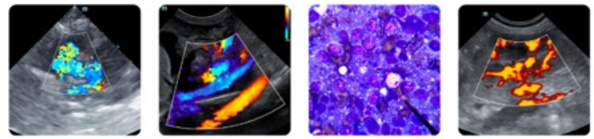


PATIENT

Potus Phibbs

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

10 years

WEIGHT

10.1 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Justin Eckenrode

HOSPITAL NAME

Carlisle Small Animal VC

REFERRING VET

Dr. Eckenrode

INVOICE

73487

DATE

3/17/26

PRESENTING CLINICAL SIGNS

- Major Medical Conditions: Chronic intermittent vomiting and progressive weight loss.
- Patient History: Potus has a 6-month history of chronic, intermittent vomiting, which occurs almost daily and consists of undigested food or bile. There has been progressive weight loss, with a decrease from 11.6 lbs in September 2025 to 10.3 lbs. The owner confirms a continued poor and fluctuating appetite.
- Primary concern or rule out: The primary differential is inflammatory bowel disease (IBD). Other rule-outs include food intolerance/allergy and gastrointestinal neoplasia (e.g., early lymphoma).
- RBC 8.80; HCT 34.8% WBC 9.7 Diff - mild stress leukogram Creat 1.5; SDMA 11; BUN 38 (16-37) ALT 61; ALKP 13; Tbil 0.1 T4 2.8

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is full 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.

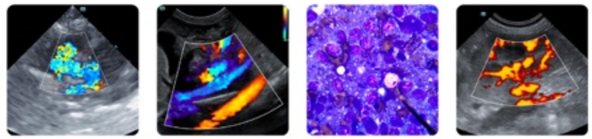
Normal renal size (left measured 3.5 cm, right measured 3.6 cm), architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident. Normal color flow pattern is evident in both kidneys.

Adrenal Glands

The left adrenal gland is normal in shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 0.83 cm in width x 0.28 cm in width. The right adrenal gland was not clearly visualized, but appears to be of normal shape, echogenic appearance and size.

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 small 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 0.3 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. A moderate amount of ingesta is present in the stomach. Chyme was present in the proximal small intestine. This is consistent with a. recent meal. Fecal material is present in the colon.

Pancreas

The 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

Prominent mesenteric lymph nodes measuring up to 0.5 x 1.0 cm in size maintaining a normal shape and echogenic appearance.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

- Enteropathy.
- Mesenteric lymphadenomegaly.

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 most likely etiology for the lymphadenomegaly would be reactive hyperplasia secondary to the enteropathy with lymphadenitis and infiltrative neoplasia a less likely differentia diagnosis.

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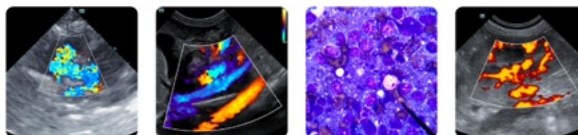

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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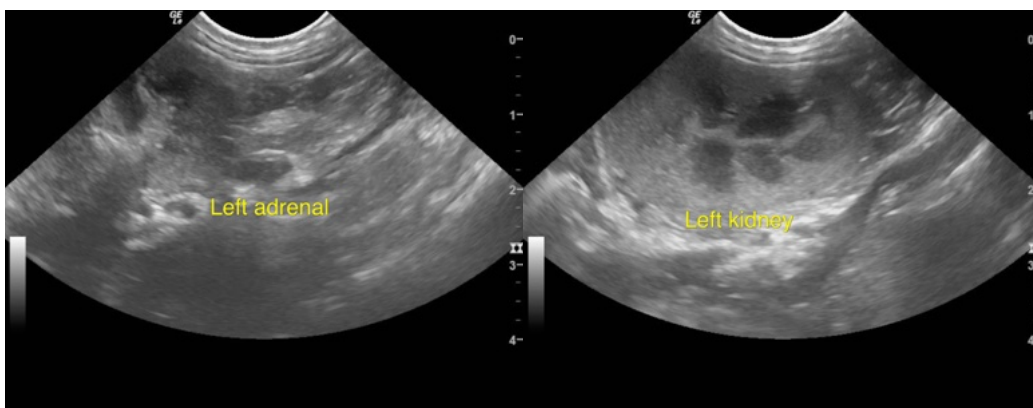
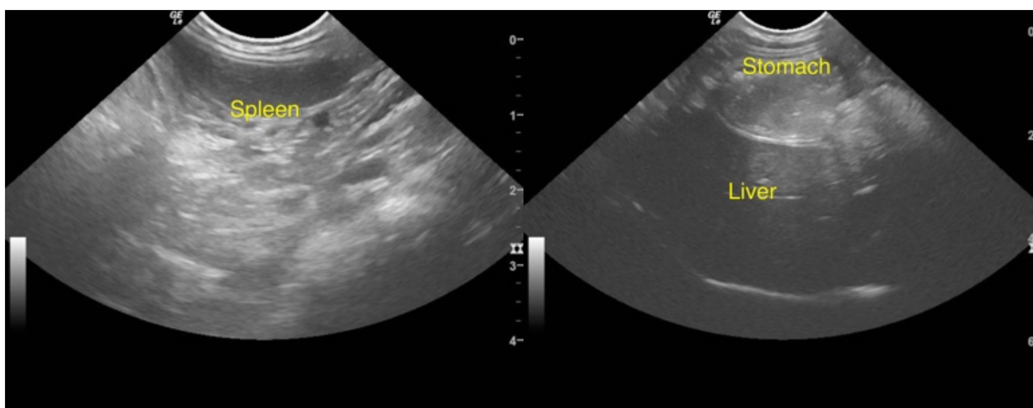
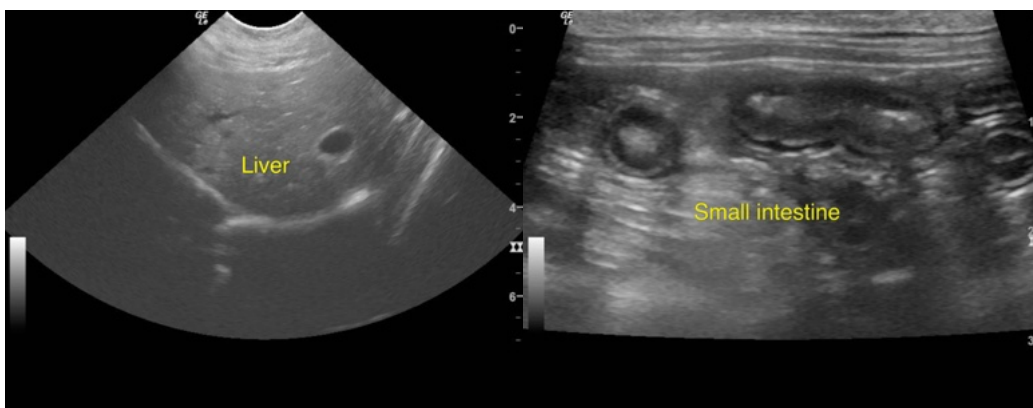
Further assessment would be fecal analysis, cobalamin and folate assay and endoscopy of the upper GI tract with biopsies.

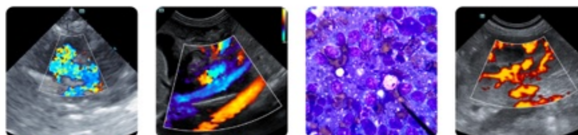
Specific therapy would be dependent on an etiological diagnosis.

Symptomatic management would be feeding a novel protein/hypoallergenic diet, course of Fenbendazole, cobalamin supplementation and to continue with the Prednisolone therapy.









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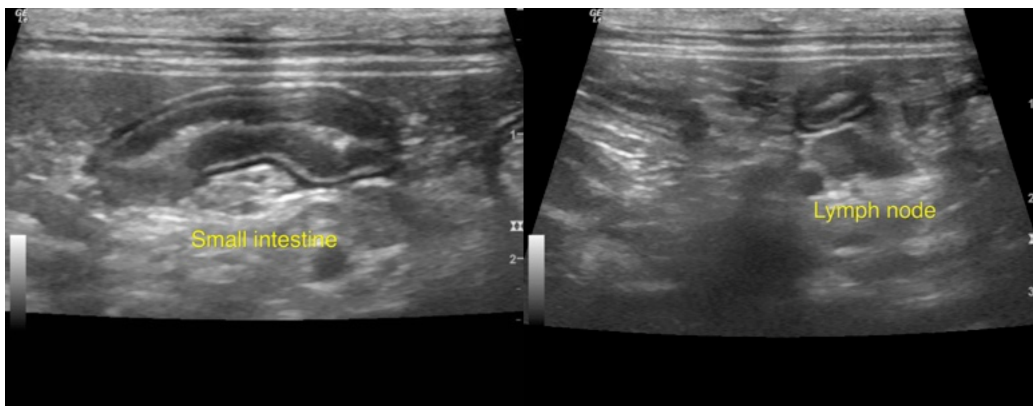

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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