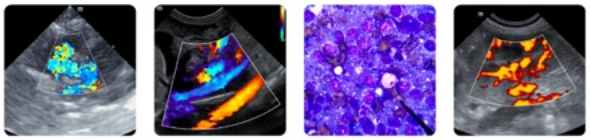


PATIENT

Stella Gozia

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

15 years

WEIGHT

12.64 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Danielle Shemanski, DVM, MA

HOSPITAL NAME

Western New York Veterinay Service

REFERRING VET

Dr. Hartman

INVOICE

74155

DATE

4/3/26

PRESENTING CLINICAL SIGNS

RDVM REASON FOR REFERRAL: Stella is a 15-year-old, diabetic cat presenting for lethargy and vomiting. She was seen at her primary veterinarian this morning. She has several singlet VPCs on ECG Lab work was performed: - Blood glucose was between 350-400 mg/dL (glucometer read 350). - SDMA was 15. - CBC showed a left shift in neutrophils but not an elevated white cell count. - Otherwise, labs were normal.
She was reported to be down and out this morning, which is abnormal for her friendly demeanor. She was given a Churu treat, ate half, and was then offered some c/d, which she ate and then vomited. Heart rate was noted to be back up to 160 bpm and sounded more regular.
Thoracic radiograph report : hepatopathy, bronchial lung pattern, collapse of the right middle lung lobe - likely associated with feline bronchial disease (asthma). Cardiac silhouette normal
The owner is currently in Germany. Stella is being cared for by a pet sitter.
CLINICAL SIGNS: lethargy, anorexia, vomiting
MEDICATIONS: Glargine Insulin - 1 1/2 units BID, Mirtazipine PRN, Cerenia 16mg - 1/4 tab SID for 5 days and then off for 2 days and then
April 3, 2026 BG: 345mg/dl. Urine Dipstick: Urine Dipsticks Results: Specific Gravity: Over 1.040 Urobil: Normal Glucose: +3 Ketone: Neg Bilirubin: Neg Protein: +2 Blood: Neg pH: 6.5 UA (WNL): RBC <5/HPF WBC <5/HPF Struvite < 1 / HPF Calcium Oxalate dihydrate < 1 / HPF Bilirubin < 0.1 / HPF Cystine < 0.1 / HPF Ammonium Biurate < 0.1 / HPF CBC: NEU 11.08 (Ref 2.30 - 10.29) K/µL HIGH EOS 1.59 (Ref 0.17 - 1.57) K/µL HIGH Blood Chem: GLU 430 (Ref 71 - 159) mg/dL HIGH SDMA 15 (Ref 0 - 14) µg/dL HIGH

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

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.

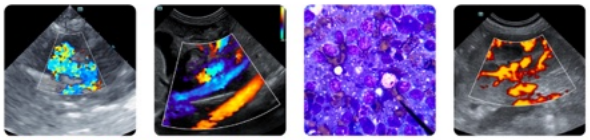
Normal renal size (left measured 4.0 cm, right measured 4.7 cm), architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident. Normal color flow pattern is evident in both kidneys.

Adrenal Glands

Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 0.43 cm in width. The right adrenal gland measured 0.39 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.



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Incidental myelolipoma is present. 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

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. Corrugated appearance of the duodenum is noted.

Pancreas

The pancreas is enlarged with a mottled echogenic and nodular appearance and an irregular capsule. The left pancreas measures 0.9 cm in width. Increased echogenic appearance of the mesentery and fat surrounding the pancreas is noted.

Free Abdomen

Enlarged mesenteric lymph nodes measuring up to 0.3 x 1.1 cm in size maintaining a normal shape, but with an increased echogenic appearance.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

- Pancreatic pathology.
- Enteropathy.
- Mesenteric lymphadenomegaly.
- Urinary bladder sediment.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiologies for the pancreas would be chronic active pancreatitis, granulomatous disease and neoplasia.

Etiologies for the enteropathy would be parasitic enteritis, dietary hypersensitivity, inflammatory bowel disease and possibly emerging lymphoma.

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

The most likely etiology for the urinary bladder sediment would be incidental debris with crystalluria and bacterial cystitis a less likely differential diagnosis.

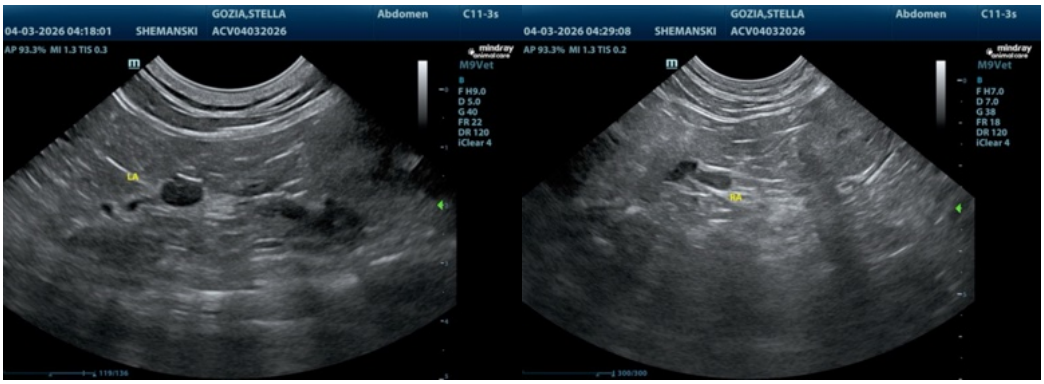
The corrugated appearance of the duodenum can be ascribed as secondary to the pancreatic pathology.

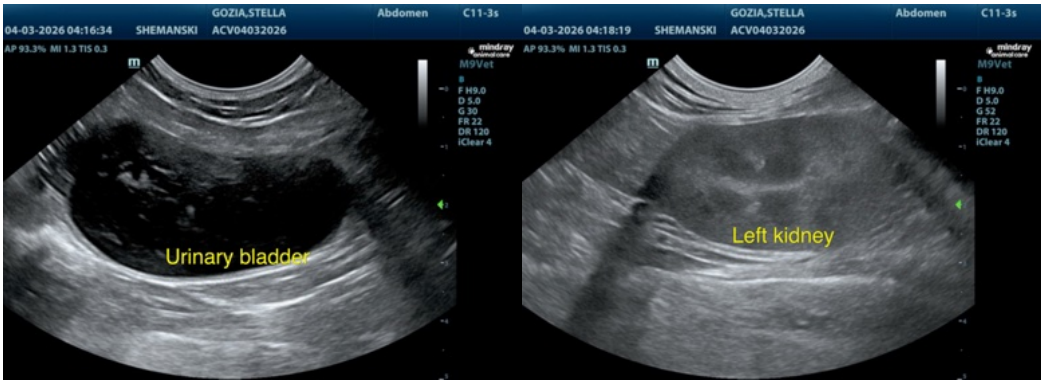
Initial further assessment would be urine and fecal analysis, possibly urine culture, FPL/PSL assay and FNA cytology of the pancreas and mesenteric lymph nodes.

Additional diagnostics that may be required would be 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 fluid therapy as needed, antiemetics, analgesics and feeding small, frequent meals of a low fat intestinal type diet.





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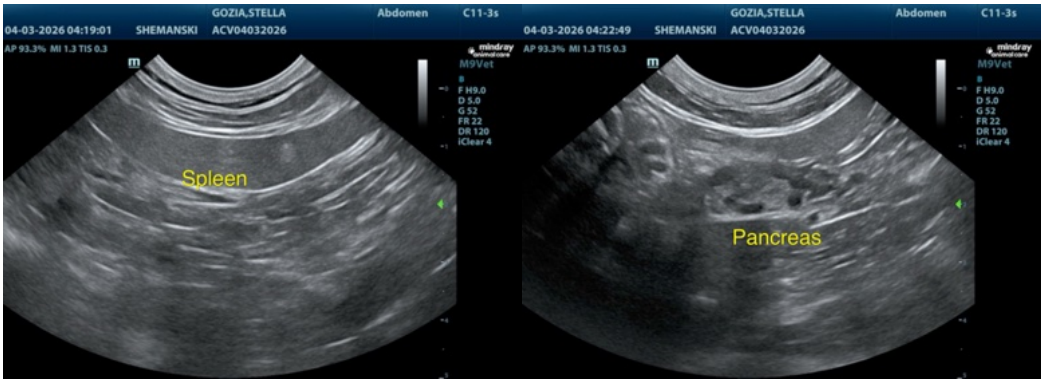

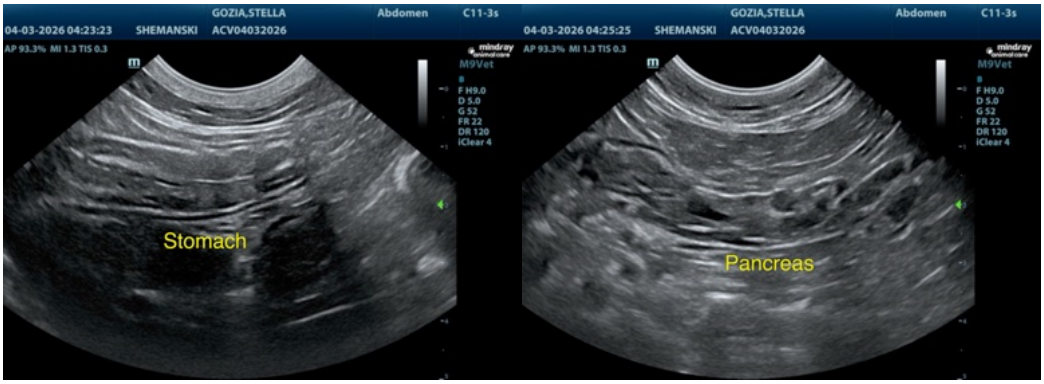

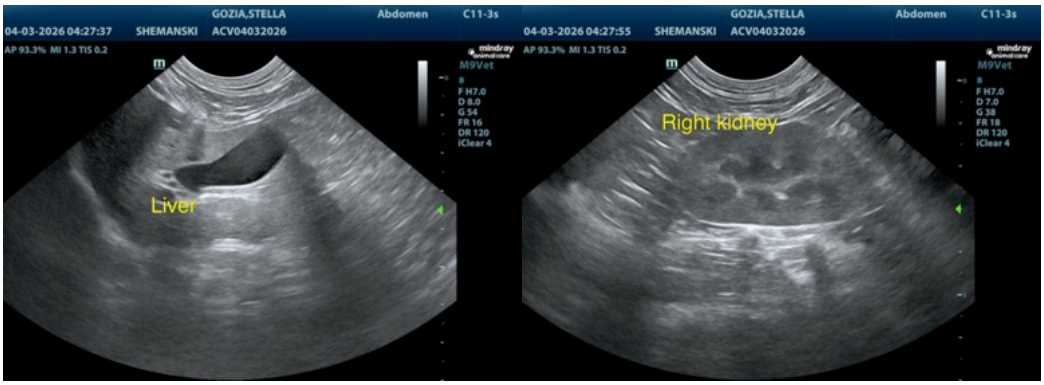

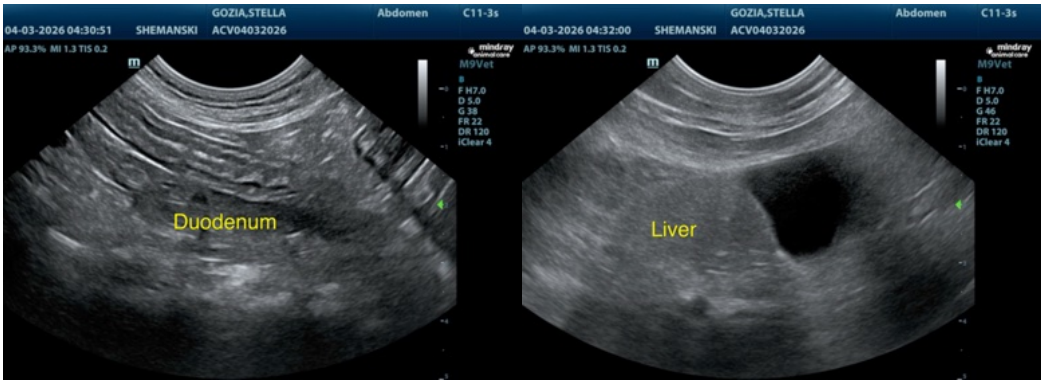

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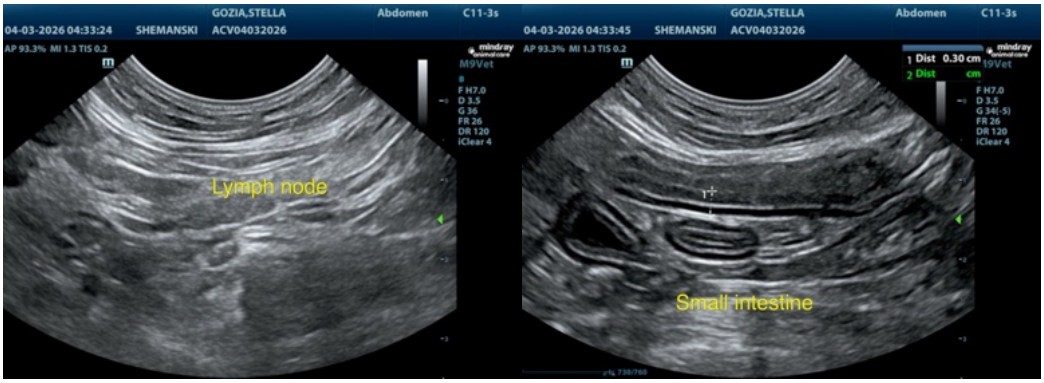

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com