



**PATIENT**

Lily Abanto

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Spayed female

**AGE**

7.7 years

**WEIGHT**

9.6 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Ginny Dodd, DVM

**HOSPITAL NAME**

Steele Creek AH

**REFERRING VET**

Dr. Judy

**INVOICE**

73740

**DATE**

3/24/26

**PRESENTING CLINICAL SIGNS**

- Prior H/O asthma. FeLV/FIV neg in 2025. Had PureVax vaccines 3/19- all 3 indoor cats were lethargic and vomited food then had diarrhea on 3/20. 3/21- vomited food (chicken) and pink bile 5 times
- 3/22- at ER- blood work, X-rays, AUS- normal except SL ^ ALT- RX ondansetron, cerenida, probiotic - ate sm ant tuna
- 3/23- hiding, acting nauseous, won't eat- other 2 cats are fine- taken to FDVM- gave SC fluids, try l/d repeated labs
- PE- no abdominal tenderness noted CBC 3/23. WBC 3.2 >; put 67> but plt clumping, neuts 1024> no bands T4 1.7 Superchem alb 2.9, glob 3.6, SDMA 18 < (<15), chol 69> (25- 160), precision PSL 15 (8- 26)

**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 3.3 cm, right measured 3.4 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 0.98 cm in length x 0.3 cm and 0.27 cm in width. The right adrenal gland measured 0.94 cm in length x 0.39 cm and 0.38 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 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. Normal size and appearance of the cystic and common bile duct. The cystic bile duct measured 0.3 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 0.25 cm) with no loss of layering, but with mild segmental increase in the muscularis to mucosa ratio, normal peristaltic activity and no distension of the lumen. Fecal material is present in the colon.

**Pancreas**

Enlarged left pancreas (0.9 cm in width) with a mottled echogenic appearance and an irregular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

**Free Abdomen**

Enlarged mesenteric lymph nodes measuring up to 0.4 x 0.9 cm in size with a hypoechoic appearance with some having a rounded shape.

No ascites evident.

**ULTRASONOGRAPHIC FINDINGS**

- Enteropathy.
- Mesenteric lymphadenomegaly.
- Chronic pancreatitis versus pancreatic fibrosis.

**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.

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

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.



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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 a course of Prednisolone would then be indicated.

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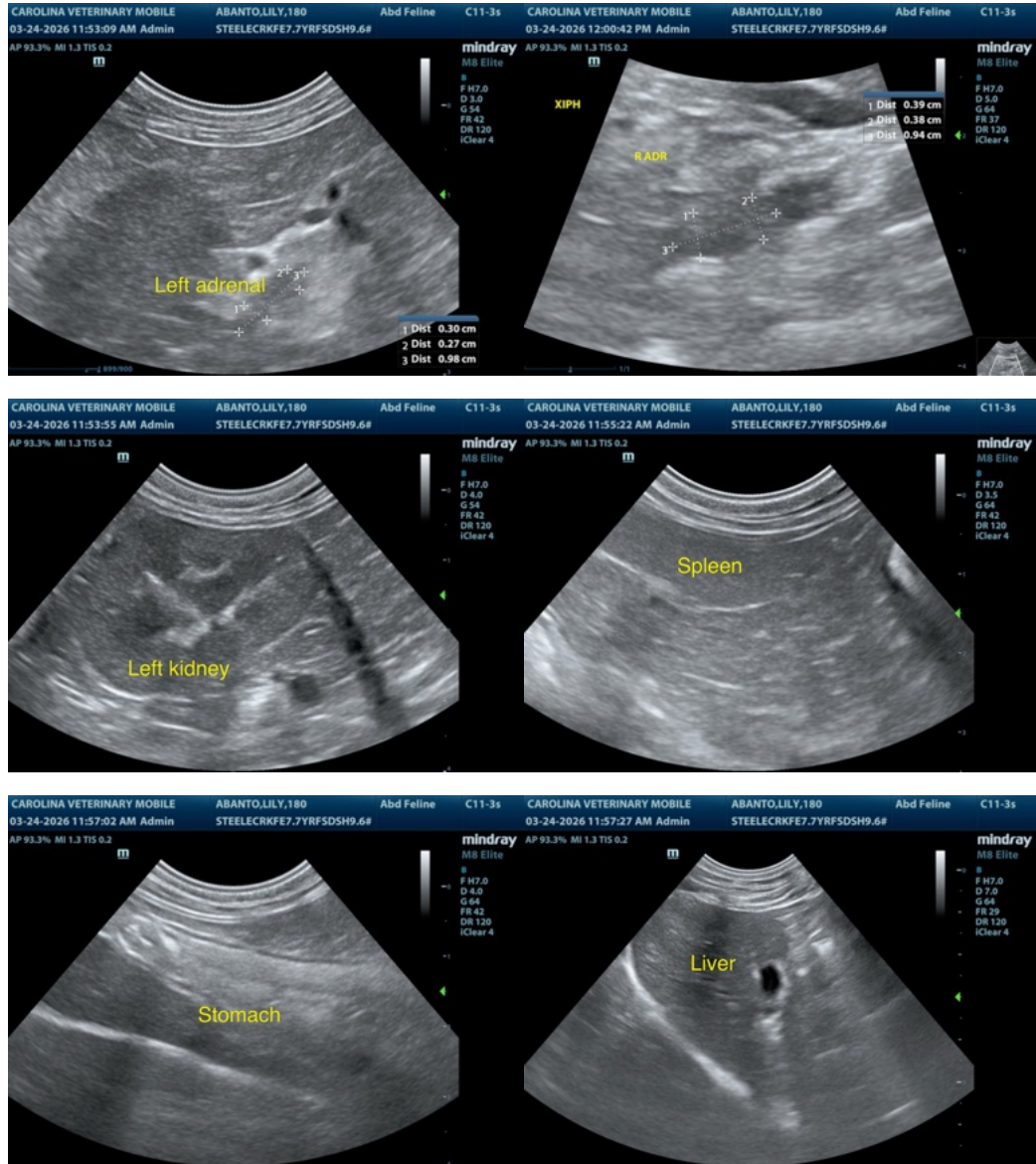
Dr. Judy

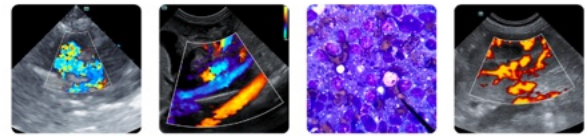
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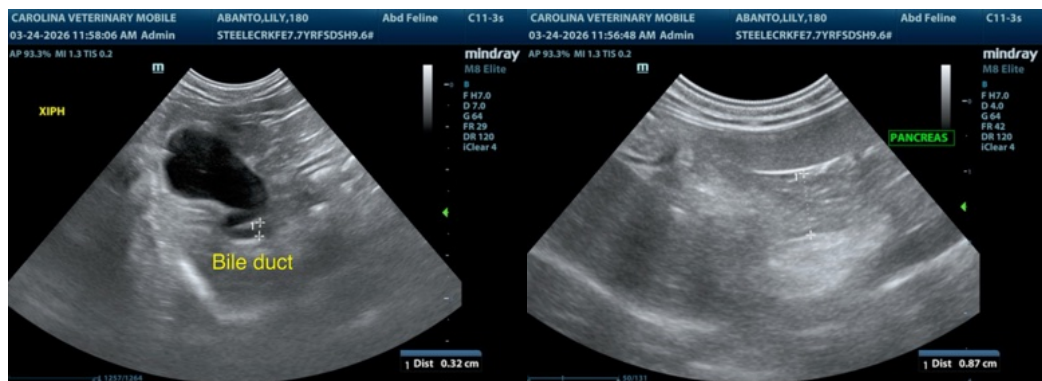
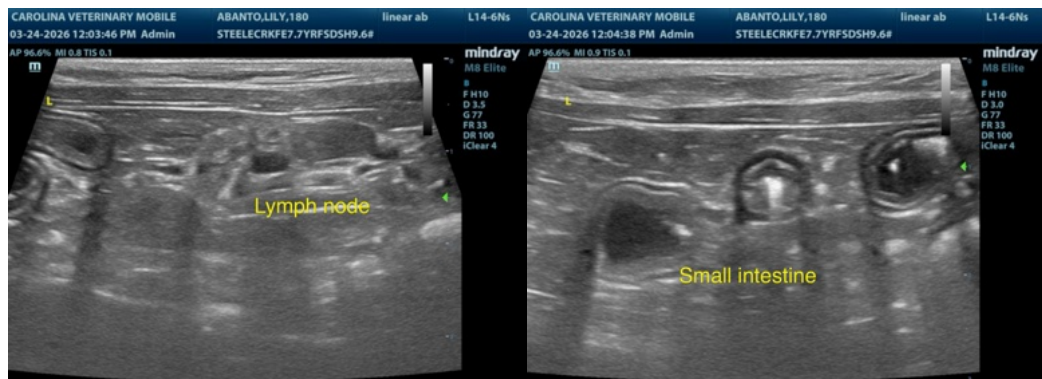
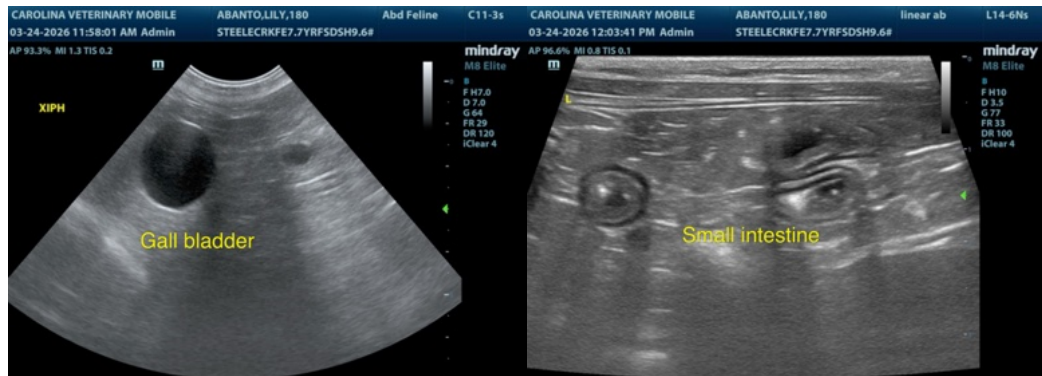
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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](mailto:info@sonopath.com)