



PATIENT

Jinger Ribeiro

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

10

WEIGHT

6.2 Pounds

INTERPRETED BY

Karen Ebersole, DVM,
DABVP (Canine and
Feline practice)

IMAGING PERFORMED BY

Dr. Brittani Nicolaci

HOSPITAL NAME

Bradenton VH

REFERRING VET

Dr. Brittani Nicolaci

INVOICE

35691

DATE

11/28/25

PRESENTING CLINICAL SIGNS

History: 10 fs dsh presents for several week history of losing weight despite regular appetite. has been lower energy. 2lb weight loss since 6/2025. indoor only cat. lives with other indoor only cat (4yo) who has no symptoms. previous FeLV/FIV test negative.

Abnormal PE/Chem/CBC/UA Results: albumin 1.9 (low), globulin 6.5 (high), TP 8.4 (high), calcium 7.6 (low), total bilirubin 0.6 (high), neutrophils 19.9 (high), WBC 22.94 (high).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder was normal in size and shape. The bladder wall was normal in thickness for the volume of urine present. The bladder contents were anechoic with echogenic sediment, without visible discrete urolith formation. There was no visible inflammation in the bladder or urethra. The urethra was visualized to a distance of 2.0 cm beyond the cystourethral junction.

Both kidneys were of a normal size and shape, with a smooth capsule contour. A normal 1:3 cortex to medulla ratio was maintained. The echogenicity of the cortex was normal. There was a hyperechoic corticomedullary band, consistent with a medullary rim sign. The left kidney measured 3.7 cm in length. The right kidney measured 3.3 cm in length.

This is a nonspecific finding that can be seen in both normal and abnormal kidneys. When associated with pathology, it has been associated with interstitial kidney disease, hypercalcemia, tubular necrosis and FIP. However, it can be seen in normal kidneys.

There was evidence of old renal infarcts in both kidneys. There was no active inflammation visible.

Adrenal Glands

The adrenal glands were not clearly visualized. The region of the adrenals appeared free of overt pathology.

Spleen

The spleen was subnormal in size (0.4 cm in width at the hilus), likely due to volume contraction. The capsule was smooth with homogenous parenchyma.

Liver/Gallbladder

The liver was normal in size with a smooth capsule contour. The hepatic parenchyma was coarse with a mild increase in portal markings. The hepatic vasculature was normal in volume and structure. There was no distinct nodules or masses present.

The gallbladder was normal size and shape, with echogenic, non-mineralized biliary sludge. The wall was normal thickness with no visible inflammation. The cystic duct and common bile ducts were normal in size with no evidence of obstruction. The common bile duct measured 0.16 cm in width.

Gastrointestinal



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The stomach was normal in size and shape, with a smooth serosal contour. The stomach wall was normal in thickness and layering. The small intestine displayed normal curvilinear patterns throughout. Subjectively normal wall thickness and layering was maintained. The visible colon wall was normal in thickness and layering. There were no visible masses or focal lesions in the GI tract.

Pancreas

The pancreas was isoechoic to the surrounding mesentery with normal size, shape and capsule contour. There was no evidence of inflammation or masses within the right and left limbs or body of the pancreas.

Free Abdomen

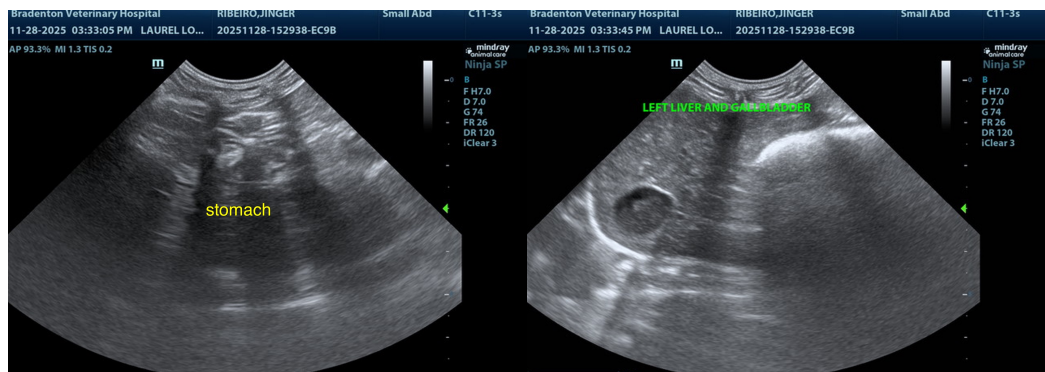
A small volume of cellular peritoneal effusion was present. The mesentery was hyperechoic and irregular with a diffuse nodular pattern.

ULTRASONOGRAPHIC FINDINGS

- Peritoneal effusion, small volume
- Medullary rim sign both kidneys with evidence of old cortical infarcts
- Gallbladder sludge, mild, with no evidence of EHBDO
- Urinary bladder sediment, mild- correlate with urinalysis for clinical significance

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the vague clinical signs, elevated white blood cell count, low A:G ratio of 0.29, and peritoneal effusion, I'm concerned for the possibility of FIP. Sampling of the abdominal fluid (if accessible) could be done for fluid analysis, as well as submitted for an FIP PCR test. The total bilirubin and red blood cell count should be monitored going forward to assess for possible early IMHA, possibly secondary to infectious disease. Liver enzymes should be monitored as well to assess for hepatic causes of elevated bilirubin.





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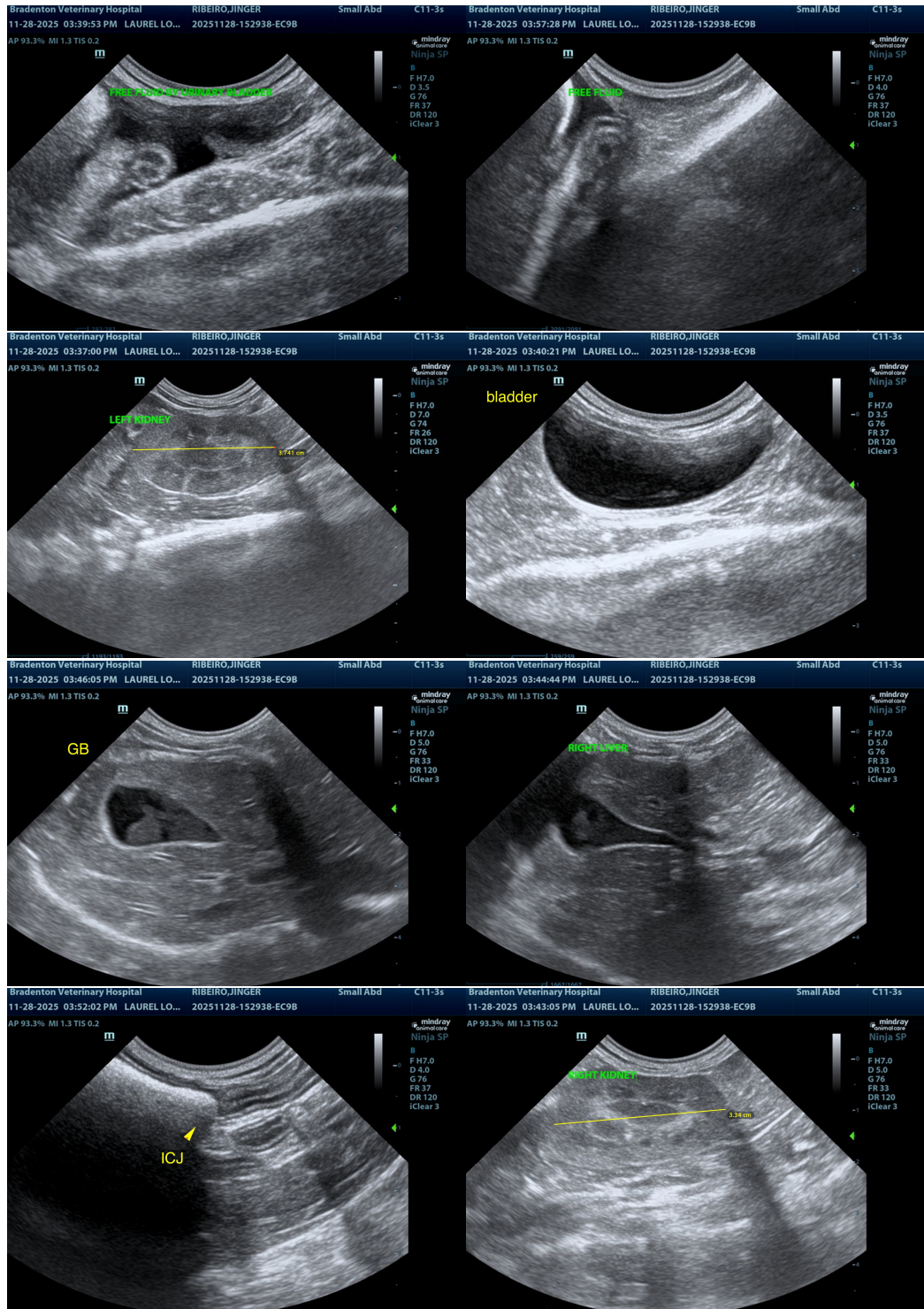
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Karen Ebersole, DVM, DABVP (Canine and Feline practice)

info@SonoPath.com