



PATIENT

Indy Rydell

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years

WEIGHT

9.1 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

Harmony Animal
Hospital

REFERRING VET

Dr. Eppler

INVOICE

12406

DATE

11/21/25

PRESENTING CLINICAL SIGNS

BCS 3/9. 11/18/25 1 mo hx PU/PD, weight loss, intermittent V+, icterus, placed feeding e-tube.

Current Meds: Amoxi 100ml bid; Famotidine 5mg sid; Denamarin 90mg sid; Prednisolone 5mg sid; a/d via E-tube-25ml qid. (rads attached)

Abnormal PE/Chem/CBC/UA Results: Tbil 4.9; ALP 356; GGT 9; USG: 1.018

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Full urinary bladder 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, architecture, echogenic appearance, some loss of cortico-medullary differentiation, bilateral pyelectasia and an irregular capsule. No infarcts, mineralization or renoliths evident. The left kidney measured 3.9 cm in length. The right kidney measured 4.2 cm in length. Normal color flow pattern was evident in both kidneys.

Adrenal Glands

Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. The left adrenal gland measured 0.33 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 0.90 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.

Gallbladder

Small containing normal anechoic bile. Thickened and hyperechogenic 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 with no loss of layering but with segmental increase in



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the muscularis: mucosa ratio. Normal peristaltic activity and no distention of the intestinal lumen. Fecal material was present within the colon.

Pancreas

Enlarged with a hypoechogenic appearance and an irregular capsule. Hyperechogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Normal mesenteric lymph nodes.

Small amount of ascites evident.

Diffuse hyperechogenic appearance of the mesentery.

ULTRASONOGRAPHIC FINDINGS

- Pancreatitis.
- Enteropathy.
- Mesenteric inflammation with ascites.
- Age-related renal changes versus early chronic kidney disease.
- Previous cholecystitis.
- Shadowing mass within the intra-abdominal fat.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiologies for the enteropathy would be secondary to the pancreatitis, parasitic enteritis, dietary hypersensitivity and inflammatory bowel disease. The mesenteric inflammation with the ascites can be described as secondary to the pancreatitis. Although the pyelectasia may be associated with the renal changes, underlying low-grade pyelonephritis should still be considered. A shadowing region within the intra-abdominal fat is consistent with a Bates body which can be clearly visualized on the abdominal radiograph.

Further assessment would be fecal analysis, urine culture and fPL/PSL assay.

Specific therapy would be dependent on an etiological diagnosis. Symptomatic management would be to continue with the current therapy but to change to a low-fat intestinal type diet and add analgesics and antiemetics. Once the pancreatitis has resolved and there is still not a satisfactory improvement, then further assessment of the enteropathy would be cobalamin and folate assay and endoscopy of the upper GI tract with biopsies.



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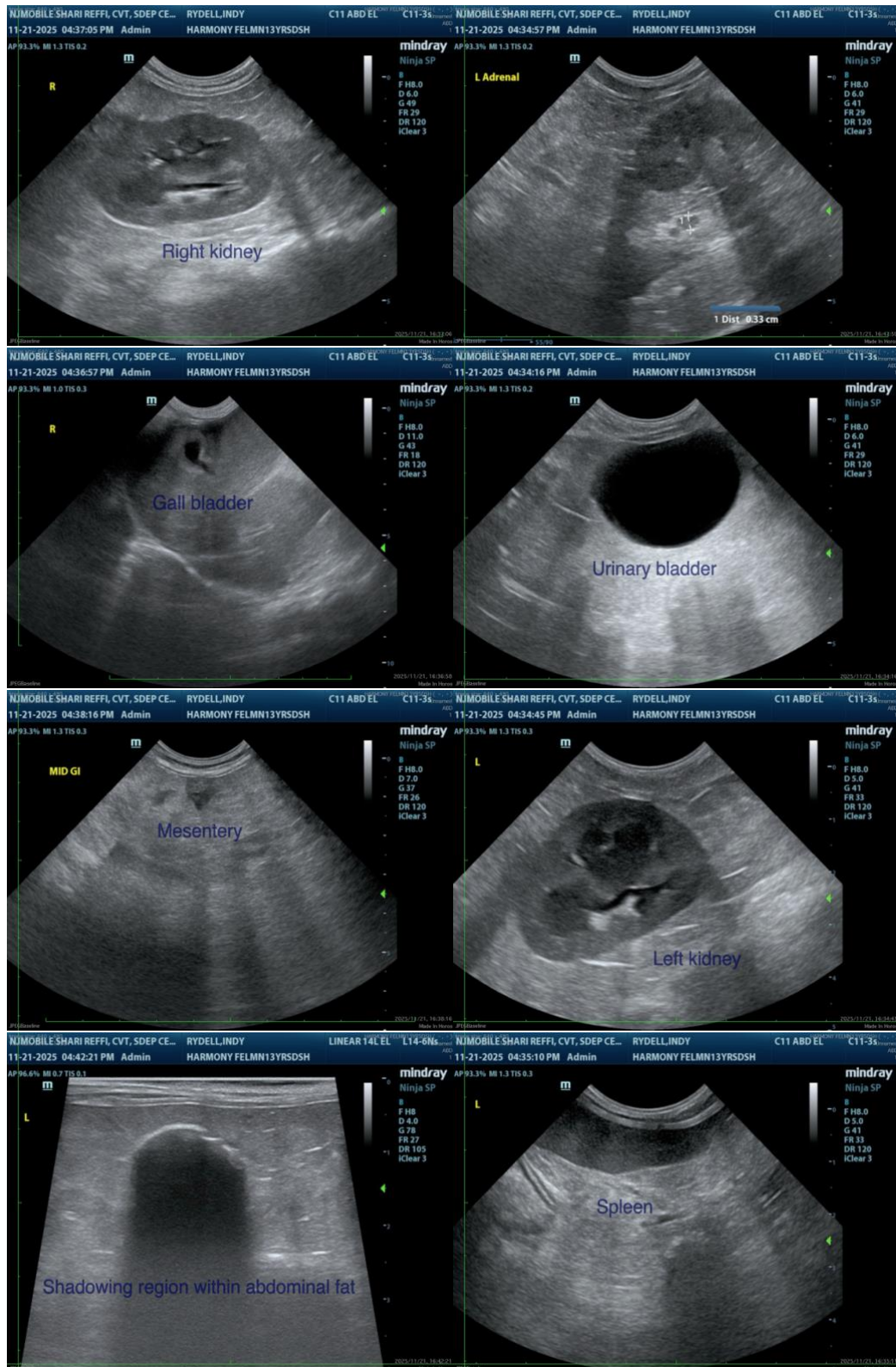
Dr. Epplé

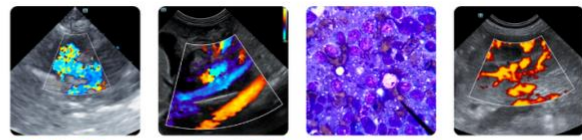
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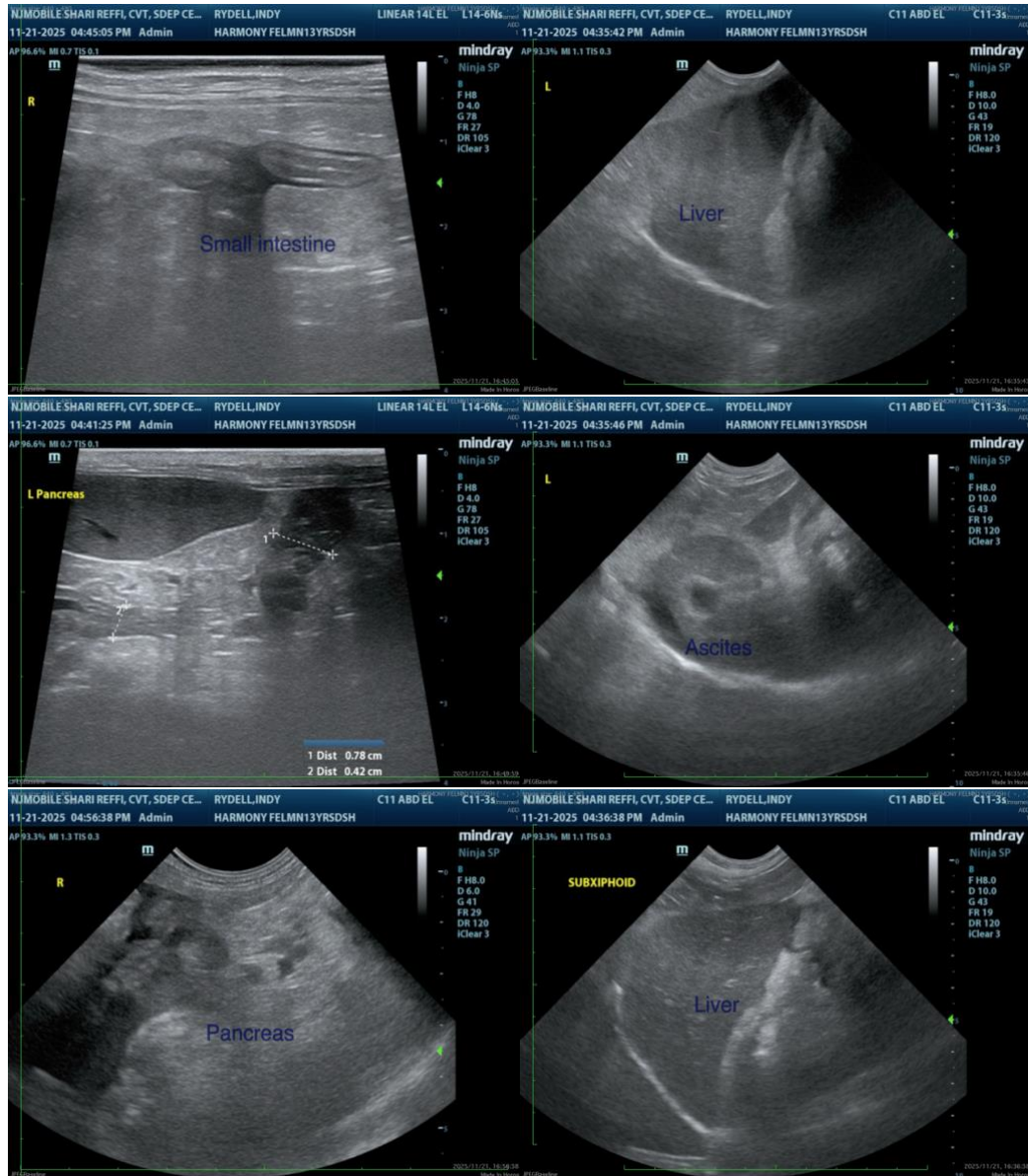
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@sonopath.com