



## PATIENT

Dolly Morris

## SPECIES

Feline

## BREED

Domestic Medium Hair

## SEX

Spayed female

## AGE

11 years

## WEIGHT

4.2 kg

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Dr. Soleil Gagne

## HOSPITAL NAME

Hart Family VC

## REFERRING VET

Dr. Gagne

## INVOICE

73728

## DATE

3/24/26

## PRESENTING CLINICAL SIGNS

- Vomiting on and off with blood. Soft feces on and off with blood
- Hx of uroliths - calcium oxalate - has had 2 cystotomies. Hx of azotemia prior to first cystotomy, kidney enzymes have been stable since. Currently on potassium citrate Receives sq fluids q48-72 hrs
- Blood work performed 01/07/2026 Alanine Aminotransferase 136 U/L (n 20-100 U/L) SDMA/T4 WNL, CBC WNL u/a most recent March 20th USG 1.042 and sediment WNL running pancreatic lipase today results WNL

## 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 3.0 cm, right measured 3.5 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.

### 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 0.22 cm in width. The right adrenal gland was not visualized.

### 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 2.6 cm in width. The spleen measured 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.



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## ***Gallbladder***

The gallbladder is small containing normal anechoic bile. Thickened (0.1 cm) and hyperechogenic 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 0.2 cm) with no loss of layering, but with segmental increase in the muscularis to mucosa ratio, normal peristaltic activity and no distension of the lumen. The stomach wall measures up to 0.38 cm. Fecal material is present in the colon.

## ***Pancreas***

The pancreas is not clearly visualized, but the visualized sections 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 0.3 x 0.8 cm in size maintaining normal shape and echogenic appearance.

No ascites evident.

## **ULTRASONOGRAPHIC FINDINGS**

- Enteropathy.
- Mesenteric lymphadenomegaly.
- Previous cholecystitis.

## **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 mesenteric lymphadenomegaly would be reactive hyperplasia secondary to the enteropathy with lymphadenitis and infiltrative neoplasia an unlikely differential diagnosis.

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

FNA cytology of the mesenteric lymph nodes can also be considered.



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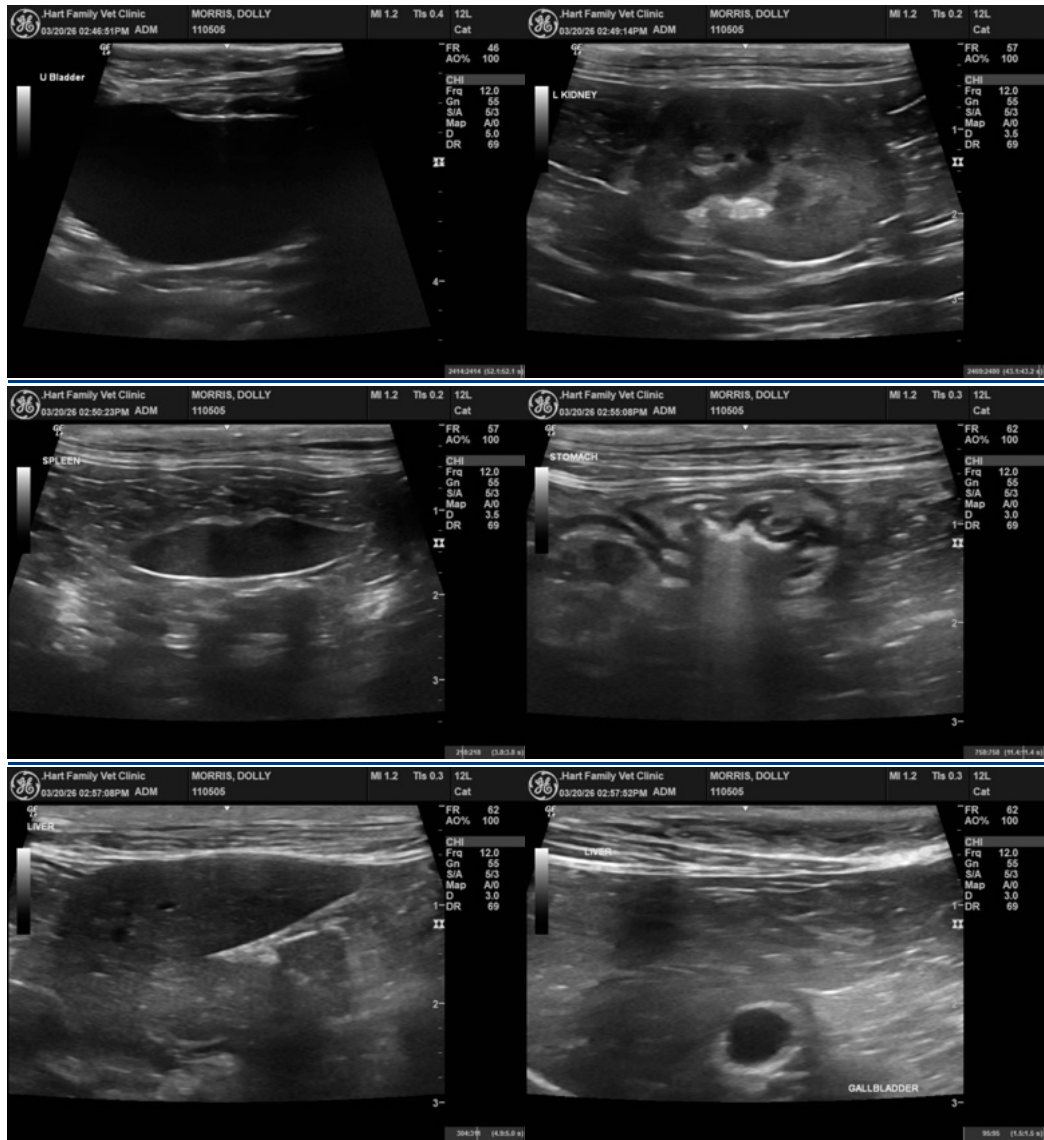
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Specific therapy would be dependent on an etiological diagnosis. Symptomatic management would be feeding small, frequent meals of a novel protein/hypoallergenic diet, course of Fenbendazole, cobalamin supplementation and if there is still not a satisfactory improvement then a course of Prednisolone would then be indicated.





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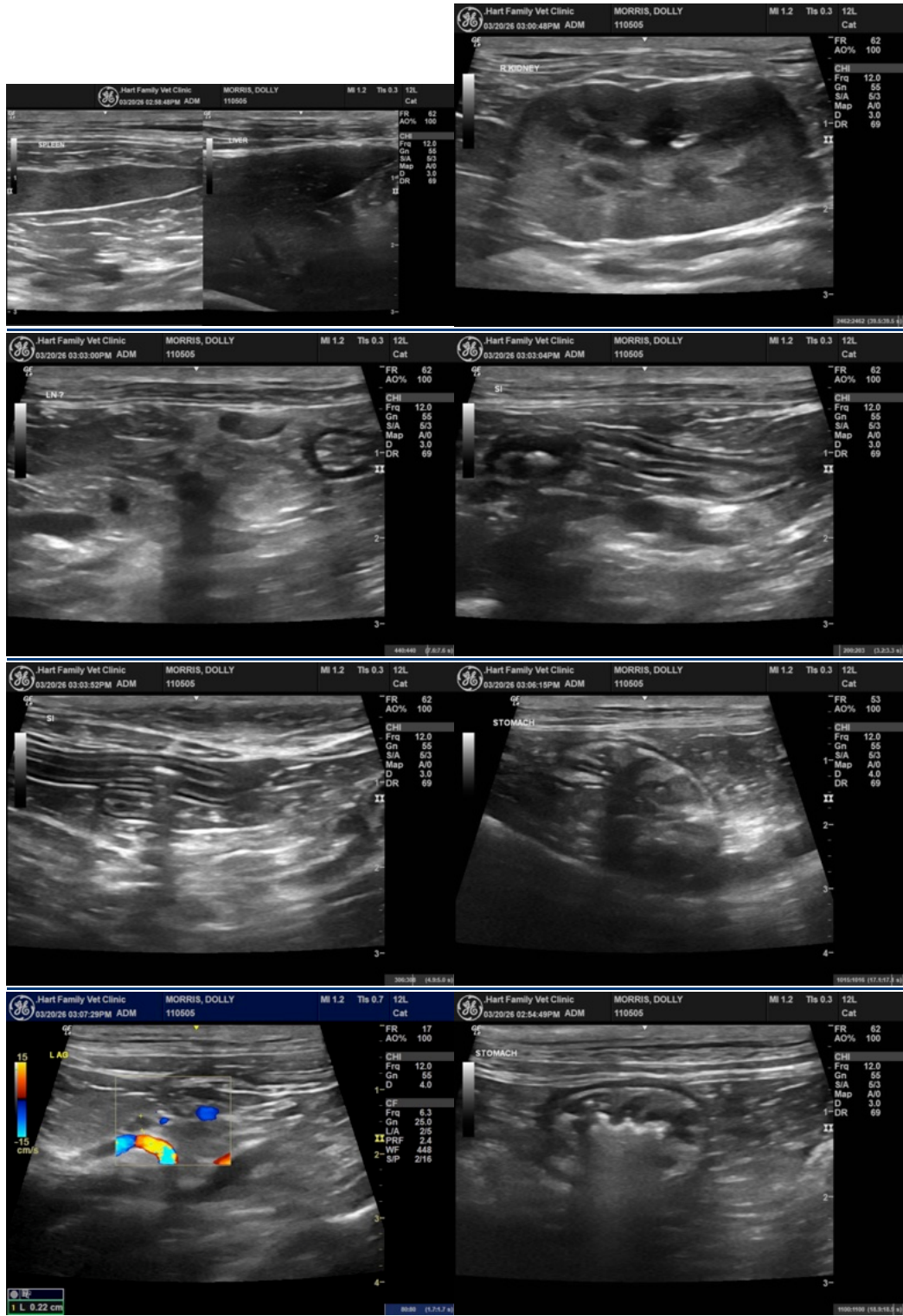
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The information and recommendations provided are based on the images presented by the



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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](mailto:info@sonopath.com)