



## PATIENT

Clark Dryden

## SPECIES

Feline

## BREED

Domestic Shorthair

## SEX

Neutered male

## AGE

13 years

## WEIGHT

11 lbs

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Nikki Kollman RVT

## HOSPITAL NAME

Airpark AH

## REFERRING VET

Dr. Kennedy

## INVOICE

71579

## DATE

2/16/26

## PRESENTING CLINICAL SIGNS

- Inappetence, lethargy starting Sunday last week, extended several days. Having loose stool, progressing to no defecation at all. Was eating treats, but no longer wanted treats. Continued weight loss a problem, unintentional. Has a history of behavioral urination/defecation treated with gabapentin. Ran blood work, gave convenia injection as tech appointment with no improvement.
- UA ran in house from cystocentesis: blood present, bilirubin and urobilinogen positive, no WBCs or bacteria noted Premier panel: PCV 34% WBC 13.8 K/uL (3.9-19) Platelets 299 k/uL Glucose 161 mg/dL creatinine 1.4 (0.9-2.3) Na/K ratio 39 mild hypochloridemia 113 (114-126) Alb 2.9 (2.6-3.9) ALT 29 (27-158) ALP 45 (12-59) GGT 1 (0-6) Total bilirubin 0.6 (0-0.3) Conjugated bilirubin 0.4 (0-0.2) Unconjugated 0.2 (0-0.2) proBNP 38 (0-100) T4 1.6 (0.8-4.7)

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is small 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 4.5 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 0.6 cm in width. The right adrenal gland measured 0.34 cm and 0.3 cm in width.

### *Spleen*

The spleen was enlarged and measured 1.2 cm in width, but maintained a normal 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.

### *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 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, small intestine, 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.

## ***Pancreas***

Normal size with a diffuse, mottled echogenic appearance and an irregular capsule. Mild increase in the echogenic appearance of the mesentery and fat surrounding the pancreas.

## ***Free Abdomen***

Enlarged mesenteric lymph nodes measuring up to 0.9 x 1.6 cm in size with an irregular shape and hypoechogenic appearance.

No ascites evident.

## **ULTRASONOGRAPHIC FINDINGS**

- Mesenteric lymphadenomegaly.
- Splenomegaly.
- Chronic pancreatitis versus pancreatic fibrosis.

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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

Etiologies for the splenomegaly would be reactive hyperplasia, splenitis and possibly infiltrative neoplasia.

Further assessment would be FPL/PSL assay and FNA cytology of the spleen and mesenteric lymph nodes.

Specific therapy would be dependent on an etiological diagnosis.



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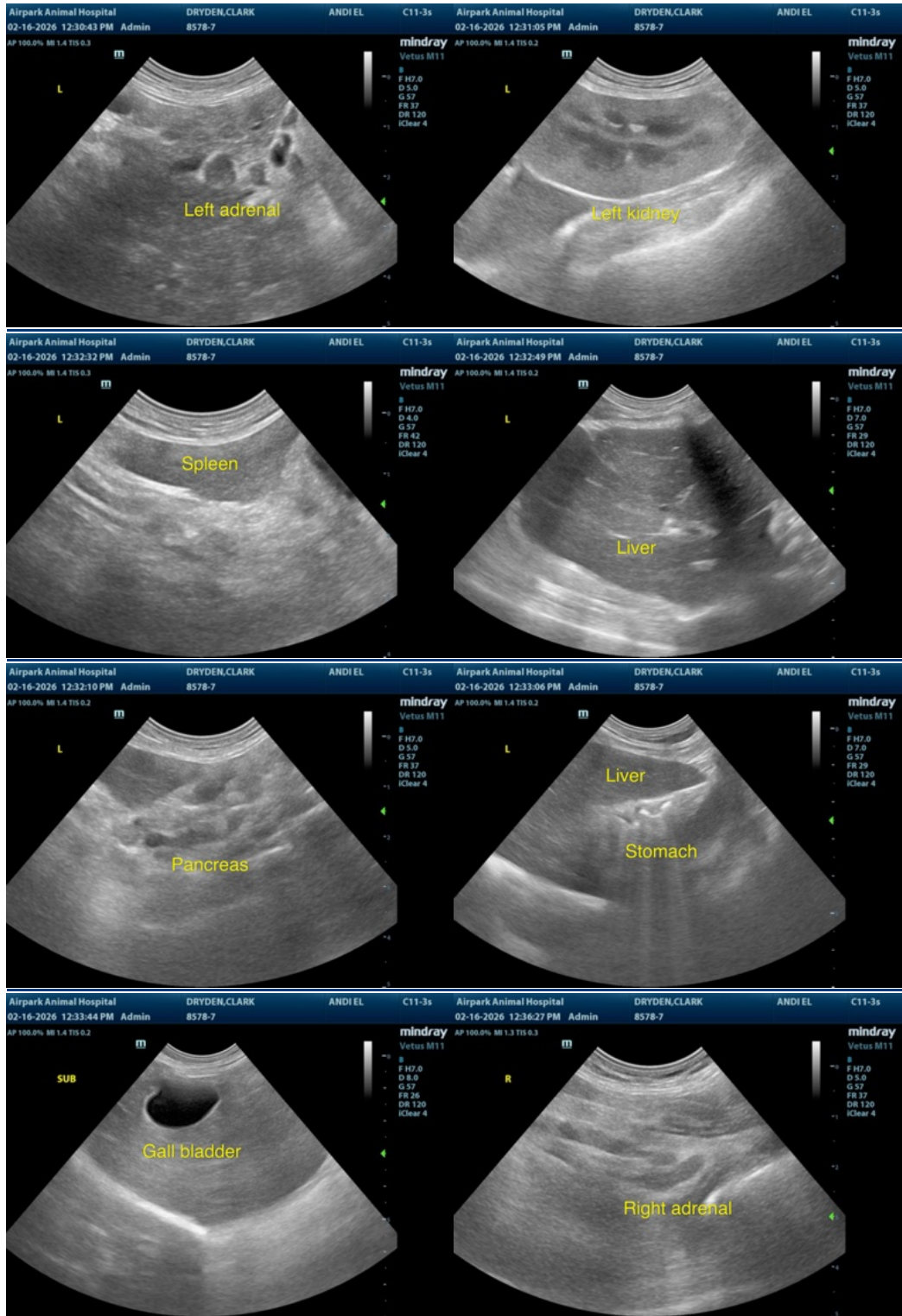
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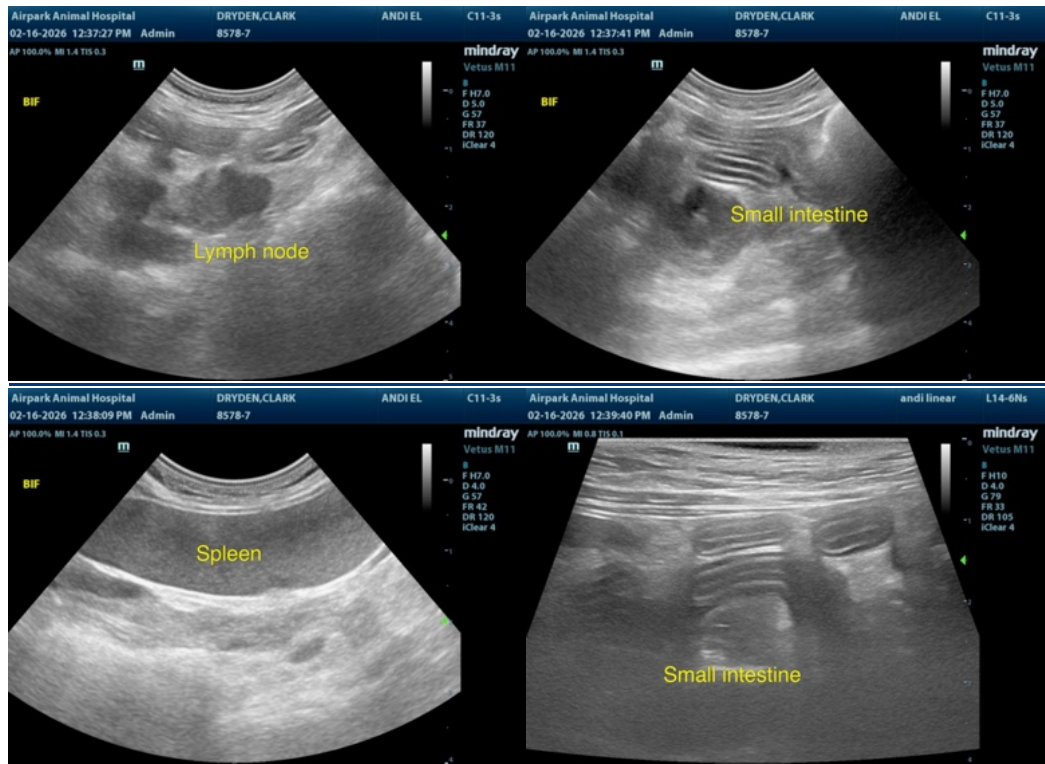
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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