



**PATIENT**

Murray Barnhardt

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Neutered male

**AGE**

9 years

**WEIGHT**

13.8 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Ginny Dodd DVM,  
 DABVP

**HOSPITAL NAME**

Monroe Road AH

**REFERRING VET**

Dr. Fackrell

**INVOICE**

69544

**DATE**

12/23/25

**PRESENTING CLINICAL SIGNS**

History: H/O visit to CARE 10/30 for vomiting- CBC showed \*WBC, mild anemia- treated with fluids, antiemetic medication and improved. Presented 12/22 with vomiting 4 times in past 3 days, less appetite, and 1 pound weight loss since 10/30. He has been terrorized by another cat in household who became aggressive after being on steroids for IBD.

Abnormal PE/Chem/CBC/UA Results: PE: very anxious so sedated for sonogram with Dexdomitor, no palpable masses CBC- wnl in house Chem- wnl in house

**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 4.2 cm, right measured 4.1 cm), increased echogenic appearance, some loss of cortico-medullary differentiation, and normal 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 0.78 cm in length x 0.25 cm and 0.33 cm in width. The right adrenal gland measured 1.14 cm in length x 0.41 cm and 0.47 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, 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 small containing normal anechoic bile. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct. The common bile duct measures 0.3 cm in diameter.

**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**

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 measuring up to 0.4 cm.

No ascites evident.

**ULTRASONOGRAPHIC FINDINGS**

- Urinary bladder sediment.
- Age related renal changes versus early chronic kidney disease.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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

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

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

Low-grade pancreatitis would be a differential diagnosis.

Further assessment would be urine and fecal analysis, possible urine culture, cobalamin, folate and FPL/PSL assay and endoscopy of the upper GI tract with biopsies.

Specific therapy would be dependent on an etiological diagnosis. Symptomatic management that can be considered would be feeding small, frequent meals of a novel protein/hypoallergenic diet, course of



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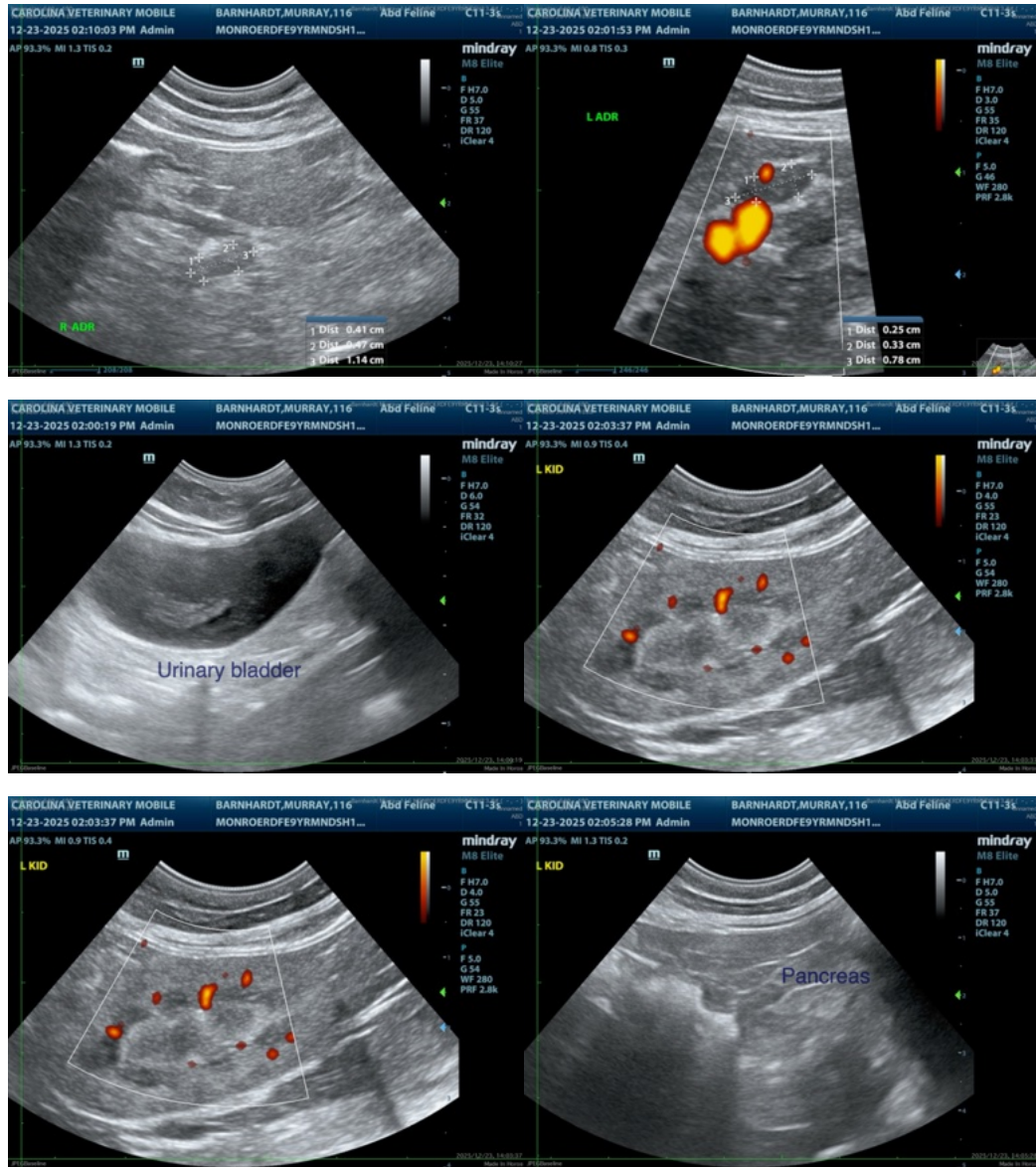
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Fenbendazole, cobalamin supplementation and if there is still not a satisfactory improvement then a course of Prednisolone would then be indicated.





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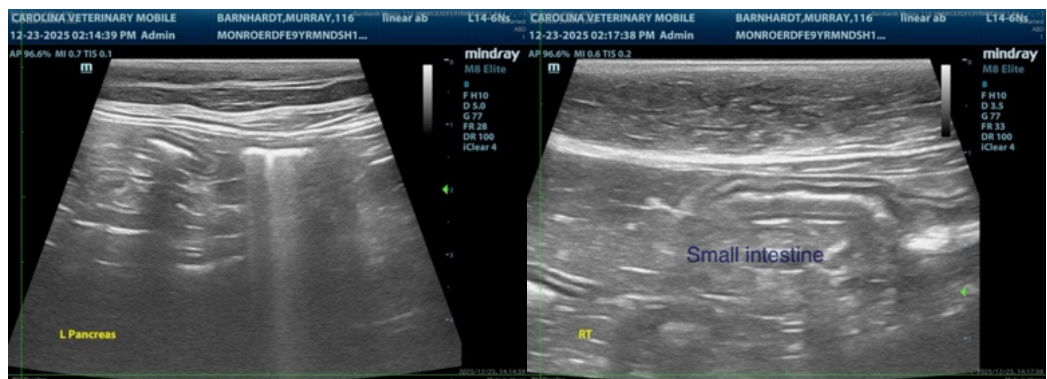
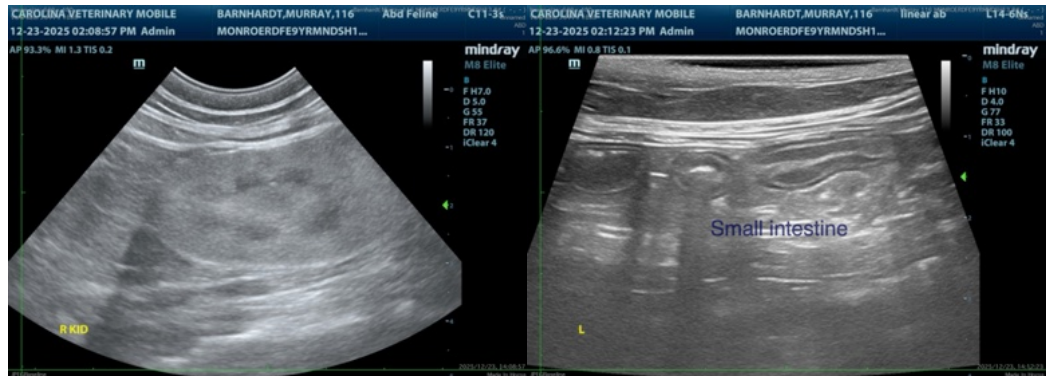
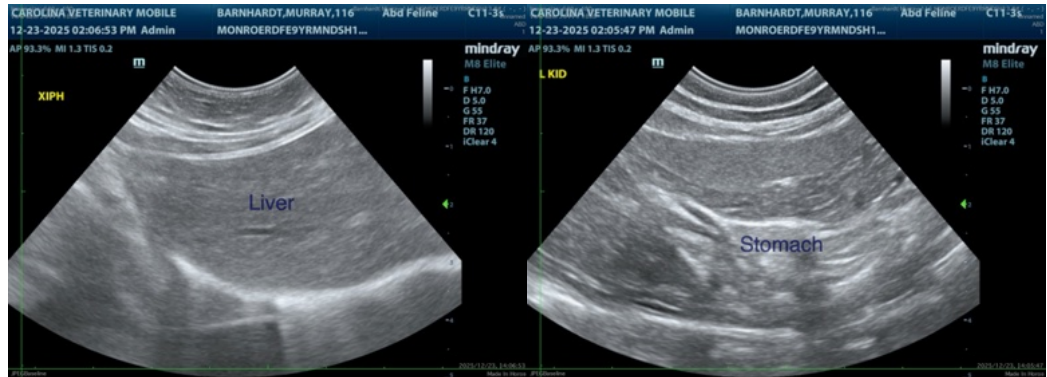
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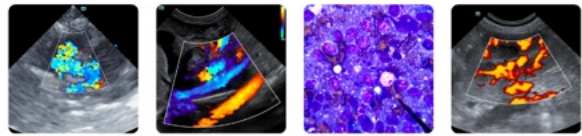
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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