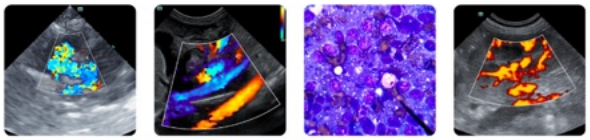


PATIENT

Reckless Brown

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Male

AGE

9 years

WEIGHT

10.65 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Danielle Shemanski, DVM, MA

HOSPITAL NAME

Western New York Vetererinay Service

REFERRING VET

Dr. Demers

INVOICE

71954

DATE

2/25/26

PRESENTING CLINICAL SIGNS

- Reason for Referral: Pancreatitis, possible nausea. Patient seems painful. Not eating, not drinking.
- History: Reckless presented with pain (improved on Gabapentin), lethargy, hiding, and reduced grooming, with owner noting lower back pain upon squatting. This normally food-motivated cat had anorexia and lost approximately 1 lb over 1.5 weeks, with vomiting prior to starting current anti-nauseant/appetite stimulant. The owner is concerned about recent environmental exposures (oven cleaner, new bed, wood stove wood) as potential pancreatitis triggers.
- Past medical history includes arthritis and chronic constipation (with a history of megacolon requiring manual extraction). He is on a Royal Canin Urinary SO diet and Dasuquin.
- MEDICATIONS: Gabapentin 250mg/5ml - 1.0 ml PO BID for 10 days, Elura 20mg/ml - 0.48 ml PO SID PRN 5 days to stim appetite, Cerenia 16mg - 1/2 tab PO SID for 4 days #2 - some improvement
- CBC chem T4 NSF

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is full with a normal thickness and smooth appearance of the wall. A small amount of floating, hyperechogenic sediment.

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.

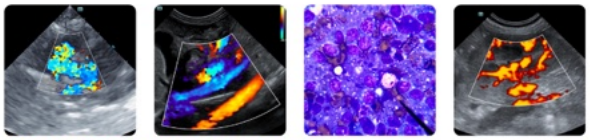
Normal renal size (left measured 3.7 cm, right measured 3.9 cm), increased echogenic appearance, some loss of cortico-medullary differentiation, and normal pelvis and capsule. No infarcts, mineralization or renoliths evident. Normal color flow pattern is evident in both kidneys.

Adrenal Glands

Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 0.27 cm in width. The right adrenal gland measured 0.33 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 bilobed and 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, 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. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Normal mesenteric lymph nodes.

No ascites evident.

Thorax

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

ULTRASONOGRAPHIC FINDINGS

- Enteropathy.
- Chronic pancreatitis versus pancreatic fibrosis.
- Age related renal changes versus early chronic kidney disease.
- Urinary bladder sediment.

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.

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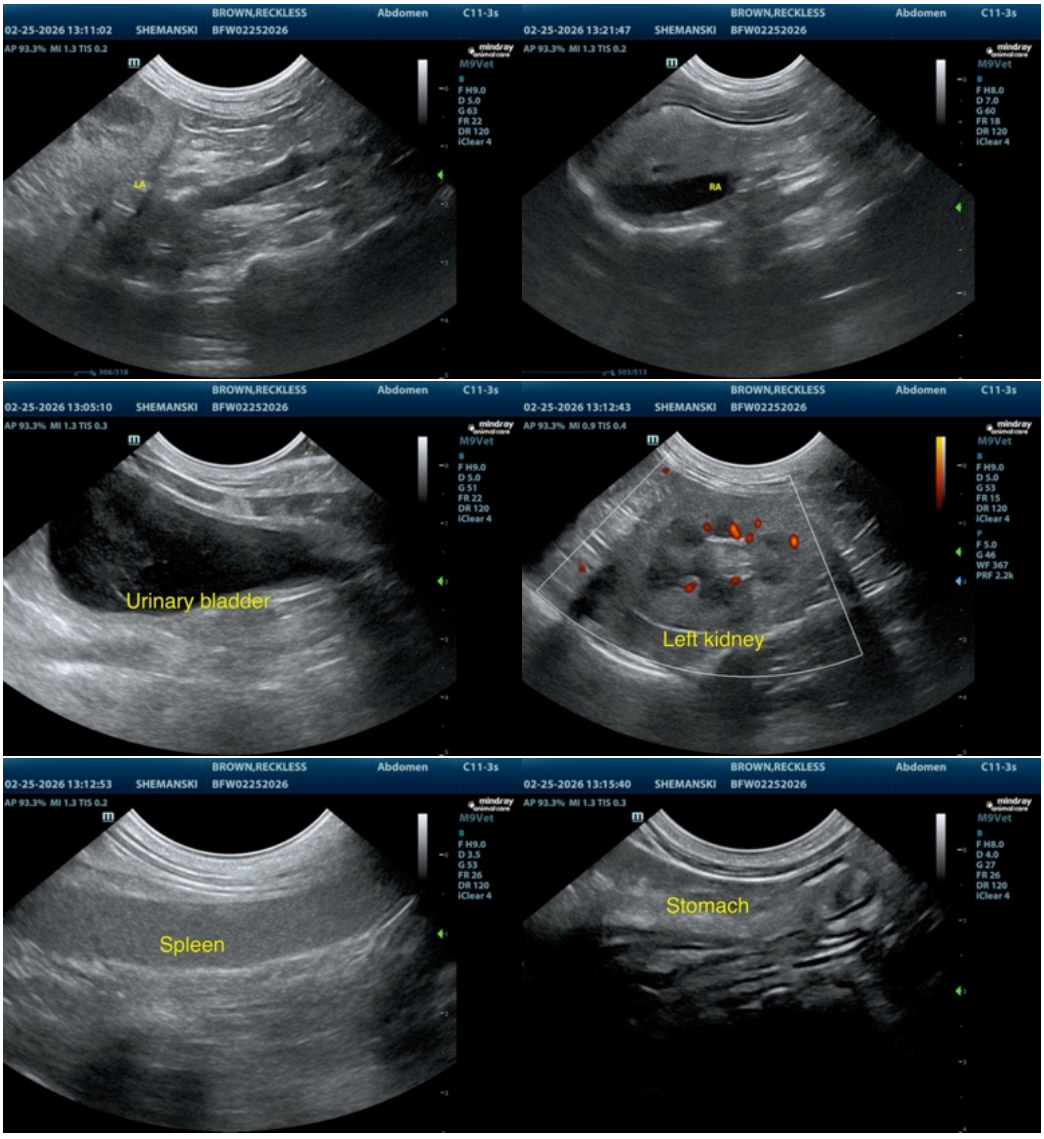
Etiologies for the urinary bladder sediment would be incidental debris, crystalluria and possibly bacterial cystitis.

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

Specific therapy would be dependent on an etiological diagnosis.

Symptomatic management would be feeding small frequent meals of a novel protein/hypoallergenic diet, course of Fenbendazole, cobalamin supplementation, antiemetics as needed and if there is not a satisfactory improvement then a course of Prednisolone would then be indicated.



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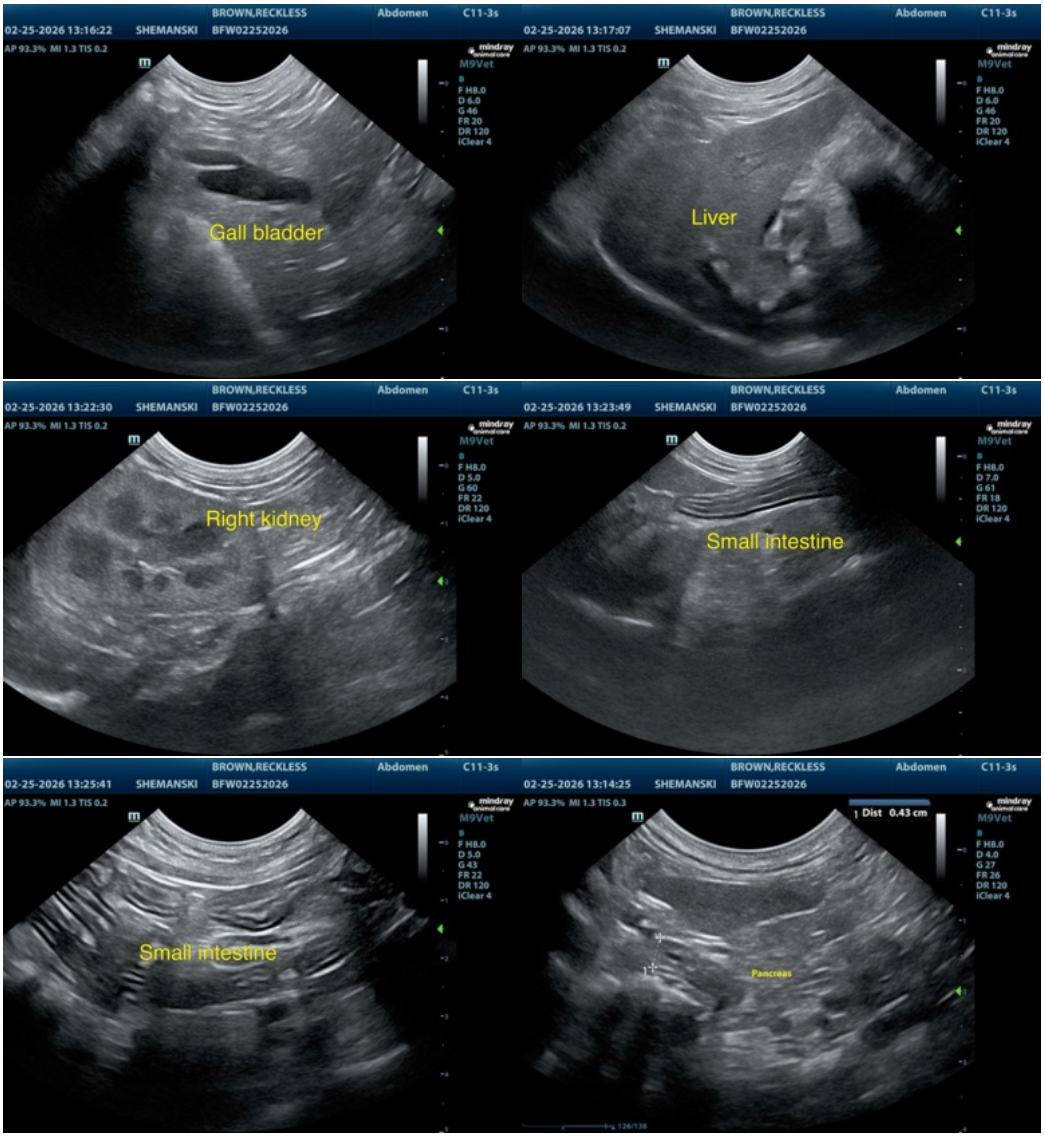

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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