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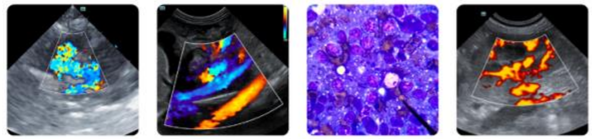


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT
Bobby Wieczorkowski

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
8 Months

WEIGHT
6 Pounds

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

IMAGING PERFORMED BY
Dr. Shauna Gross

HOSPITAL NAME
TotalBond VH-Paw Creek

REFERRING VET
Dr. Shauna Gross

INVOICE
35892

DATE
2/20/26

PRESENTING CLINICAL SIGNS

- At shelter Bobby self traumatized tail and required a tail amputation
- Since being adopted in August from the shelter Bobby has always had large bowel, watery diarrhea.
- Unable to make it to litter box, high urgency, yellow colored watery stools
- Occasional clear vomiting, sometimes post-prandial
- Has always been a ravenous eater but doesn't gain weight
- No response to food trials (Hill's ID, Fresh Pet, and another prescription food)
- No response to daily fortiflora or daily Proviable
- No response to metronidazole
- Still playful at home
- Abnormal PE/Chem/CBC/UA Results: Exam - BCS 4/9, symmetric muscling. Abdomen palpates mildly abnormal with ropey intestines and mildly distended abdomen. Fecal incontinence (dripping yellow-green stools) Fecal submitted, but unable to perform testing due to HIGH amounts of mucous and blood and minimal actual fecal material present FeLV/FIV negative/negative No overt abnormalities on BW (attached)

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.

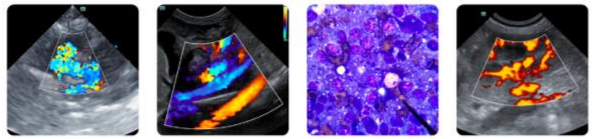
Normal renal size, architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident. The left kidney measured 3.1 cm. The right kidney measured 3.5 cm.

Adrenal Glands

The left adrenal gland was not visualized.

Normal right adrenal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. The right adrenal gland measured 0.36 cm in width.

Spleen



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Normal size (0.8 cm in width) 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.

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

Full gallbladder, 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 and duodenum, 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 (up to 0.35 cm) and colon (0.24 cm) with no loss of layering, but with an increase in the muscularis to mucosa ratio, normal peristaltic activity, and no distention of the lumen. Liquid fecal material was present within the colon.

Pancreas

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

Normal mesenteric lymph nodes.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

- Enteropathy

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiologies for the enteropathy would be parasitic enteritis, dietary hypersensitivity, inflammatory bowel disease, and possibly exocrine pancreatic insufficiency.

Further assessment would be fecal analysis, screening for tritrichomonas fetus, cobalamin folate and TLI assay, and endoscopy of both the upper and lower GI tract with biopsies.

Specific therapy would be dependent on an etiological diagnosis.

Symptomatic management that could be considered would be feeding a novel protein/hypoallergenic diet, a course of fenbendazole, cobalamin supplementation, and if there if still not a satisfactory improvement, then a course of prednisolone would then be indicated.

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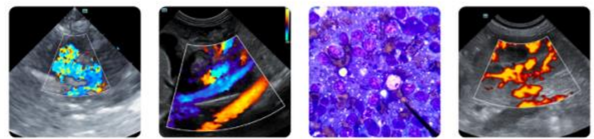

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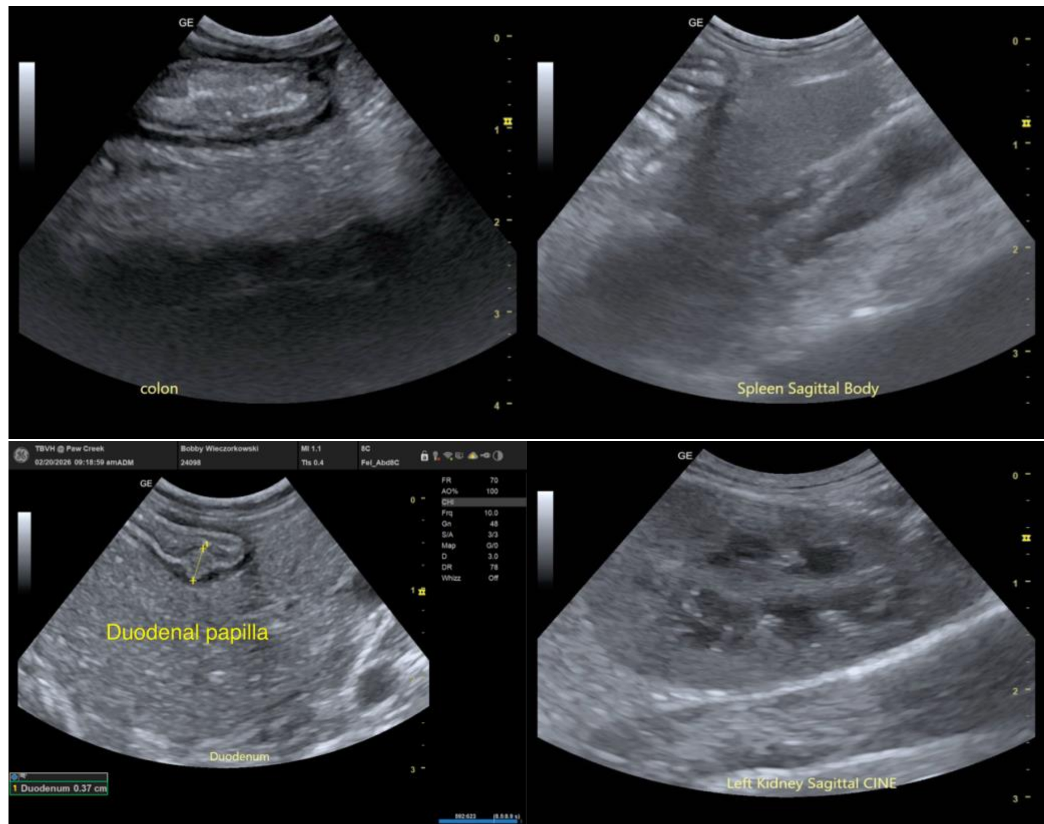

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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