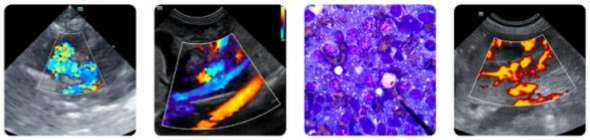


PATIENT

Fred Gattis

SPECIES

Feline

BREED

DSH

SEX

Male

AGE

17 Years

WEIGHT

7.8 Pounds

INTERPRETED BY

Remo Lobetti BVSc, MMedVet, PhD, DECVIM

IMAGING PERFORMED BY

Danielle Shemanski, DVM, MA

HOSPITAL NAME

Western New York VS

REFERRING VET

Brenda Lefler, DVM

INVOICE

35916

DATE

2/20/26

PRESENTING CLINICAL SIGNS

RDVM REASON FOR REFERRAL: Patient presented as a new patient for weight loss and decreased appetite.

Physical Exam: Thin, mild dehydration, muscle atrophy, no obvious masses palpated. Recommending ultrasound to rule out neoplasia.

History: Fred is an 18-year-old MN DSH with a 6-month history of decreased appetite, noticeable weight loss, and increased vomiting (2-3 times/week). Owners note he has always been a vomiter, and the recent change may be related to a move from Oregon six months ago. He is an indoor cat who is currently eating American Journey wet food, Temptations wet food, and a high-calorie supplement gel, with decreased interest in dry food. He goes outside on a harness.

BCS = 1.5/5

Fred's Abdomen was clearly uncomfortable during the scan

Abnormal PE/Chem/CBC/UA Results: ALT 165 (12 - 130 U/L) H AST 60 (0 - 48 U/L) H Lipase 1,568 (100 - 1,400 U/L) H CBC and T4 were WNL per RDVM.

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 (left 4.1 cm/right 3.8 cm), with increased echogenic appearance, some loss of cortico-medullary differentiation, and normal pelvis and capsule. No infarcts, mineralization or renoliths evident.

Adrenal Glands

Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. The left adrenal gland measured 0.42 cm in width. The right adrenal gland measured 0.39 cm in width.

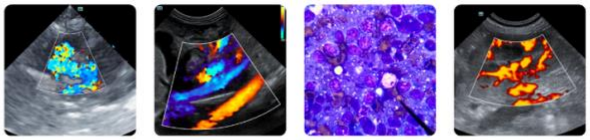
Spleen

Normal size (0.7 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



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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, 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 (up to 0.2 cm) with no loss of layering, but with mild segmental increase in the muscularis to mucosa ratio, normal peristaltic activity, and no distention of the lumen.

Pancreas

The pancreas was enlarged (left pancreas 0.8 cm in width) with an increased echogenic appearance and an irregular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas. Dilated pancreatic duct (0.5 cm in diameter).

Free Abdomen

Normal mesenteric lymph nodes.

Small amount of acellular ascites present.

Thorax

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

ULTRASONOGRAPHIC FINDINGS

- Enteropathy
- Chronic pancreatitis versus pancreatic fibrosis
- Ascites
- Age related renal changes versus early chronic kidney disease

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 ascites can be ascribed as secondary to the enteropathy. The appearance of the pancreatic duct would be consistent with chronic pancreatitis or an age-related change.

Further assessment would be fecal analysis, cobalamin, folate, and FPL/PSL assay, and ideally, endoscopy of the upper GI tract with biopsies (taking the patient's age into account for an anesthetic risk).

Specific therapy would be dependent on an etiological diagnosis.

Symptomatic management that could be considered would be feeding small frequent meals of a novel protein/hypoallergenic diet, cobalamin supplementation, a course of fenbendazole, and possibly a course of prednisolone.

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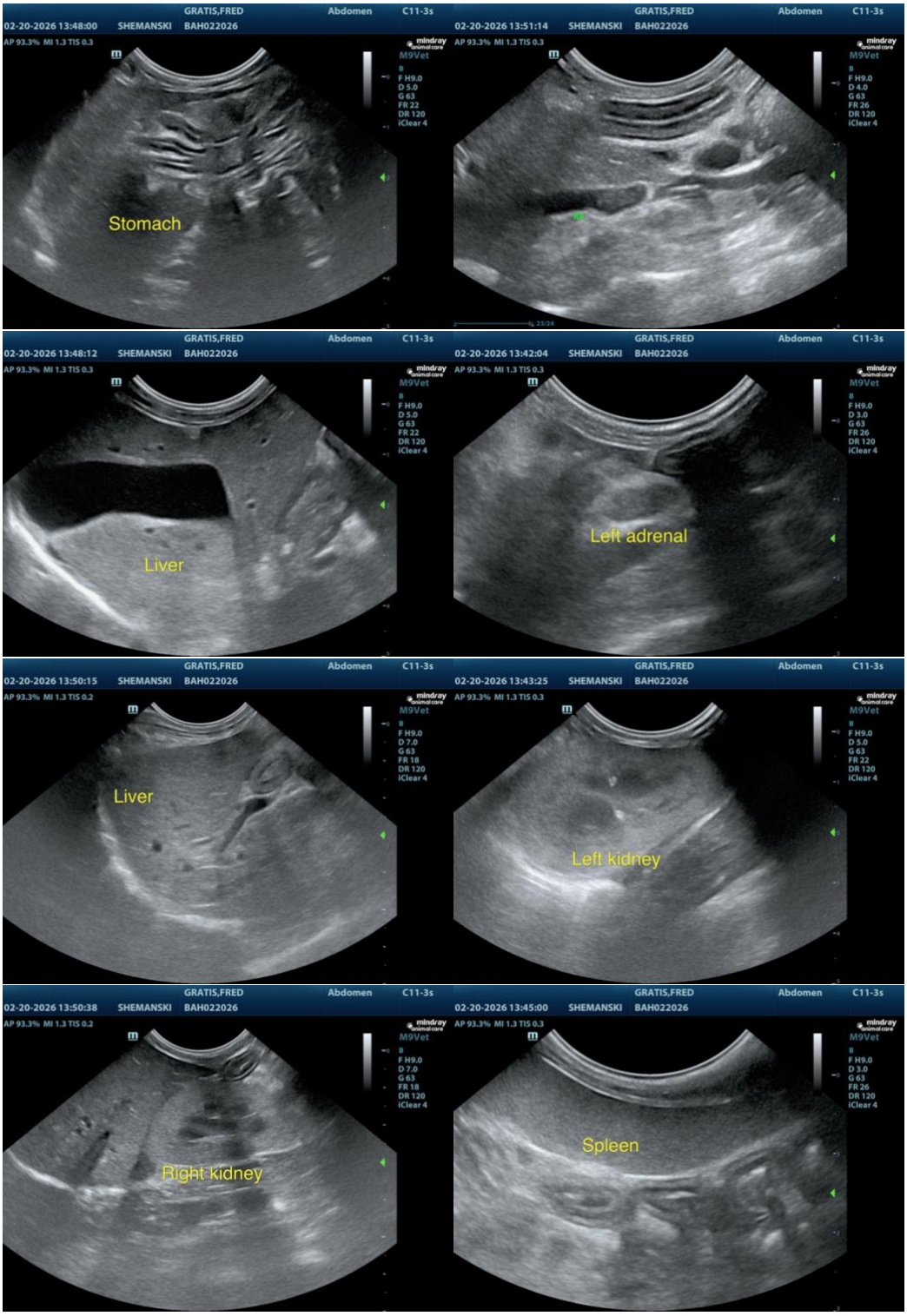

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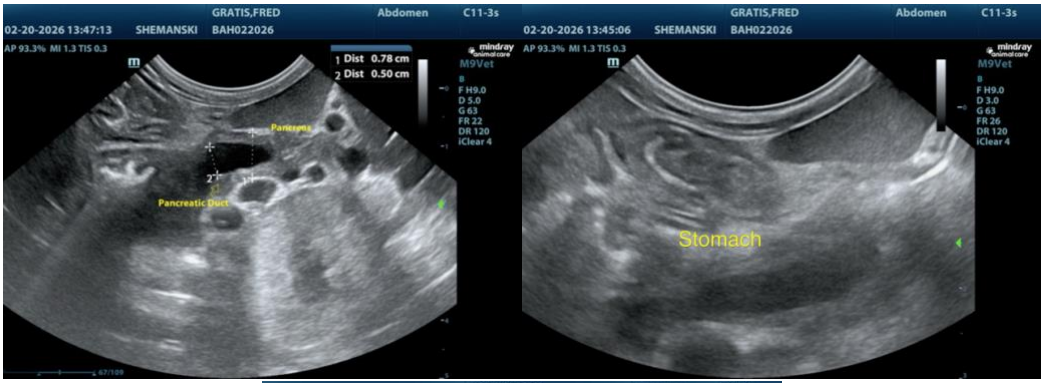

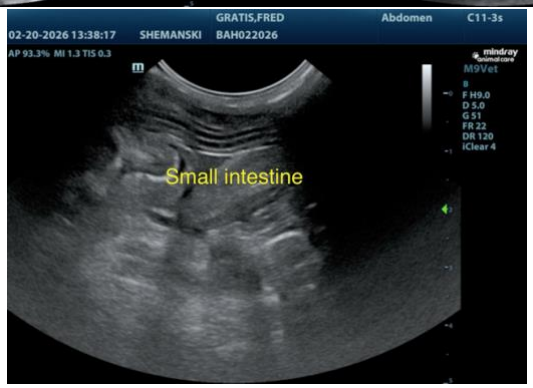

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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