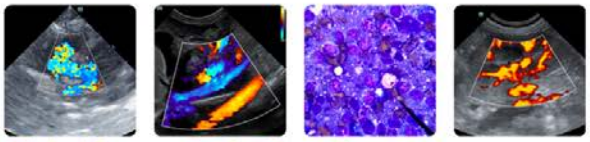



**PATIENT**

Lacy Horsley

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

15 Years 6 Months

**WEIGHT**

10.3 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Dr. Stephanie Wehmer

**HOSPITAL NAME**

Evendale-Blue Ash Pet Hospital

**REFERRING VET**

Dr. Stephanie Wehmer

**INVOICE**

73155

**DATE**

2/20/26

## PRESENTING CLINICAL SIGNS

Chronic vomiting - started as a few times a month progressing to a few times a week. Increased to 1-2x daily over the last month. Vomit consistency varies: clear mucous when stomach empty, sometimes undigested food kernels, sometimes chewed food. Decreased appetite: eating approximately 1/8 cup every other day when offered 1/4 cup. Eating Hill's digestive dry food. Increased water intake noted, no vomiting after drinking. Energy level unchanged. Initiated 2 days of IVFT starting 2/19/26 - pulled IVC on 2/20/26. Administered Cerenia SID and Famotidine BID both days + Mirtazapine and B-12 on 2/20/26. No other current medications noted. Did not vomit overnight between 2/19 and 2/20. Ate a small amount of kibble readily 2/20

Abnormal PE/Chem/CBC/UA Results: 2/19/26 - PE abnormality - Abdomen: Soft, non-tender, no masses or organomegaly, possibly thickened/ropey intestines on palpation BW on 2/19/26 showed kidney values trending up and are high normal but otherwise unremarkable. owner declined PLI 2/20/26 - PE - WNL Texas A&M GI Panel pending - obtained bw prior to administering B-12 injection

## 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. Left kidney measures 3.3 cm. Right kidney measures 3.5 cm.

### *Adrenal Glands*

Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left measures 0.57 cm in length x 0.23 cm in width. Right measures 0.28 cm in width.

### *Spleen*

Normal size (0.80 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 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 thickness of the small intestine (up to 0.35 cm) with no loss of layering, but with a segmental increase in the muscularis to mucosa ratio, normal peristaltic activity and no distention of the lumen. Normal appearance of the stomach, 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*

Visible sections present normal size and echogenic appearance. 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.

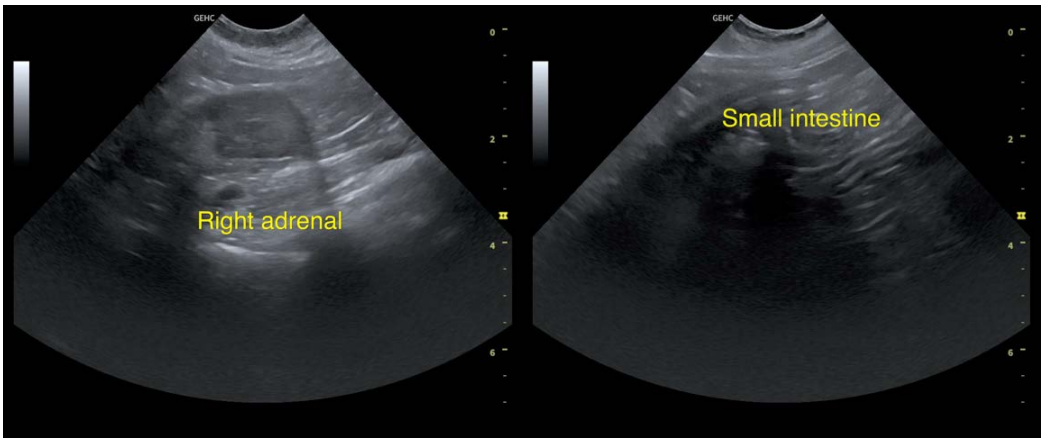
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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

Further assessment needs to be based on the pending results, but could include fecal analysis and endoscopy of the upper GI tract with biopsies.

Specific therapy would be dependent on an etiological diagnosis.

Symptomatic management would be to feed small, frequent meals of a novel protein/hypoallergenic diet, continuing with the cobalamin supplementation, a course of Fenbendazole, and if there is still not a satisfactory improvement, then a course of Prednisolone would then be indicated.



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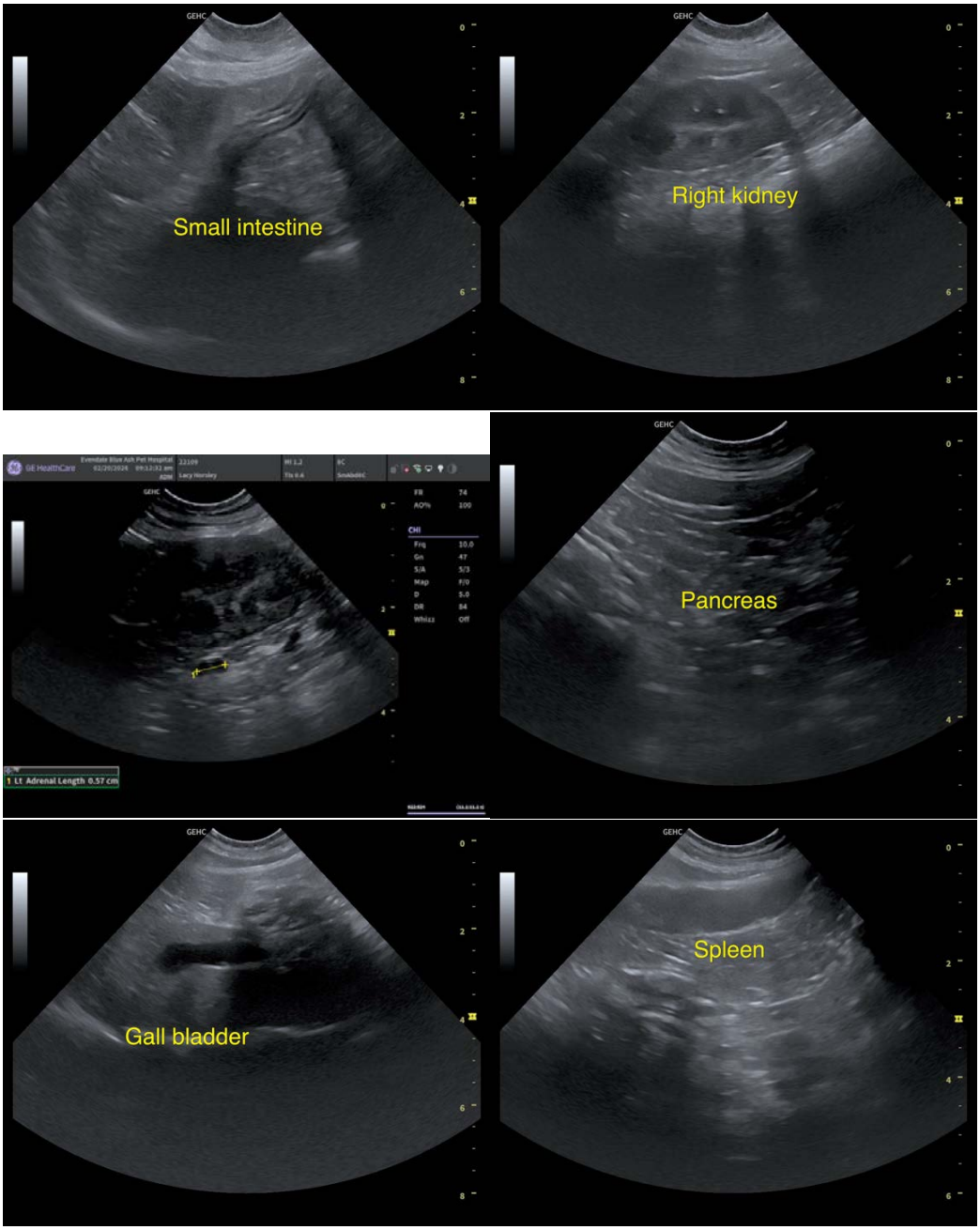

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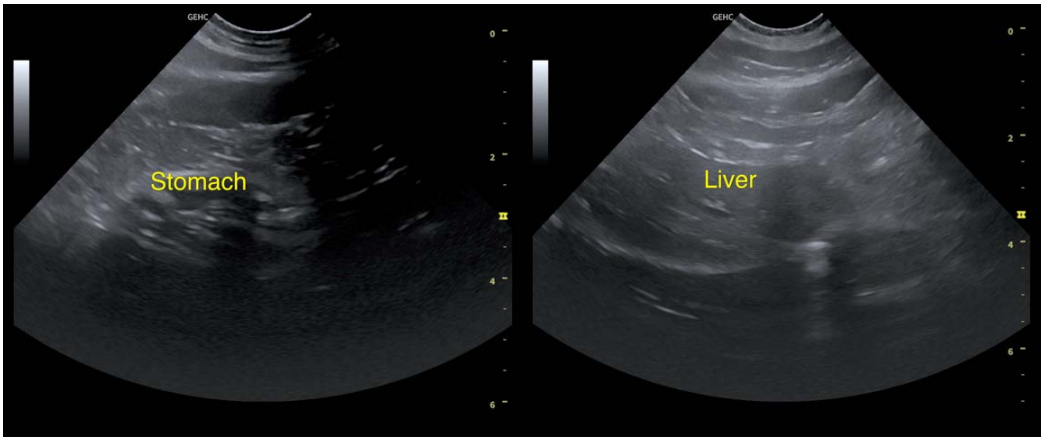


**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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