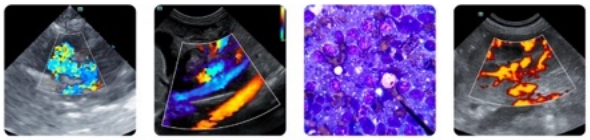


PATIENT

Cali Rossi

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

14 years

WEIGHT

6.72 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Amanda Olsen

HOSPITAL NAME

Limestone VH

REFERRING VET

Dr. Olsen

INVOICE

68521

DATE

11/10/25

PRESENTING CLINICAL SIGNS

History: Patient presented in early 2022 with a history of weight loss and chronic vomiting. AUS was suspicious of possible Inflammatory Bowel Disease. The patient was started on prednisilone and has done well, but O has noted PU/PD ever since starting pred. Recently, O has been giving Pred 5 mg once daily to every other day but notes a distinct drop in appetite if they miss a dose. Presented 2 months ago with complaints of anorexia x 2 days, persistent PU/PD, and weight loss. Submitted BW and instructed O to continue Pred 5 mg SID and switch from Fancy Feast to a hypoallergenic diet. Patient would not eat hypoallergenic diet and is still eating Fancy Feast. Patient is vomiting occasionally. Suspect IBD, but concern for progression to lymphoma vs. pancreatitis Weight: 11/24: 10.74lbs 5/25: 10.26 lbs 9/25: 8.78 lbs 11/25: 6.72lbs
9/25: Na 159, PSL 27, Lymph 1066, Eos 1230, USG 1.047, 1+ protein, 1+ blood, RBC 4-10, UPC 0.2

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is full with a normal thickness and smooth appearance of the wall. Normal anechoic urine with no sediment or uroliths evident.

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 3.3 cm, right measured 4.8 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. Mild, bilateral, corticomedullary rim sign was noted.

Adrenal Glands

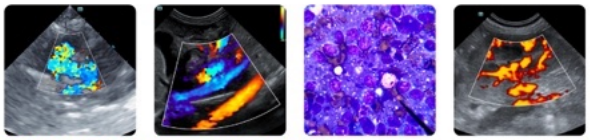
The left adrenal gland is normal in shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 0.3 cm in width. The right adrenal gland was not clearly visualized, but appears to be of normal shape, echogenic appearance and size.

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 0.6 cm in width.

Liver

Normal size, echogenic appearance, portal markings, and regular curvilinear capsule. Small, focal, hypoechogenic parenchymal nodule measuring 0.6 cm in the left lobe. Normal appearance of the hepatic and portal vasculature.



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Gallbladder

The gallbladder is full containing normal anechoic bile. 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. The small intestine had normal thickness with no loss of layering, but with mild segmental increase in the muscularis to mucosa ratio, normal peristaltic activity and no distension of the lumen. A moderate amount of ingesta is present in the stomach and chyme is present in the proximal small intestine. Both are compatible with a recent meal.

Pancreas

The pancreas was poorly visualized, but the visible sections of the pancreas are of normal size and echogenic appearance with a regular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Enlarged mesenteric lymph nodes measuring up to 0.6 x 2.1 cm in size.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

- Enteropathy.
- Mesenteric lymphadenomegaly.
- Corticomedullary rim sign.
- Hepatic nodule.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiologies for the enteropathy would be inflammatory bowel disease, parasitic enteritis, dietary hypersensitivity and possibly emerging lymphoma (which is being masked by the Prednisolone therapy).

Etiologies for the mesenteric lymphadenomegaly would be reactive hyperplasia, lymphadenitis and infiltrative neoplasia.

The hepatic nodule can be considered an incidental finding representing nodular hyperplasia.

Although the corticomedullary rim sign may merely be a reflection of the patient's age, it has been associated with bacterial nephritis, lymphoma and granulomatous disease.

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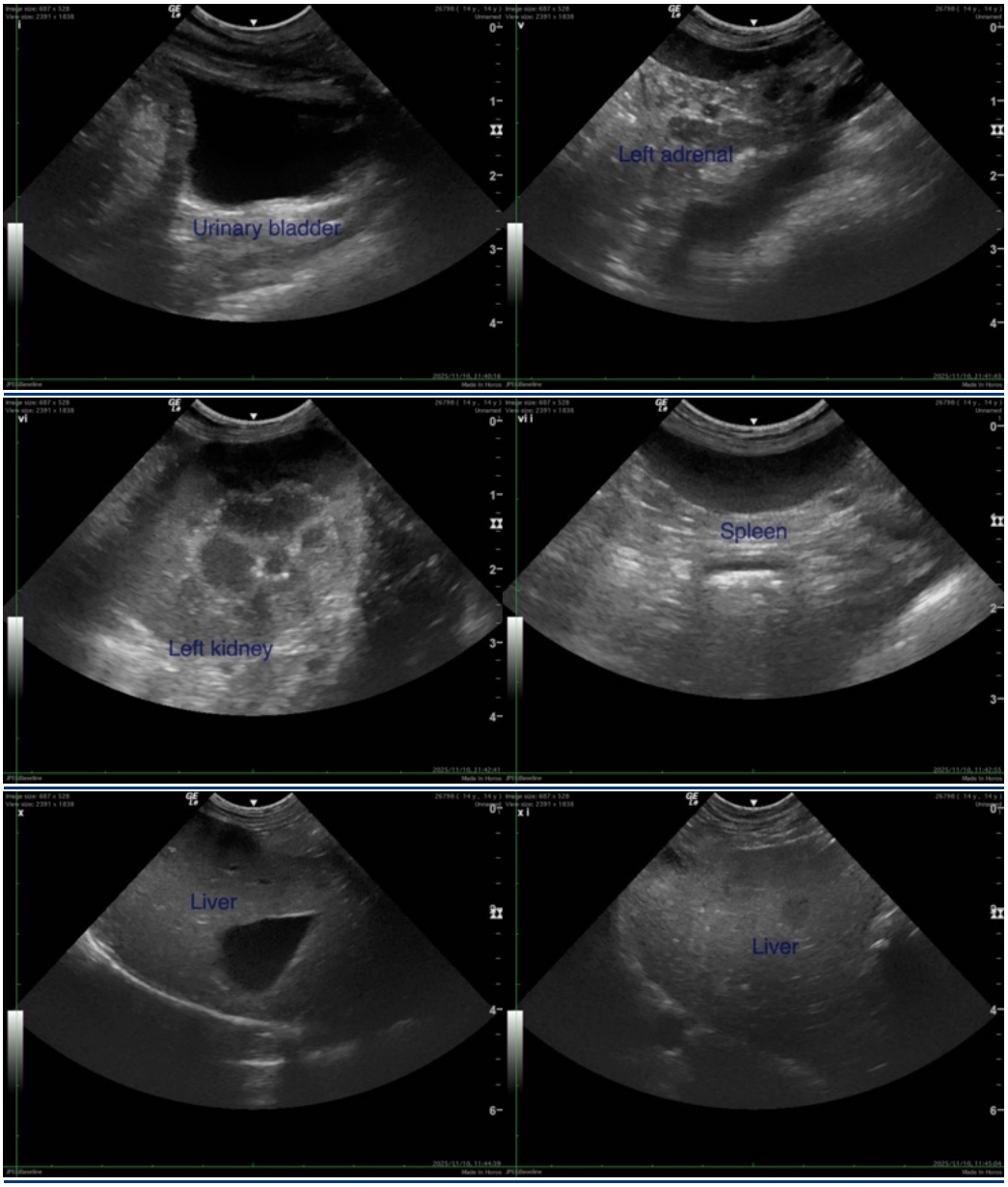
Further assessment would be urine and fecal analysis, possibly urine culture, cobalamin and folate assay and endoscopy of the upper GI tract with biopsies. FNA cytology of the mesenteric lymph nodes can also be considered.

Further specific therapy would be dependent on an etiological diagnosis. Symptomatic management would be to continue with the Prednisolone or possibly change to Budesonide, cobalamin supplementation, course of Fenbendazole and a daily feed of hypoallergenic/novel protein diet.



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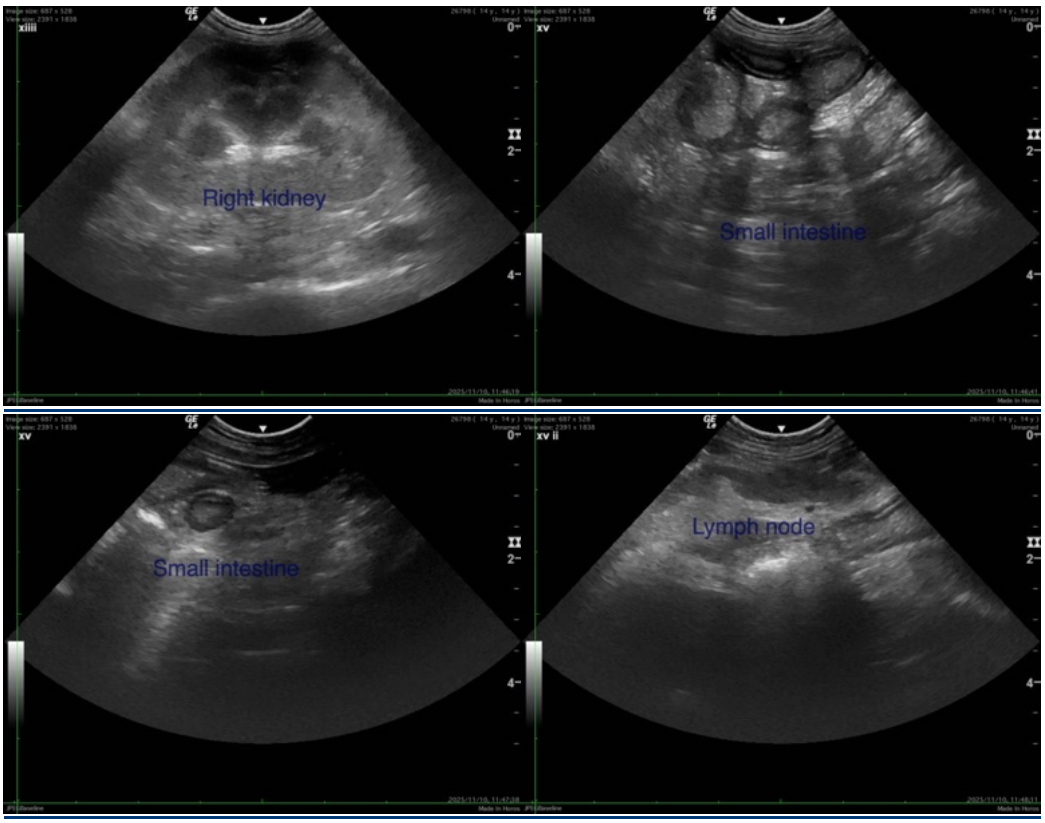

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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