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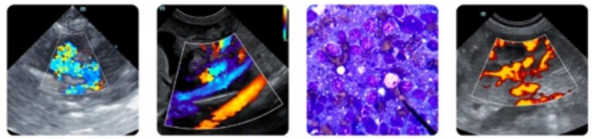


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Pedey Flaherty

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

12 years

WEIGHT

9.36 lbs

INTERPRETED BY

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM

IMAGING PERFORMED BY

Danielle Shemanski DVM, MA

HOSPITAL NAME

Western New York VS

REFERRING VET

Bob Lann, DVM

INVOICE

70146

DATE

1/14/26

PRESENTING CLINICAL SIGNS

History: RDVM REASON FOR REFERRAL: Gradual weight loss over the past three years, from 10.5 lbs to 9.3 lbs. Pedey is reported to be CKD stage 1. The cat does gain weight when on 5 mg of prednisolone once a day. He was last on prednisolone in June of last year. He has a history of FLUTD & diagnosed in 2019 with crystals. He also has a history of what the owner describes as stress-induced cystitis. This has resolved with the use of a Feliway diffuser. Prior to using Feliway, he would have episodes of loud meowing, followed by vomiting and urination. He has a history of vomiting, which occurs in phases. He is currently in a period of increased vomiting. Stools are reported to be firm and regular. MEDICATIONS: None
Abnormal PE/Chem/CBC/UA Results: Abnormal bloodwork (1/13/2026): LYM 0.69 K/μL (0.92-6.88) LOW EOS 0.15 K/μL (0.17-1.57) LOW

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is full with a normal thickness and smooth appearance of the wall. A small amount of floating, hyperechogenic sediment.

Normal appearance of the trigone area, proximal urethra, and iliac blood vessels.

Normal appearance and size of the iliac lymph nodes. Ureters not visualized, which can be considered a normal finding.

Normal renal size (left measured 4.2 cm, right measured 4.1 cm), architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident. Normal color flow pattern is evident in both kidneys.

Adrenal Glands

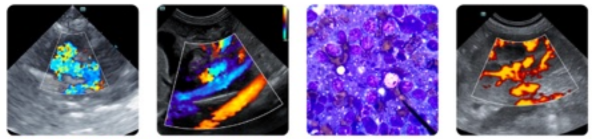
Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 0.35 cm in width. The right adrenal gland measured 0.34 cm in width.

Spleen

Normal size and echogenic appearance. Smooth homogenous parenchyma and regular curvilinear capsule. Normal volume of the splenic vasculature without any overt congestion or thrombosis evident. No inflammatory, neoplastic, infarction, or infiltrative changes evident. The spleen measured 0.8 cm in width.

Liver

Normal size, echogenic appearance, portal markings, and regular curvilinear capsule. No nodules or masses evident. Normal appearance of the hepatic and portal vasculature.



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Gallbladder

The gallbladder is full containing a small amount of non-adhered, hyperechogenic sediment. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.

Gastrointestinal

Normal appearance of the stomach, duodenum, ileo-cecal junction, and colon with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen. Normal thickness of the small intestine (up to 0.25 cm) with no loss of layering, but with an increase in the muscularis to mucosa ratio, normal peristaltic activity and no distension of the lumen.

Pancreas

Normal size with an increased echogenic appearance and an irregular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Normal mesenteric lymph nodes.

No ascites evident.

Thorax

Normal appearance of the heart. No pericardial or pleural effusion evident.

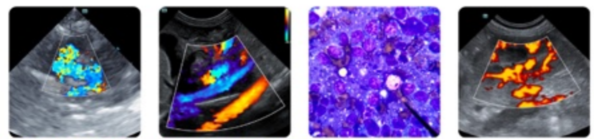
ULTRASONOGRAPHIC FINDINGS

- Enteropathy.
- Chronic pancreatitis versus pancreatic fibrosis.
- Urinary bladder sediment.
- Gallbladder sediment.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiologies for the enteropathy would be parasitic enteritis, dietary hypersensitivity and inflammatory bowel disease with emerging lymphoma a less likely differential diagnosis.

Etiologies for the urinary bladder sediment would be incidental debris, hematuria and possibly bacterial cystitis.



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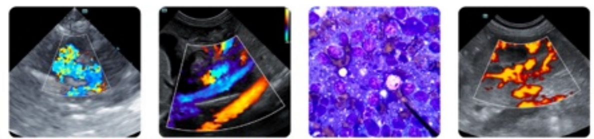
The gallbladder sediment can be considered an incidental finding. Further assessment would be urine and fecal analysis, possibly urine culture, cobalamin, folate and FPL/PSL assay and endoscopy of the upper GI tract with biopsies.

Specific therapy would be dependent on an etiological diagnosis.

Symptomatic management that could be considered would be feeding a novel protein/hypoallergenic diet, course of Fenbendazole, cobalamin supplementation and if there is still not a satisfactory improvement then a course of Prednisolone would then be indicated.



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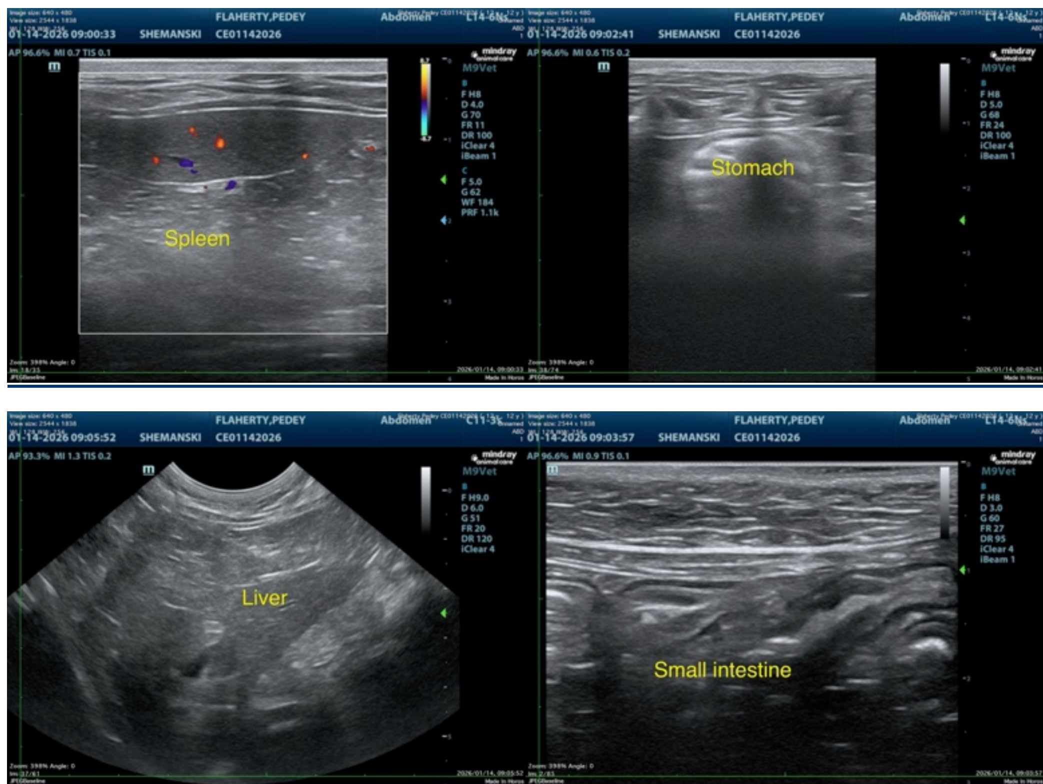

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)

info@sonopath.com