



## PATIENT

Sabrina Capparelle

## SPECIES

Feline

## BREED

Domestic Shorthair

## SEX

Female

## AGE

1 year

## WEIGHT

9.4 lbs

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Dr. Hollway

## HOSPITAL NAME

Valley Green VH

## REFERRING VET

Dr. Oberer-Gerber

## INVOICE

73878

## DATE

3/27/26

## PRESENTING CLINICAL SIGNS

- Presents today as new client/new patient. Noticed Wednesday evening - vomit - has been lethargic since. P has not eaten since yesterday. O concerned P drank septic tank fluid overflow. Adopted her in January. NO hx of getting in to anything.
- IDX X-ray Conclusions:
- Gastric content presumably represents normal food, although if this P has been recently fasted or is anorectic the possibility of gastric foreign material or delayed emptying (due to gastritis or other cause of hypoperistalsis) should be considered, especially in a vomiting patient.
- There is no current evidence of a complete intestinal obstruction. However, partial obstruction cannot completely be ruled out regarding the GI tract content and current digestion.
- A rounded well-defined irregularly marginated soft tissue opaque structure is visible in a ventral small intestinal loop on both lateral views: This could indicate passage of residual food/kibble and normal digestion, however, a nonobstructive or partially obstructive soft tissue opaque foreign body at this level cannot be ruled out with this image.
- Multiple lobulated soft tissue opacities are noted dorsally to the colon, only visible on the right lateral view: This could be artifactual due to cross-sectioned corrugated SI, without ruling out sSIplication, and/or multiple enlarged mesenteric LN due to reactivity.
- Mild loss of serosal detail in the cranial/mid abdomen could indicate steatitis and/or scant amount of abdominal effusion.
- ~10% dehydrated. Significant ABD pain, diffuse w/out focal/regional foci noticed. Too tense to adequately palpate abdominal structures. Differed abdominal pain noted on spinal palpation. No obv heart or lung abnormalities though P is purring. Prev medical records indicate that Patient is spayed though no spay certificate included. No obvious spay scar, tattoo, or ear tip present. acky mm. External LNs = NSF. FELINE CCE1 RESULTS -- HCT = 33% borderline low WBC = 29.69 HIGH Neutr = 22.56 HIGH Mono = 0.98 HIGH Eos = 0.2 LOW BG = 215 HIGH Creat = 1.3 normal BUN = 81 HIGH GLOB = 5.2 HIGH Na = 140 LOW Cl - 98 LOW T4 = 1.2 normal PL = 1.4 (0-4.4) us-guided cystocentesis --> taken after IVF started USG = 1.024 7.0 pH trace protein

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

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

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 4.2 cm, right measured 4.5 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. Bilateral corticomedullary rim sign is present.

### Adrenal Glands



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Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 0.88 cm in length x 0.32 cm in width. The right adrenal gland measured 0.76 cm in length x 0.28 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 0.8 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***

The gallbladder is 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***

A fluid filled, hypomotile stomach was noted with the wall having a normal thickness showing no loss of layering and maintaining a 1:3 muscularis to mucosa ratio. Thickened section of loop of intestine measuring up to 0.45 cm with no loss of layering and a small amount of fluid present within the lumen. There is a hyperechogenic appearance of the surrounding mesentery and prominent appearance of regional lymph nodes measuring 0.3 x 0.7 cm in size. The lymph nodes maintained a normal shape and echogenic appearance. There is a small amount of fluid accumulating around the thickened section of small intestine. The rest of the small intestine is of normal thickness with no loss of layering and maintaining a 1:3 muscularis to mucosa ratio. Normal appearance of the 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.

### ***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***

Normal mesenteric lymph nodes (except those associated with the thickened intestinal loop).



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A small amount of ascites is present.

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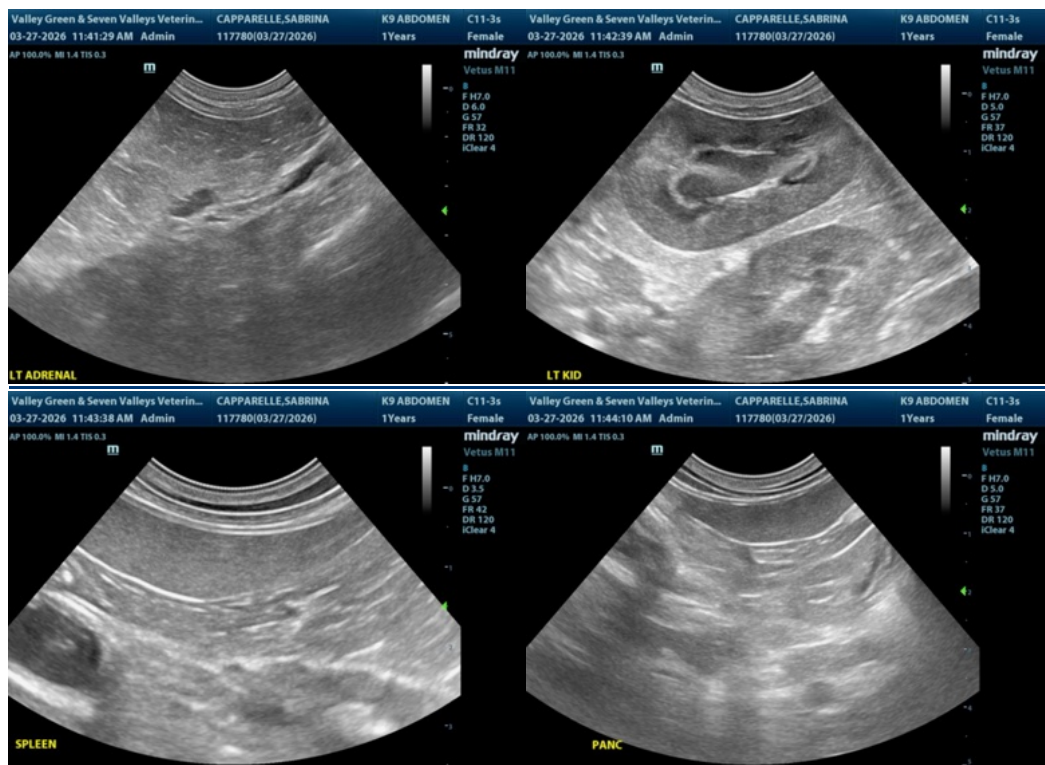
3/27/26

**ULTRASONOGRAPHIC FINDINGS**

- The most likely etiology would be intestinal obstruction and with the presence of ascites, hyperechogenic mesentery and prominent regional lymph nodes, perforation would be an important consideration.
- Although the bilateral corticomedullary rim sign can be considered an incidental finding, it can be associated with the hypercalcemia, lymphoma and granulomatous nephritis.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Further assessment would be laparotomy with further specific therapy would be dependent on an etiological diagnosis.





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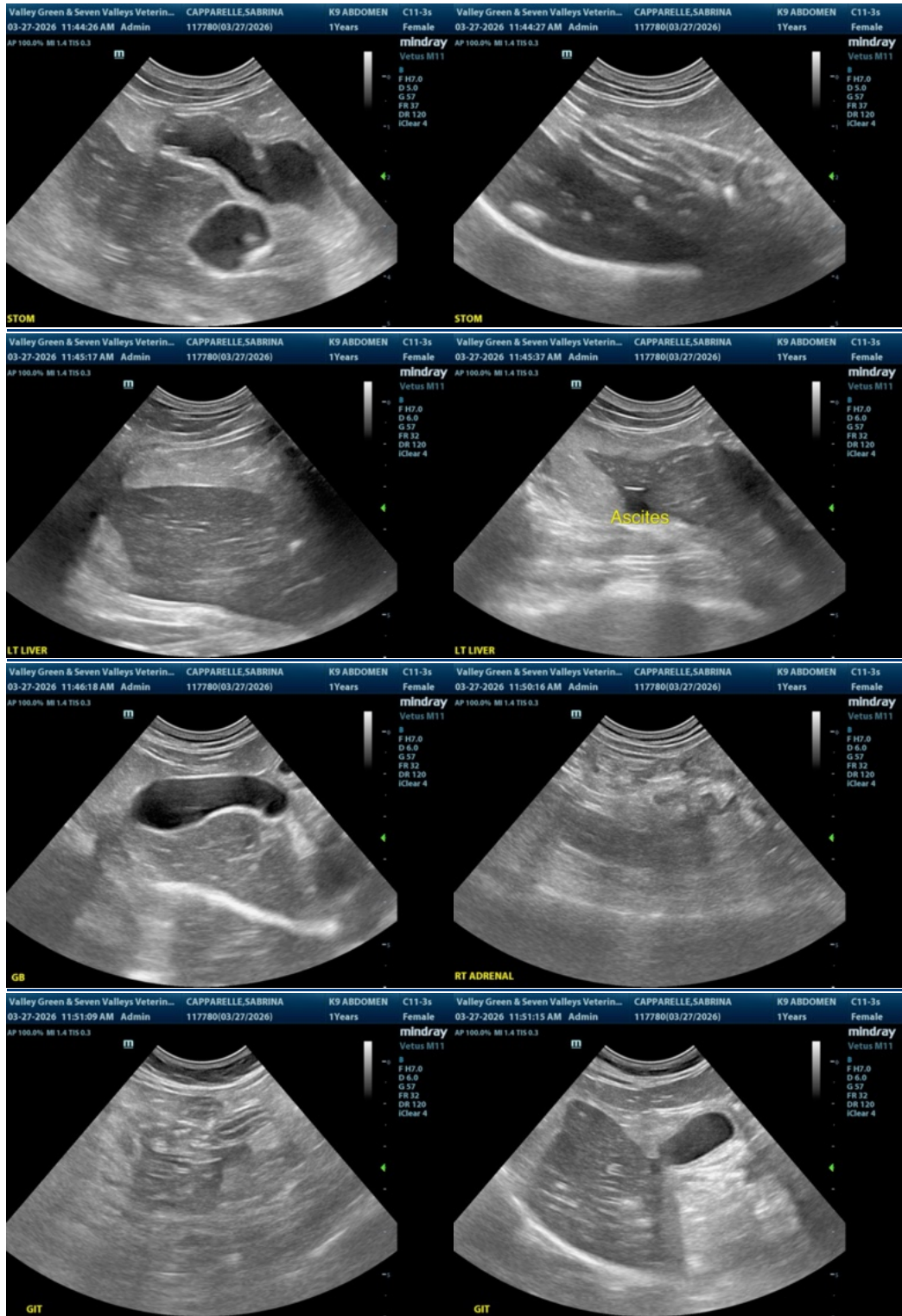
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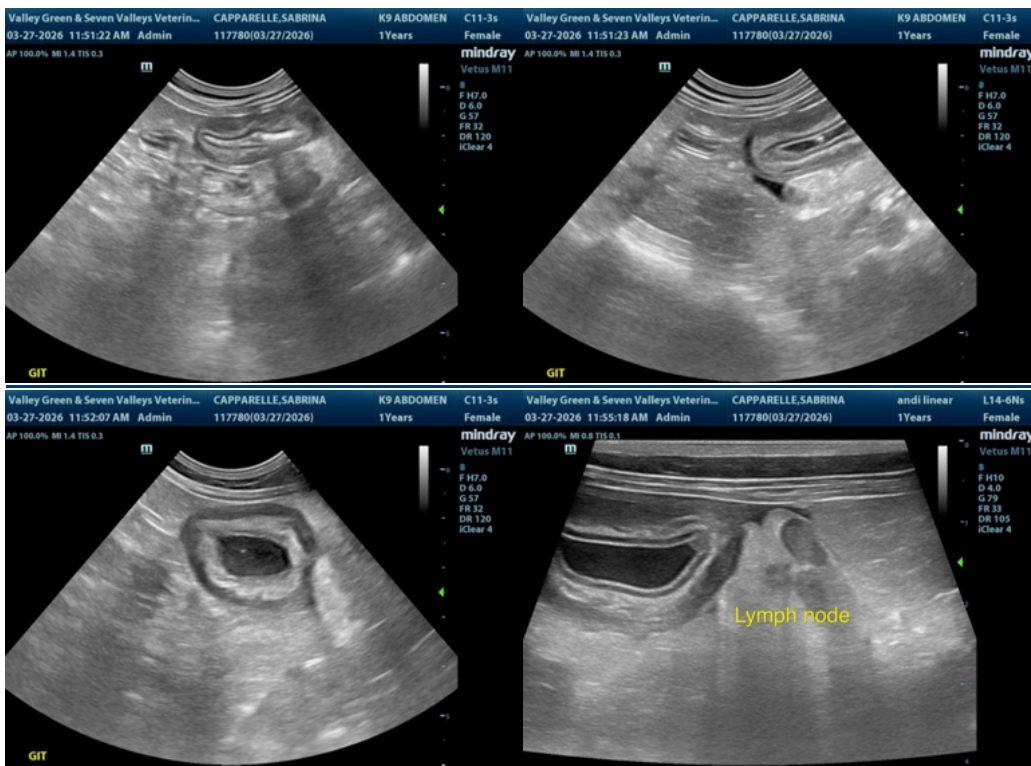
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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