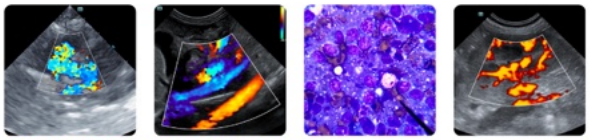


PATIENT

Theo Harvey

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

8 years

WEIGHT

13 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Danielle Shemanski, DVM, MA

HOSPITAL NAME

Western New York Vetererinay Service

REFERRING VET

Dr. Budby

INVOICE

75068

DATE

4/30/26

PRESENTING CLINICAL SIGNS

History: Weight loss, vomiting, suspect abdominal pain.
History: Theo has shown ongoing behavioral changes, aggression, weight loss, and increased lethargy. February labs and an April pancreatic lipase test were normal; T4 was 1.8 ug/dL. Miranda, the owner's daughter, reported a severe lethargic episode where Theo could barely open his eyes. Usually food-motivated, he recently refused all food and treats and stopped jumping onto furniture. These acute signs followed several months of subtle changes. Appetite returned with anti-nausea medication, though missing a dose leads to anorexia the next day. Pain medication was last given last night and this morning. Vomiting consists of stomach acid; no diarrhea has been noted. The last bowel movement is unknown. Symptoms began before a new kitten arrived, though lethargy worsened afterward. Theo is separated from the kitten but typically coexists well with other cats. He eats a mix of Iams and urinary dry/wet food. Currently, he approaches his bowl but walks away without eating.
CLINICAL SIGNS: Anorexia and weight loss
MEDICATIONS: Cerenia 8 mg SID, Gabapentin 50 mg SID-BID
February 23, 2026 Globulin 5.5 g/dL HIGH Urinalysis - USG 1.049 WNL, pH 8.0 (HIGH) T4 1.8 ug/dL WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is full with a normal thickness and smooth appearance of the wall. A moderate 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.

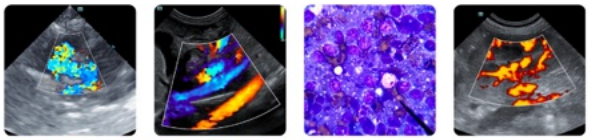
Normal renal size (left measured 4.3 cm, right measured 3.9 cm), architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident. Normal color flow pattern is evident in both kidneys.

Adrenal Glands

Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 0.52 cm in width. The right adrenal gland measured 0.41 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 0.7 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 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, small intestine, 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. Fecal material was noted 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

Normal mesenteric lymph nodes.

No ascites evident.

Thorax

Normal appearance of the heart. No pericardial or pleural effusion evident.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder sediment.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The likely etiologies for the urinary bladder sediment would be incidental debris and crystalluria with hematuria and bacterial cystitis an unlikely differential diagnosis.

On this ultrasound there is no obvious etiology for the presenting clinical signs.

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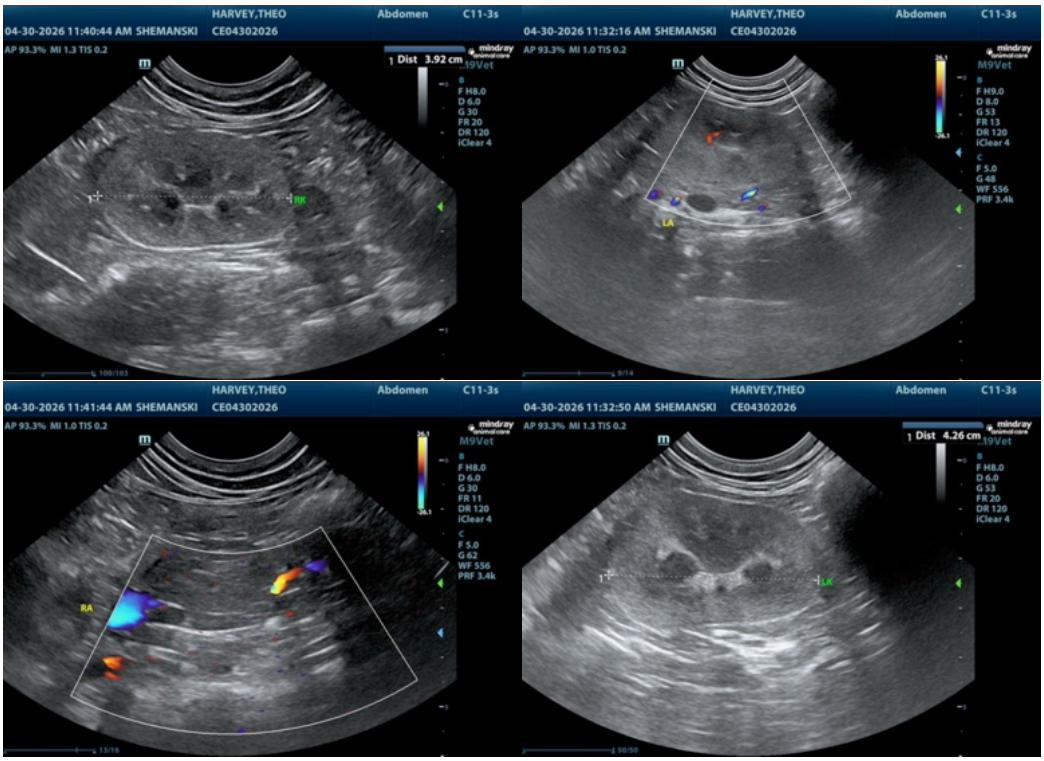
Although the GI tract appears ultrasonographically normal with the presenting clinical signs, an underlying gastropathy such as parasitic gastroenteritis, dietary hypersensitivity, chronic gastritis, Helicobacter gastritis and inflammatory bowel disease should still be considered.

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 small frequent meals of a novel protein/hypoallergenic diet, course of Fenbendazole, cobalamin supplementation and if there is still not a satisfactory improvement then triple therapy for Helicobacter gastritis and if there is still not a satisfactory improvement then a course of Prednisolone would then be indicated.



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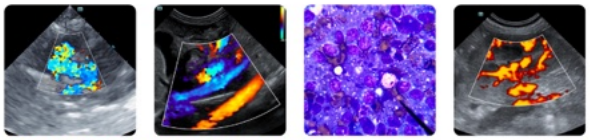

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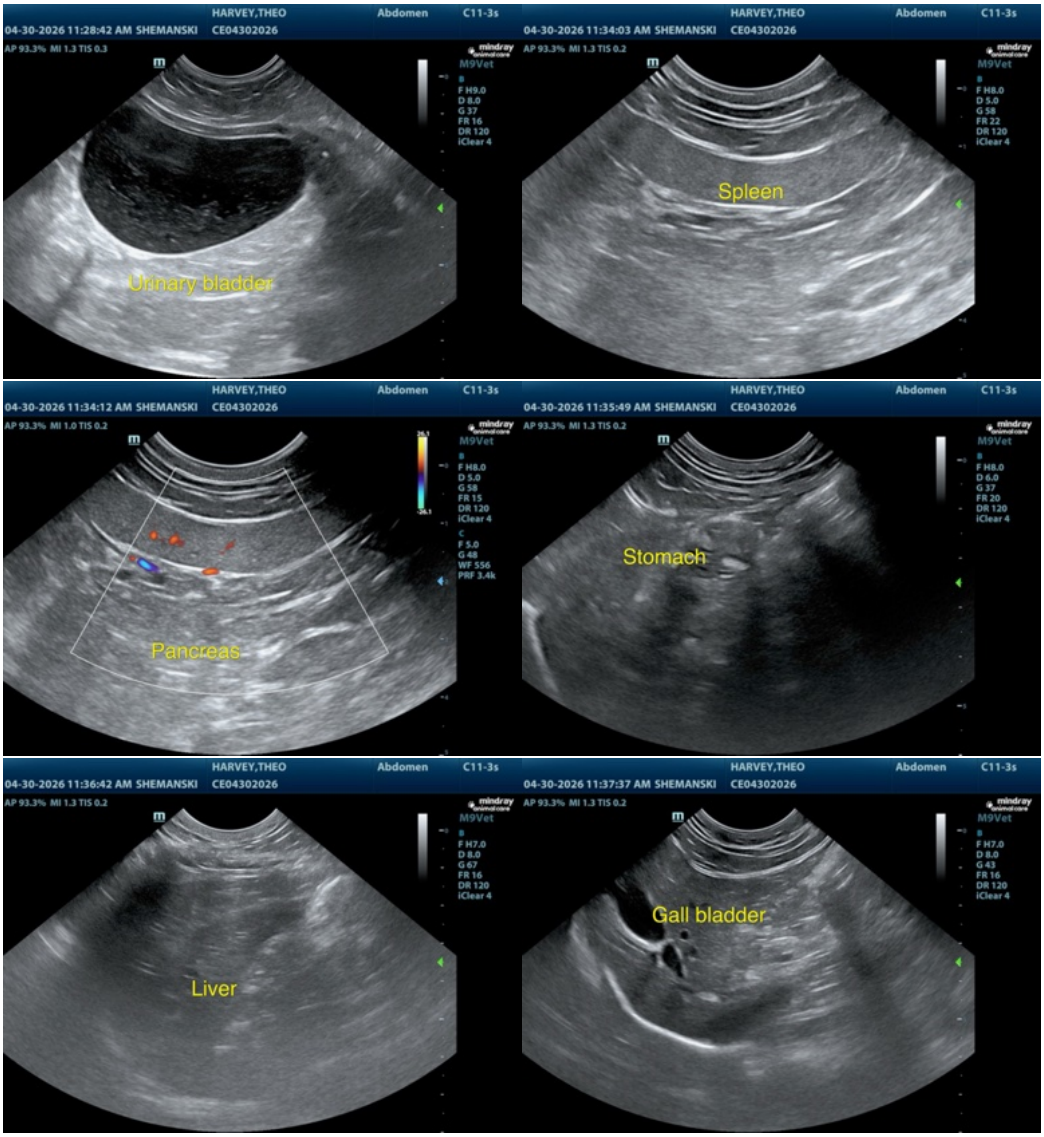

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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