



PATIENT

Jasmine Connelly

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

15 years

WEIGHT

12.6 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Allison Maxey

HOSPITAL NAME

Evergreen AH

REFERRING VET

Dr. Maxey

INVOICE

75515

DATE

5/13/26

PRESENTING CLINICAL SIGNS

History: Had episode of vomiting and decreased appetite in Feb 2026. Bloodwork at that time was unremarkable. Responded to supportive care. Currently has 3-4 day duration of vomiting multiple times per day, decreased appetite, and decreased energy level. Had lost ~1lb since Feb and 2lbs since 9/2025. PE mostly unremarkable other than weight loss and poor hair coat.

Abnormal PE/Chem/CBC/UA Results: Most recent bloodwork: Mild neutrophilia (~16,000/ul), severely elevated ALT (1224 U/L), mild hyperbilirubinemia (1.1 mg/dl). Mild hyperglycemia (188 mg/dl) with normal fructosamine (281).

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.

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 3.9 cm, right measured 3.8 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 0.34 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 0.7 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 full containing normal anechoic bile. Normal thickness and echogenic appearance of the wall. Dilated and tortuous appearance of both the cystic and common bile ducts with no obvious obstruction evident. The cystic bile duct measured 0.4 cm in diameter.

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. A small amount of ingesta was present in the stomach compatible with a recent meal.

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.

ULTRASONOGRAPHIC FINDINGS

- Enteropathy.
- Dilated tortuous bile duct.

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 appearance of the bile duct can be considered an incidental age related finding.

On this ultrasound there is no obvious etiology for the elevated ALT activity and although the liver appears ultrasonographically normal with a severely elevated ALT activity, an underlying hepatopathy such as hepatitis, infiltrative neoplasia and metabolic (such as hyperthyroidism) should still be considered.

Further assessment would be fecal analysis, cobalamin, folate and T4 assay (if not already done), endoscopy of the upper GI tract with biopsies and FNA cytology of the liver.

A tru cut or wedge biopsy of the liver may be required for a final etiological diagnosis.



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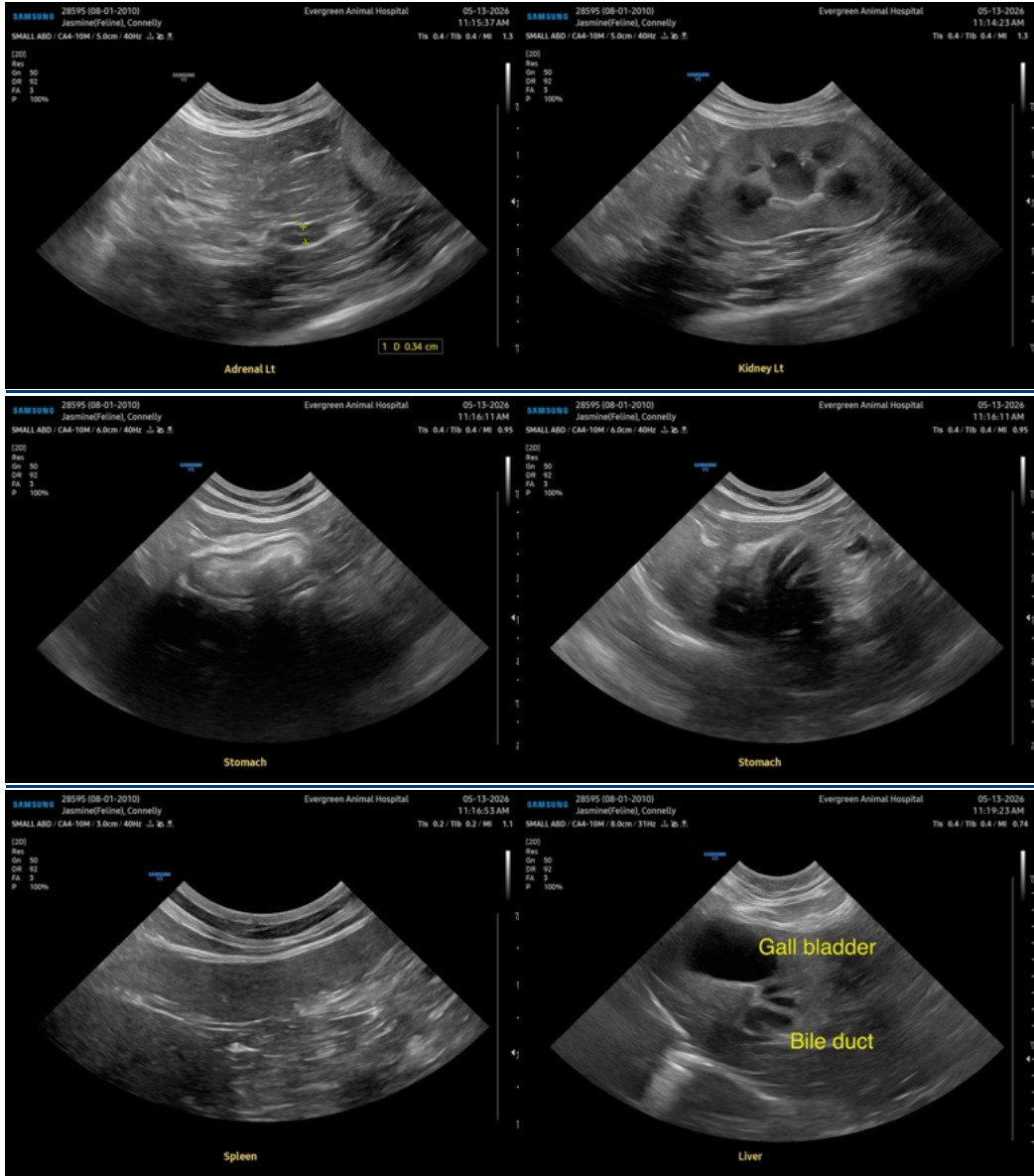
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Specific therapy would be dependent on an etiological diagnosis.

Symptomatic management that could be considered would be feeding small frequent meals of a novel protein/hypoallergenic diet, cobalamin supplementation, course of Fenbendazole, Ursodiol and if there is still not a satisfactory improvement then a course of Prednisolone would then be indicated.





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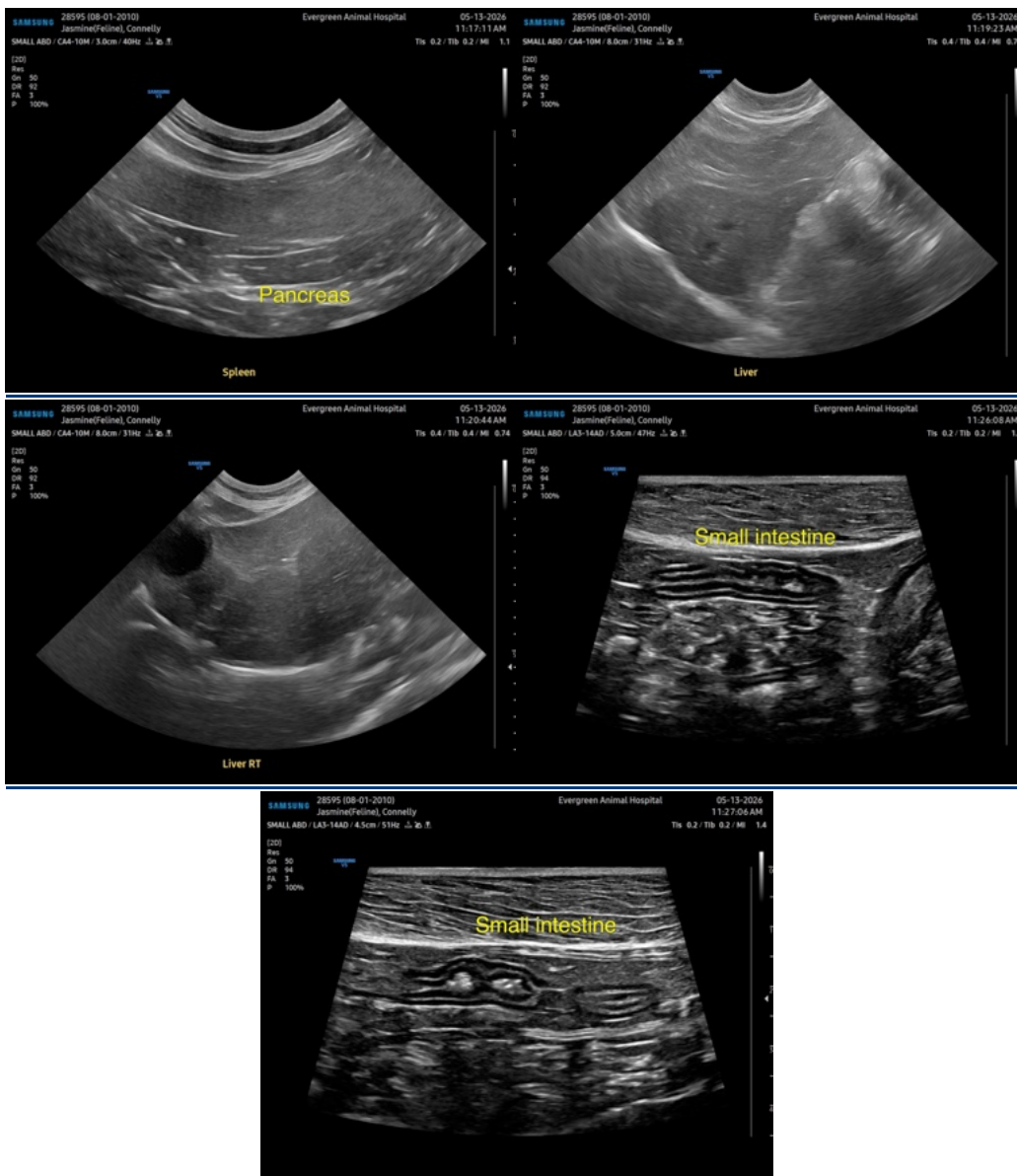
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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