



PATIENT

Witabit Coughlin

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

13 years

WEIGHT

5.2 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Danielle Shemanski

HOSPITAL NAME

Western New York
Veterinary Services

REFERRING VET

Dr. Richard Parsons

INVOICE

11492

DATE

3/13/2026

PRESENTING CLINICAL SIGNS

- Patient referred for abdominal ultrasound due to thickened intestines and unexplained dehydration, compounded by regular vomiting.
- History: The patient has a lifelong history of regular vomiting (1-2 times/week) of digested and sometimes undigested food (no hairballs). She has lost 1 lb (6.2 lbs to 5.2 lbs). Bowel movements are regular, solid, and once daily, with no blood. Energy was low but improved after starting ear medication. Appetite is good. Water intake decreased recently; she was dehydrated. Diet includes Fancy Feast soft food, Iams/Purina ONE dry food, and Friskies treats.
- MEDICATIONS: Tresaderm Otic 15mL for an ear infection.

Abnormal PE/Chem/CBC/UA Results: Blood work labs within normal limits. - Nucleated red blood cells are suspected. - Band neutrophils are suspected. - Total T4: 1.9 mcg/dL (Ref 0.8-4.7 ug/dL)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Small 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 and the right kidney measures 3.4 cm.

Adrenal Glands

Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature.

Left adrenal measures 0.36 cm in width, and the right adrenal measures 0.32 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 measures 0.6 cm in width.

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 containing normal anechoic bile. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.

Gastrointestinal

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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. Thickening of the small intestine (up to 0.36 cm) with no loss of layering but with an increase in the muscularis to mucosa ratio. Normal peristaltic activity and no distension of the lumen.

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Pancreas

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Normal size with a hypoechogenic appearance and an irregular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

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Enlarged mesenteric lymph nodes measuring up to 0.5 cm x 1.0 cm in size with an increased echogenic appearance but maintaining a normal shape.

Hyperechoic appearance of the mesentery surrounding the lymph nodes.

WEIGHT

5.2 lbs

Scant amount of ascites present.

Thorax

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

ULTRASONOGRAPHIC FINDINGS

- Enteropathy.
- Mesenteric lymphadenomegaly.
- Ascites.
- Chronic pancreatitis versus pancreatic fibrosis.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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

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Etiologies for the mesenteric lymphadenomegaly would be reactive hyperplasia, lymphadenitis, and infiltrative neoplasia.

The ascites can be ascribed as secondary to the mesenteric lymphadenomegaly and the enteropathy.

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

Specific therapy would be dependent on an etiological diagnosis.

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Symptomatic management that could be considered would be feeding small frequent meals of a novel protein/hypoallergenic diet, a course of fenbendazole, cobalamin supplementation, and if it's not at a satisfactory improvement, then a course of prednisolone would then be indicated.



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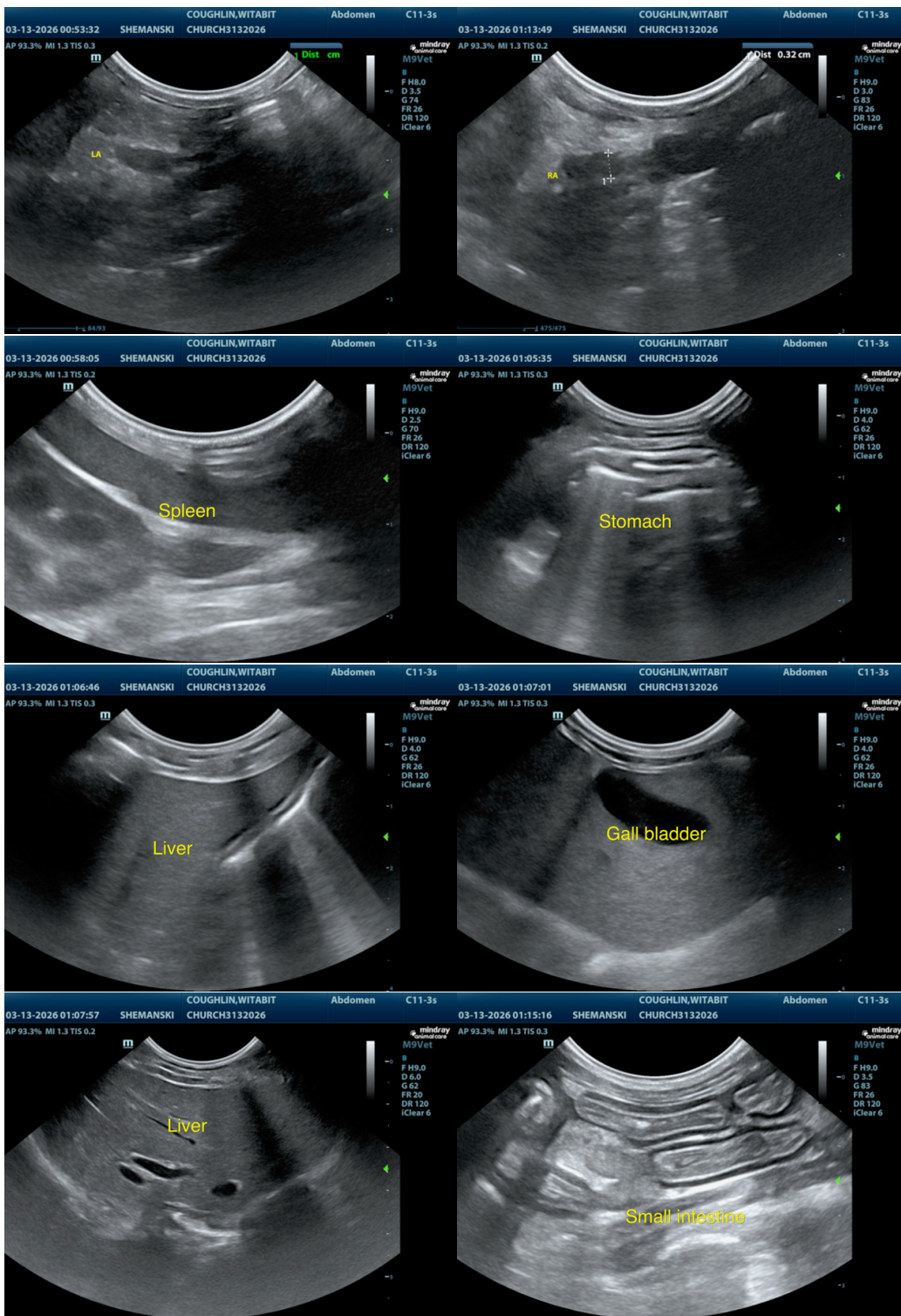
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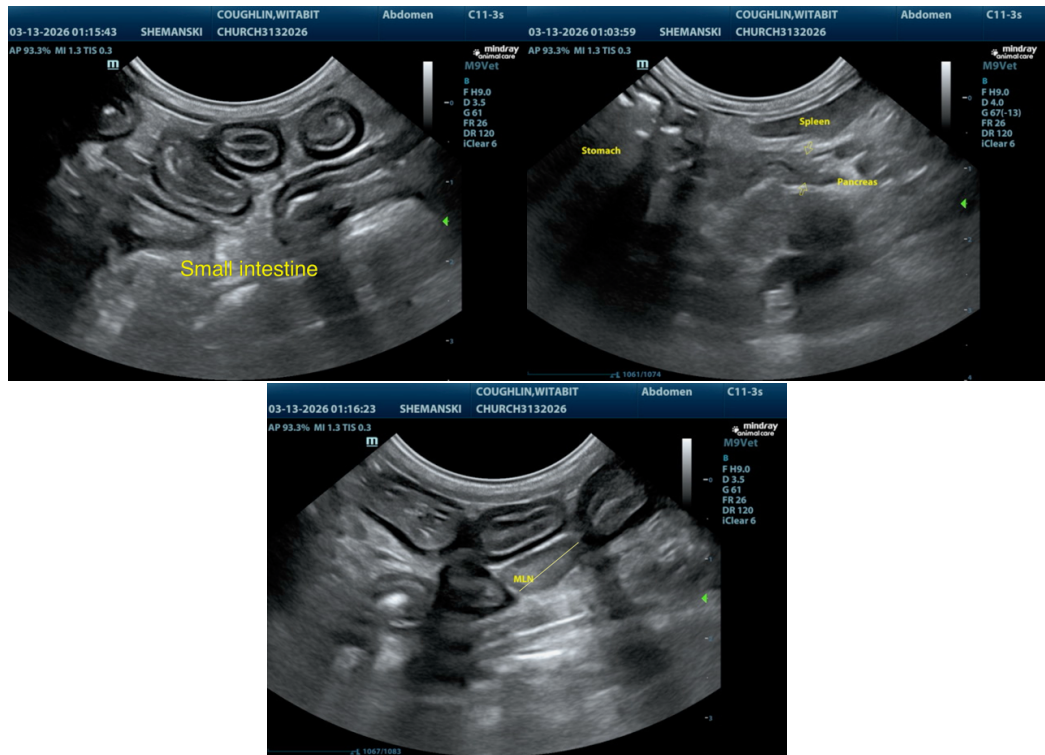
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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