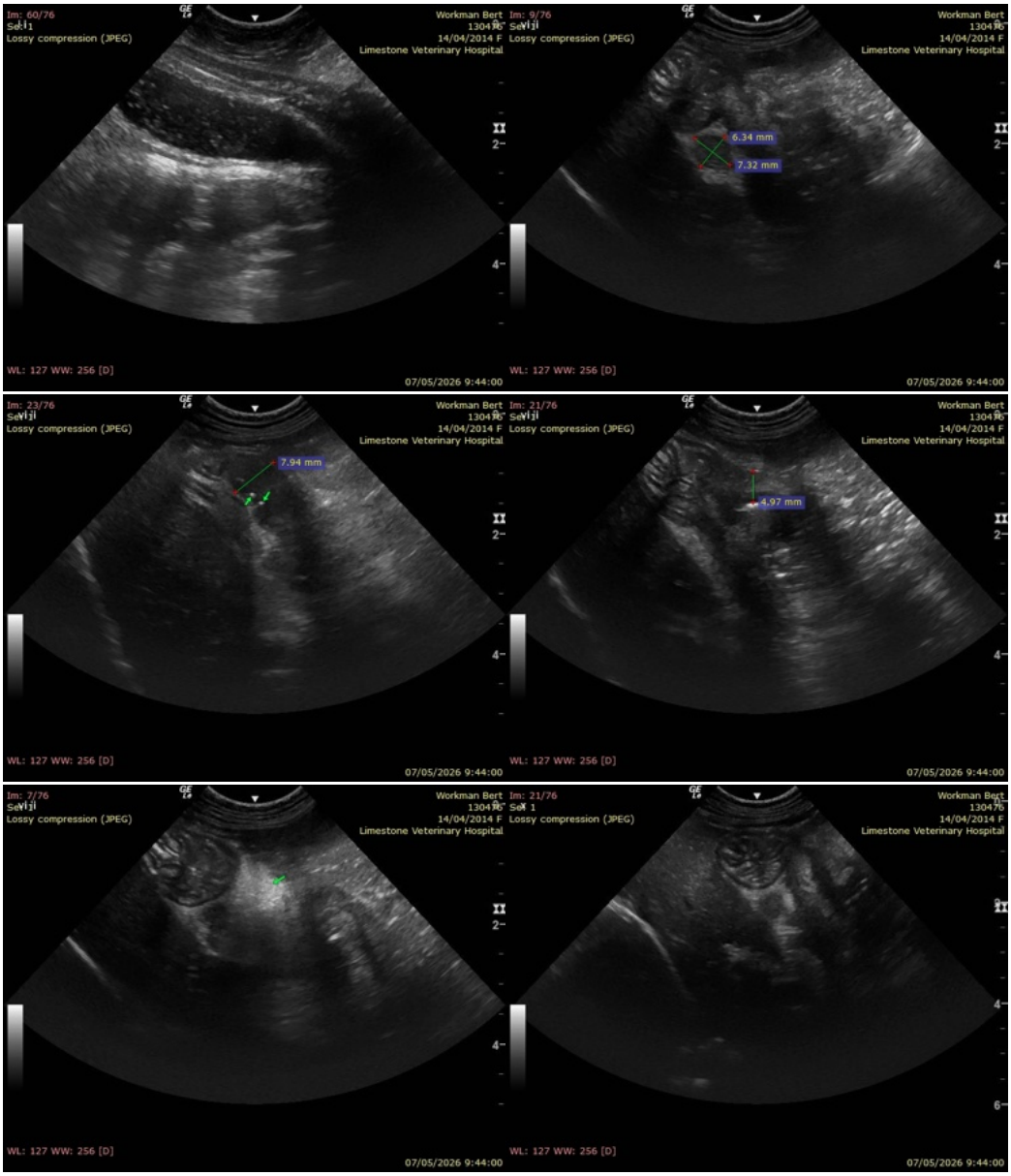

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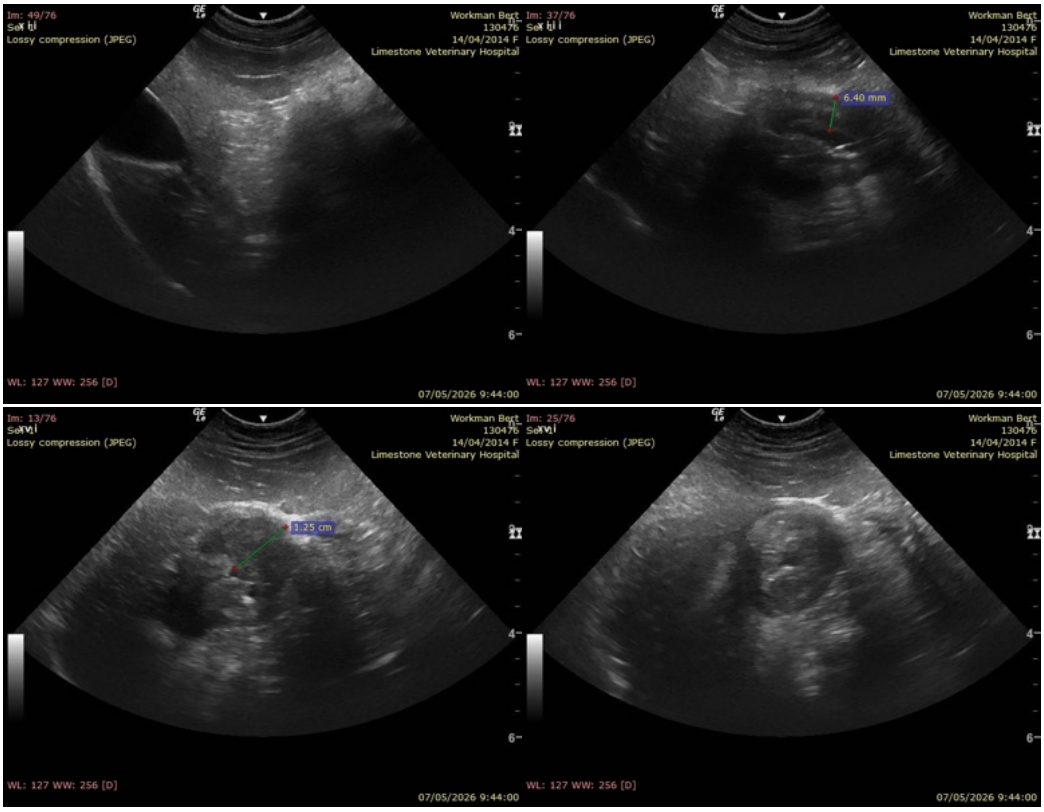

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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