



PATIENT

Ozzie Nichols

SPECIES

Canine

BREED

American Bobtail

SEX

Male

AGE

8 years

WEIGHT

10.81 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Danielle Shemanski,
DVM, MA

HOSPITAL NAME

Western New York
Vetererinary Service

REFERRING VET

Dr. Brenda Buck

INVOICE

71737

DATE

2/19/26

PRESENTING CLINICAL SIGNS

- The owner notes that the vomit appears as larger amounts of undigested food with moist food mixed in. The owner changed the patient's dry food several months before vomiting from Purina Sensitive Skin & Stomach to Purina One Urinary Tract. The owner is also feeding Nine Lives moist food. No diarrhea. Appetite is within normal limits. No thirst changes. Urination is unknown. Occasional sneezing. Activity is within normal limits. Owner notes patient sometimes gets into the other cat in the home's food: Blue Buffalo KM Kidney Diet and Royal Canin Renal Support. Patient is an indoor/outdoor cat and does hunt on occasion. He has not had any previous medications for vomiting.
- Lab Work (RDVM) - CBC: Within normal limits. Low platelets, but there was clumping, so no concern. - Chem 17: Within normal limits. - Total T4: High normal and in the gray zone for hyperthyroidism. - Plan per RDVM: Recheck weight and T4 in 3 months.

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 3.9 cm, right measured 4.3 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 0.57 cm in width. The right adrenal gland measured 0.6 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 0.6 cm in width.



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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

The gallbladder is small containing normal anechoic bile. Thickened and hyperechogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.

Gastrointestinal

A small amount of ingesta is present in the stomach compatible with a recent meal. 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 an increase in the muscularis to mucosa ratio, normal peristaltic activity and no distension of the lumen.

Pancreas

Normal size (left measured 0.4 cm in width) with a hypoechogenic appearance and an irregular capsule. Mild, increased echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Enlarged mesenteric lymph nodes measuring up to 0.5 x 1.6 cm in size maintaining a normal shape and echogenic appearance.

No ascites evident.

Thorax

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

ULTRASONOGRAPHIC FINDINGS

- Enteropathy.
- Mesenteric lymphadenomegaly.
- Chronic pancreatitis.
- Previous cholecystitis.



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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.

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

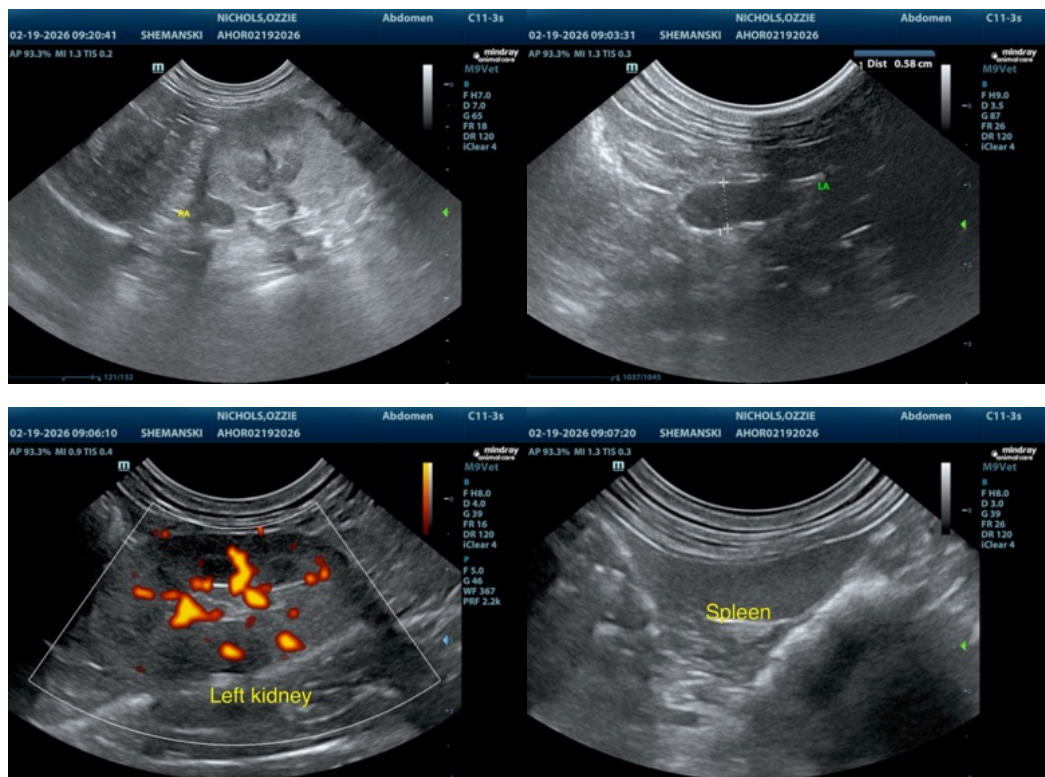
Further assessment would be fecal analysis, cobalamin, folate and FPL/PSL assay and endoscopy of the upper GI tract with biopsies.

FNA cytology of the mesenteric lymph nodes could also be considered.

Further assessment for possible hyperthyroidism would be T3 and TSH assay.

Specific therapy would be dependent on an etiological diagnosis.

Symptomatic management that can be considered would be feeding small frequent meals of 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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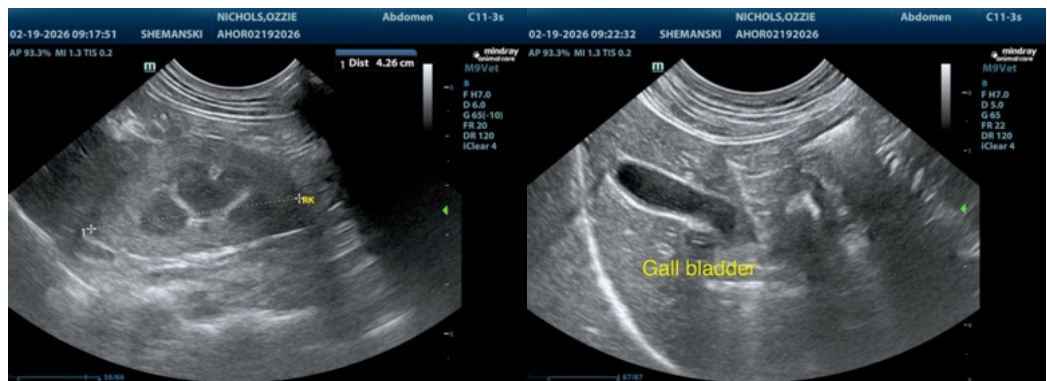
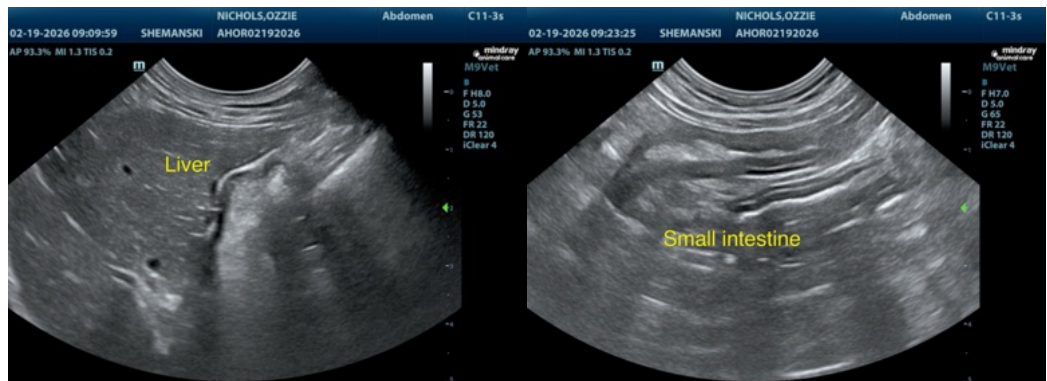
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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