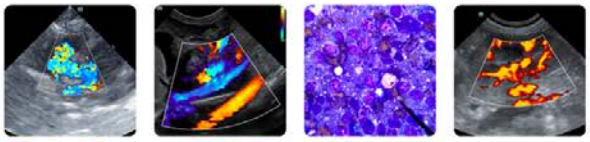


PATIENT

Pinky Knoll

SPECIES

Feline

BREED

Sphynx

SEX

Spayed Female

AGE

3 Years

WEIGHT

3.6 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershey Animal Emergency Center

REFERRING VET

Dr. Brittany Lang

INVOICE

73897

DATE

3/21/26

PRESENTING CLINICAL SIGNS

Chronic vomiting for months; previously up to 4x/day for 3 weeks, then resolved, now daily since January. Vomiting triggered by hard food, wet food, and recently water; today vomited 6x after wet food, treats, and water. Previous trial of EN diet (Jan 2025); no hydrolyzed diet trial performed. No known ingestion of foreign material. Appetite remains; continues to seek food despite vomiting.

Abdominal: Intestines palpably thickened, ropey, more prominent, soft and compliant with no other abnormalities or pain on palpation

Abnormal PE/Chem/CBC/UA Results: CBC: Unremarkable Chem 15: Creat 0.5 (L), BUN 15 (L) EPOC: BUN 13 (L) Urinalysis: USG 1.048, pH 7.0, inactive sediment 3 view radiographs: Thickening of small intestinal loops with scant feces seen in colon. Stomach empty with mild gas in lumen. No obvious obstructive foreign body pattern noted.

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 3.7 cm. Right kidney measures 4.0 cm. Normal color flow pattern evident in both kidneys. Corticomedullary rim sign is present in both kidneys.

Adrenal Glands

Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left measures 0.41 cm in width. Right measures 0.36 cm in width.

Spleen

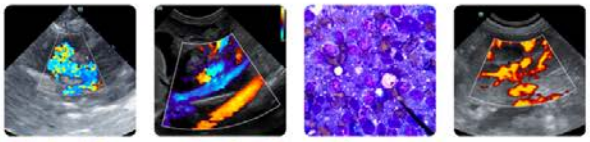
Normal size (0.80 cm in width) and echogenic appearance. Smooth homogenous parenchyma and regular curvilinear capsule. Normal volume of the splenic vasculature without any overt congestion or thrombosis evident. No inflammatory, neoplastic, infarction, or infiltrative changes evident.

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

Thickening of the small intestine (up to 0.40 cm) with no loss of layering, but with an increase in the muscularis to mucosal 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 of the pancreas present normal size and echogenic appearance. Regular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas. Left pancreas measured 0.40 cm in width.

Free Abdomen

Enlarged mesenteric lymph nodes measuring up to 0.30 cm x 1.3 cm in size, maintaining normal shape and echogenic appearance.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

- Enteropathy.
- Mesenteric lymphadenomegaly.
- Bilateral cortical medullary rim sign.

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 possible differential diagnosis.

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

Although the corticomedullary rim sign is most likely an incidental finding, it can be associated with hypercalcemia, granulomatous disease, bacterial nephritis, and lymphoma.

Further assessment would include fecal analysis, cobalamin and folate assay, and endoscopy of the upper GI tract with biopsies. FNA cytology of the mesenteric lymph nodes could also be considered.

If not already done, total and/or ionized calcium assay recommended.

Specific therapy would be dependent on an etiological diagnosis.

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

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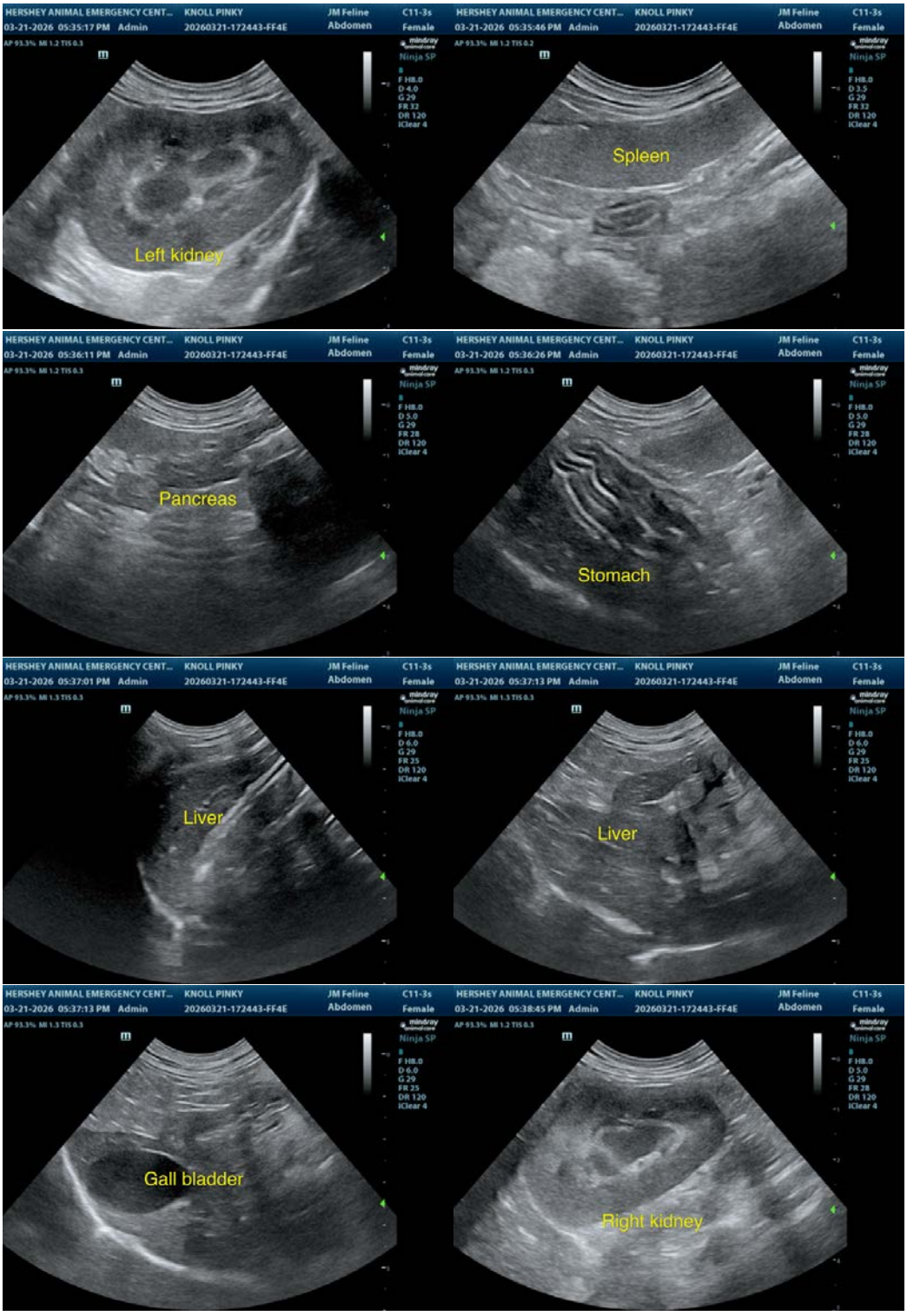

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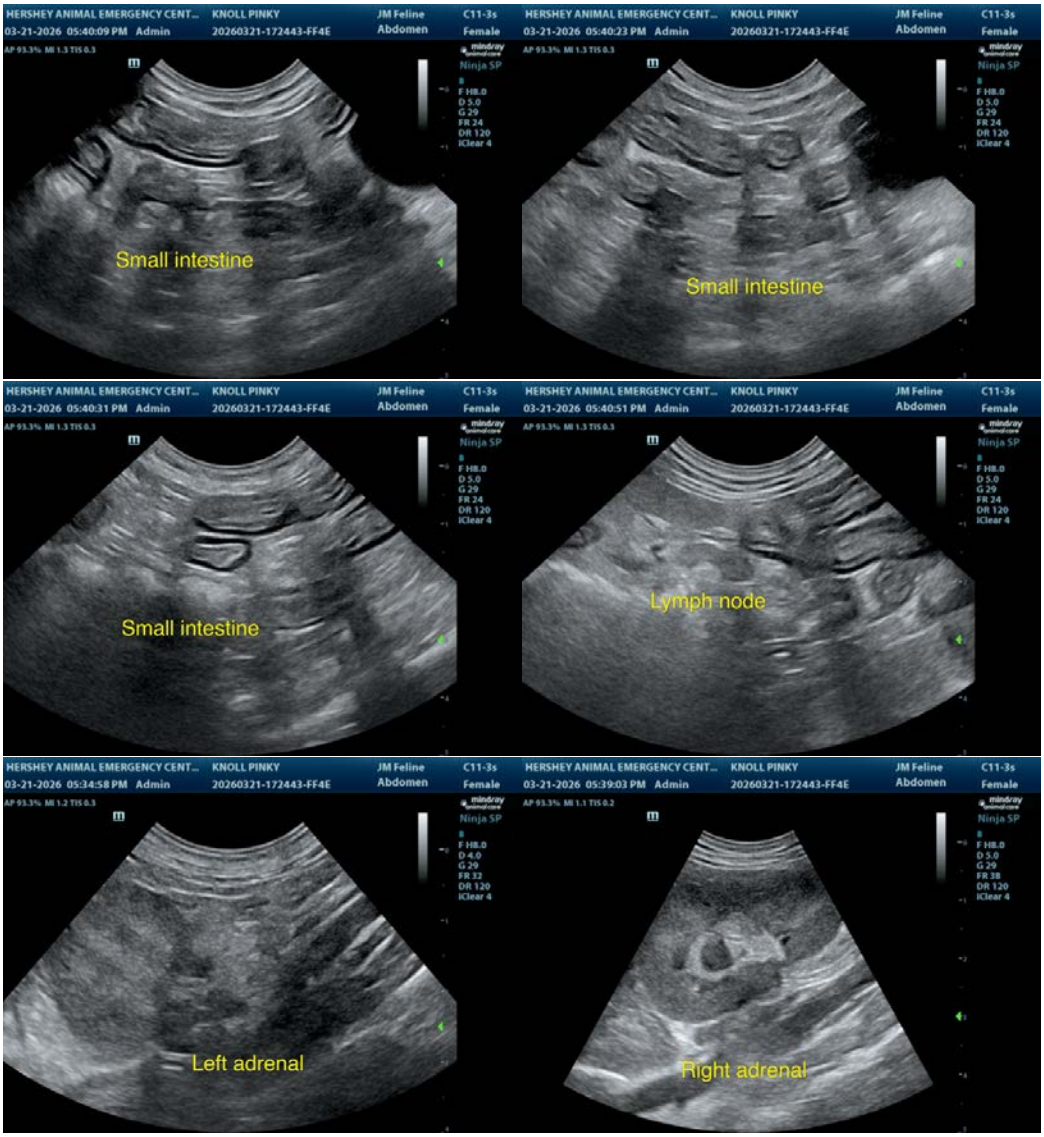

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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