

PATIENT

Whitney Graham

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

2012

WEIGHT

5.4 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Denise Bruno, LVT,
RDMS

HOSPITAL NAME

Ideal Pet Vet

REFERRING VET

Dr. Kolta

INVOICE

69557

DATE

12/23/25

PRESENTING CLINICAL SIGNS

History: Not eating. Newly T4 medications. Labs attached

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is full with a normal thickness and smooth appearance of the wall. A scant 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, 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. The left kidney measured 3.1 cm. The right kidney measured 3.4 cm.

Adrenal Glands

Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. The left adrenal gland measured 0.73 cm in length x 0.49 cm in width. The right adrenal gland measured 0.96 cm in length x 0.37 cm in width.

Spleen

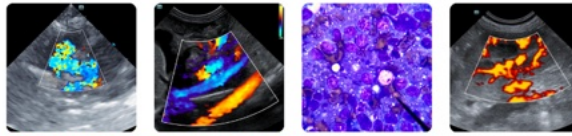
Normal size (0.8 cm in width) with an increased echogenic and fine nodular appearance with a scalloped appearance of the capsule. A larger nodule measured 0.4 x 0.5 cm in size in the body of the spleen with bulging of the overlying capsule present. Normal volume of the splenic vasculature without any overt congestion or thrombosis evident.

Liver

Normal size, echogenic appearance, portal markings, and regular curvilinear capsule. Small, focal, hyperechogenic, parenchymal nodule in the left lobe measuring 0.5 cm in size. No additional nodule or masses evident. Normal appearance of the hepatic and portal vasculature.

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.



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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. Segmental thickening of the small intestine measuring up to 0.42 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. A small amount of fluid is present in the stomach.

Pancreas

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 0.7 x 1.6 cm in size maintaining normal shape and echogenic appearance.

A small amount of ascites present in the cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

- Enteropathy.
- Mesenteric lymphadenomegaly.
- Splenic nodules.
- Hepatic nodule.
- Ascites.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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

The most likely etiology for the mesenteric lymphadenomegaly would be reactive hyperplasia with lymphadenitis and infiltrative neoplasia a less likely differential diagnosis.

Etiologies for the splenic nodules would be reactive hyperplasia, splenitis and neoplasia such as lymphoma.

The hepatic nodule can be considered an incidental finding.

The ascites can be ascribed as secondary to the enteropathy and the mesenteric lymphadenomegaly.

Further assessment would be fecal analysis, cobalamin and folate assay and FNA cytology of the spleen and mesenteric lymph nodes. Endoscopy of the upper GI tract could also be considered.



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Specific therapy would be dependent on an etiological diagnosis.

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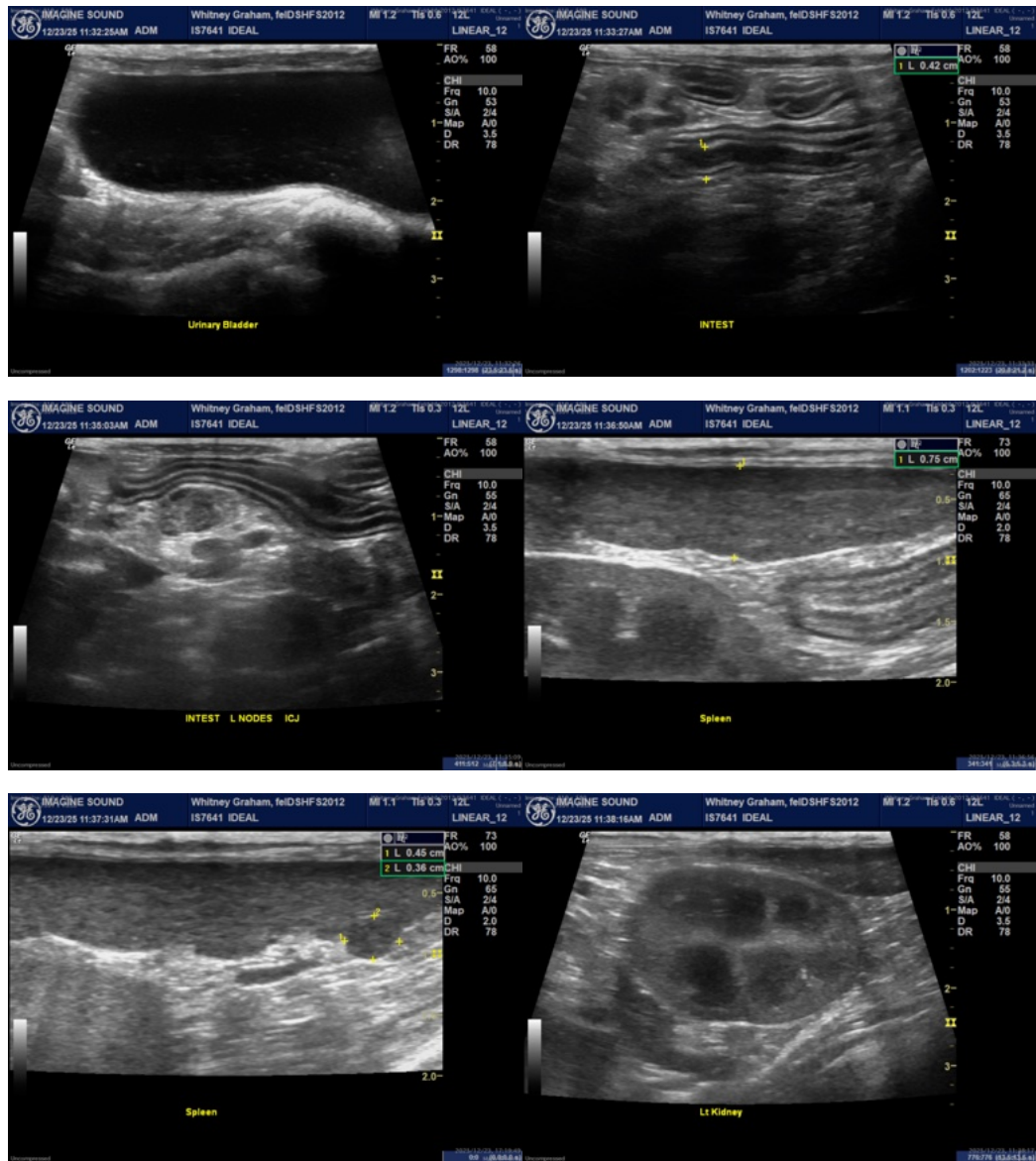
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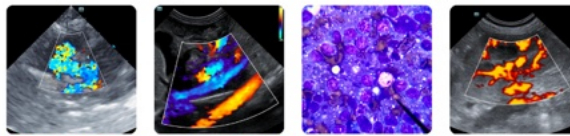
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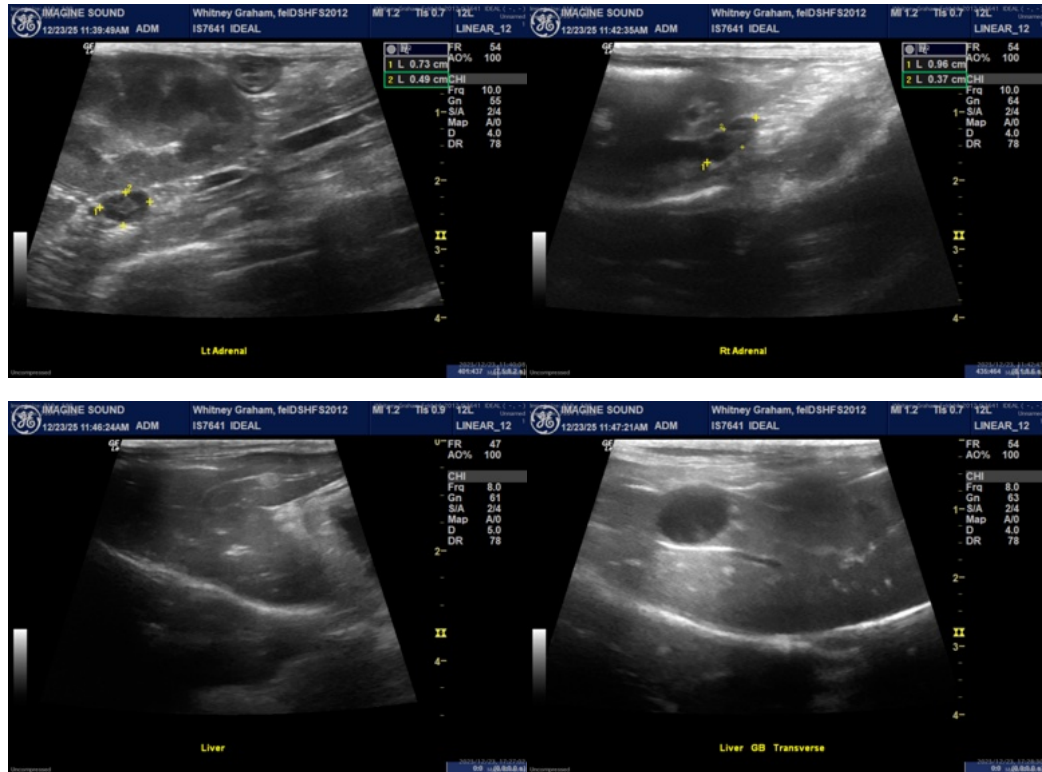
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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