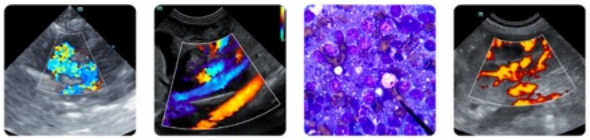


PATIENT

Tulip Hines

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

10 years

WEIGHT

8.2 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Wolfe

HOSPITAL NAME

HomeVets

REFERRING VET

Dr. Wolfe

INVOICE

74266

DATE

4/7/26

PRESENTING CLINICAL SIGNS

- Anorexia, vomiting, and weight loss
- Hx of hyperthyroidism well controlled on y/d food.
- Hx of FIV pos
- Borderline anemia HCT 30% chronic but worsening neutropenia 0.99K Chronic ALT elevation (10/25/25) 217, (4/3/26) 175 T4 normal 2.0

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is small 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 3.5 cm, right measured 3.6 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

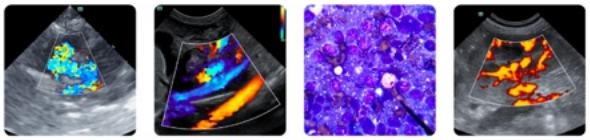
Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 0.32 cm in width. The right adrenal gland measured 0.25 cm in width.

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 1.0 cm in width.

Liver

Normal size with a diffuse increased echogenic and coarse appearance, normal 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 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.

Pancreas

Normal size (left 0.6 cm in width) with a hypoechogenic appearance and an irregular capsule. Mild increase in the echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Prominent mesenteric lymph nodes measuring up to 0.3 x 0.7 cm in size with a hypoechogenic appearance, but maintained a normal shape.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

- Pancreatitis.
- Hepatopathy.
- Mesenteric lymphadenomegaly.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiologies for the hepatopathy would be reactive hyperplasia, vacuolar and metabolic (secondary to the hyperthyroidism) with hepatitis and infiltrative neoplasia an unlikely differential diagnosis.

The most likely etiology for the mesenteric lymphadenomegaly would be reactive hyperplasia with lymphadenitis and infiltrative neoplasia an unlikely differential diagnosis.

Although the presenting clinical signs can be attributed to pancreatitis, an underlying enteropathy such as parasitic enteritis, dietary hypersensivity and inflammatory bowel disease should still be considered.

Further assessment would be fecal analysis, cobalamin, folate and FPL/PSL assay, endoscopy of the upper GI tract with biopsies and possibly FNA cytology of the mesenteric lymph nodes.

Specific therapy would be dependent on an etiological diagnosis.

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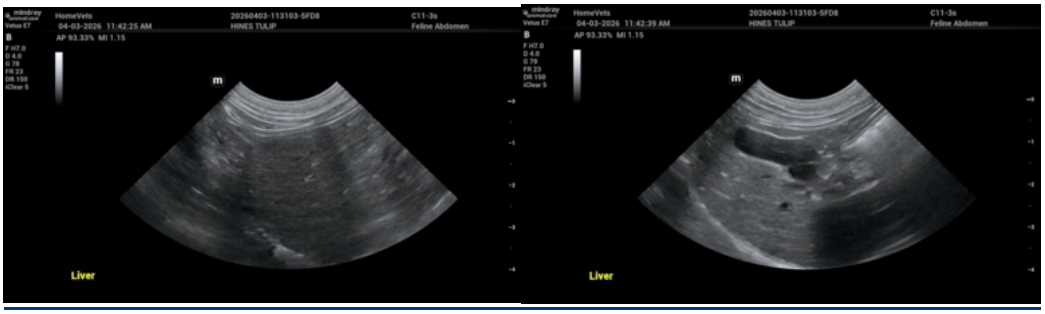
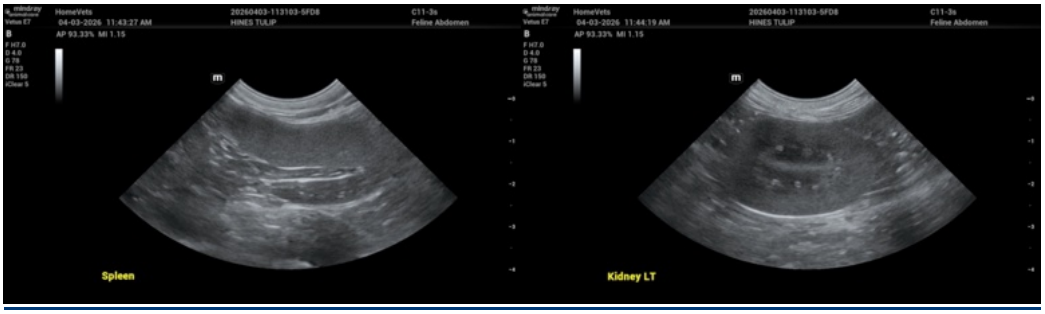
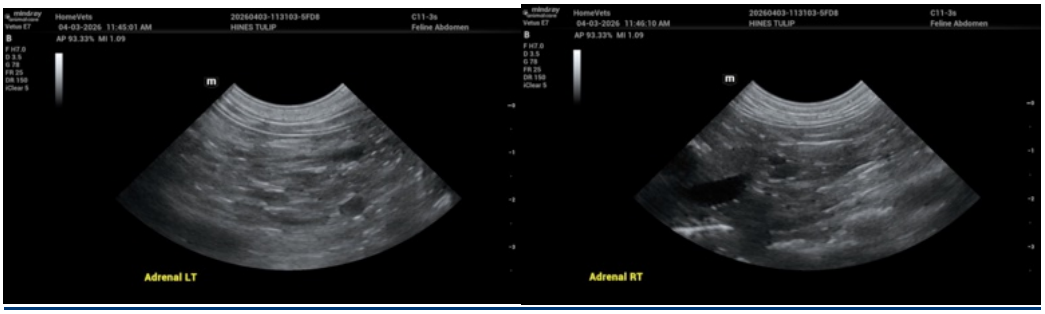
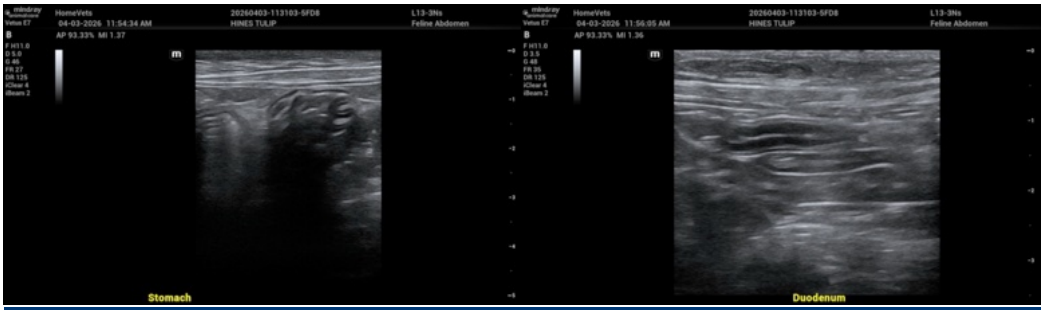
Initial management of the pancreatitis would be feeding small frequent meals of an intestinal type diet, antiemetics and analgesics.

Symptomatic management of a possible underlying enteropathy would be feeding a novel protein/hypoallergenic diet, course of Fenbendazole, cobalamin supplementation and if there is still no improvement then a course of Prednisolone would then be indicated.









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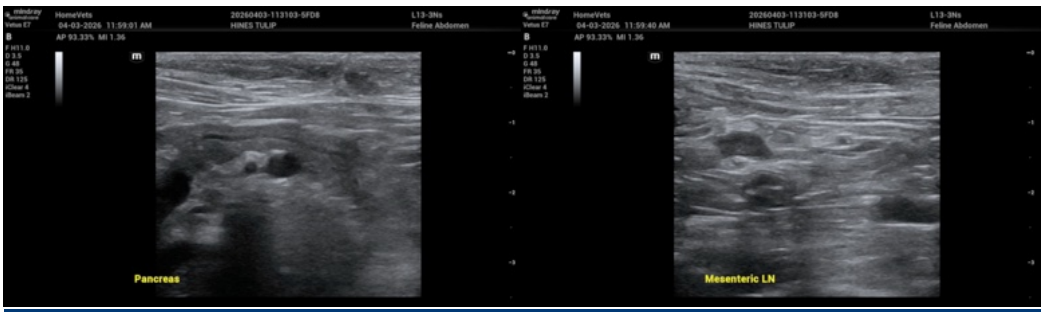

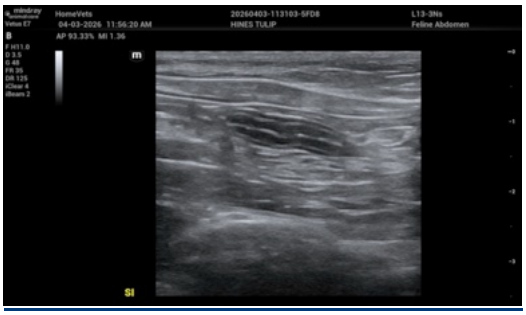

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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