

**PATIENT**

Gus Gus Zahn

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Male Neutered

**AGE**

08.07.2012

**WEIGHT**

08.18.2025

**INTERPRETED BY**

Andrea Nicastrò DVM  
Diplomate ACVIM  
(Sm Animal Internal Med)

**IMAGING  
PERFORMED BY**

Andrea Nicastrò DVM  
Diplomate ACVIM  
(Sm Animal Internal Med)

**HOSPITAL NAME**

Salt Marsh AH

**REFERRING VET**

Dr Christina Wiles

**INVOICE**

22286

**DATE**

11-20-25

**PRESENTING CLINICAL SIGNS**

Gus Gus presents for Annual exam. Appetite/drinking normal. Vomiting daily, sometimes multiple times/day Possible weight loss. No diarrhea, coughing, or sneezing. Urinating/defecating normal. Indoor only On Bravecto Plus. History of dental disease; most teeth previously extracted. Noted increased drooling.

BCS 5/9  
EENT: Ears/eyes clean & clear. Periodontal disease stage 2/4. Many missing teeth. MMs pink & moist, crt <2s. No nasal discharge noted. Oral cavity: no masses, no obvious dental pathology on awake exam Integumentary: Unkempt hair coat. No external parasites noted.

Cardiovascular: No heart murmur ausculted, normal heart rate & rhythm. Lungs clear, normal respiratory rate.

Abdomen: Soft, nonpainful. No masses palpated.

Musculoskeletal: Ambulatory x 4

Neuro: Appropriate mentation.

Genitourinary: WNL

PLN: WNL

Chronic vomiting, possible weight loss - r/o hyperthyroidism, chronic kidney disease, gastrointestinal disease (e.g., IBD, neoplasia)

Unkempt hair coat - r/o systemic illness (e.g., hyperthyroidism, renal disease), decreased grooming due to oral discomfort. Increased drooling, history of dental disease - r/o residual dental pathology, oral pain, nausea.

Diagnostics: CBC/chem/t4/Spec CPL pending. UA attempted, bladder empty.

Client Communication: Discussed possible causes for vomiting and weight loss (hyperthyroidism, renal disease, stress, dental disease). Discussed next steps if bloodwork inconclusive (abdominal ultrasound) Client aware of diagnostic plan; will call with results (attached to email).

Abnormal lab-work values: 08.19.2025: LMOM - BW wnl, including normal T4, normal SPec CPL. No evidence of renal dz, pancreatitis or hyperthyroidism being the cause of the frequent vomiting and weight loss. Recommend abdominal ultrasound as next step, rec schedule with Dr. Nicastrò if O would like to pursue. (attached to email)

Current Medications: N/A

Radiographic Findings: N.A

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. A moderate amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (3.66 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. The cortex is hyperechoic relative to the spleen. Mild pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.45 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. The cortex is hyperechoic relative to the spleen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.



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**Adrenal Glands**

The left adrenal gland is normal size (0.41 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.36 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

**Spleen**

The spleen is normal in size (0.81 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

**Liver**

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A scant amount of suspended echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

**Gastrointestinal**

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is moderately distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is diffusely distended with chyme. The small intestinal wall thickness is normal. There is disruption in the normal 1:3 muscularis: mucosal ratio in several segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

**Pancreas**

The base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

**Lymph Nodes**

A few prominent hypoechoic mesenteric lymph nodes are visualized (one measuring 2.34 x 0.69 cm). Surrounding mesentery is hyperechoic.

**Free Abdomen**

Trace free fluid is observed.

**Other**

A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window.

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- The small intestinal wall changes could be consistent with inflammatory bowel disease or emerging small cell lymphoma.



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- The prominent mesenteric lymph nodes could be consistent with lymphoid hyperplasia, lymphadenitis, or emerging neoplasia (i.e., lymphoma).

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- Trace ascites

**Secondary Findings**

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- If the patient was fasted for this study, the presence of ingesta within the gastric lumen could suggest delayed gastric emptying.

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- Bilateral nonspecific age-related renal changes with trace left pyelectasia
- Minor pancreatic parenchymal remodeling, with a lower possibility of low-grade chronic pancreatitis

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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- Repeat baseline bloodwork (including a CBC, chemistry panel, urinalysis, and T4) is recommended to assess overall metabolic function.

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- A fecal evaluation for ova and Giardia should also be considered.
- A GI panel including serum cobalamin and folate, TLI and PLI is recommended to assess for maldigestion/malabsorption and pancreatic disease.

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- Consider fine-needle aspiration of the mesenteric lymph nodes (assuming normal clotting status). Twenty-five gauge-needles should be used.
- Depending on the results of the above diagnostics, further work-up (i.e., endoscopic or surgical GI biopsies) may be indicated.

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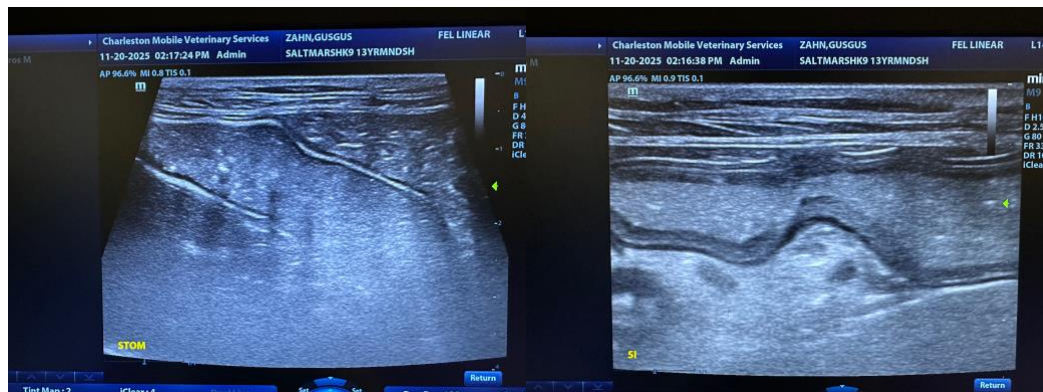
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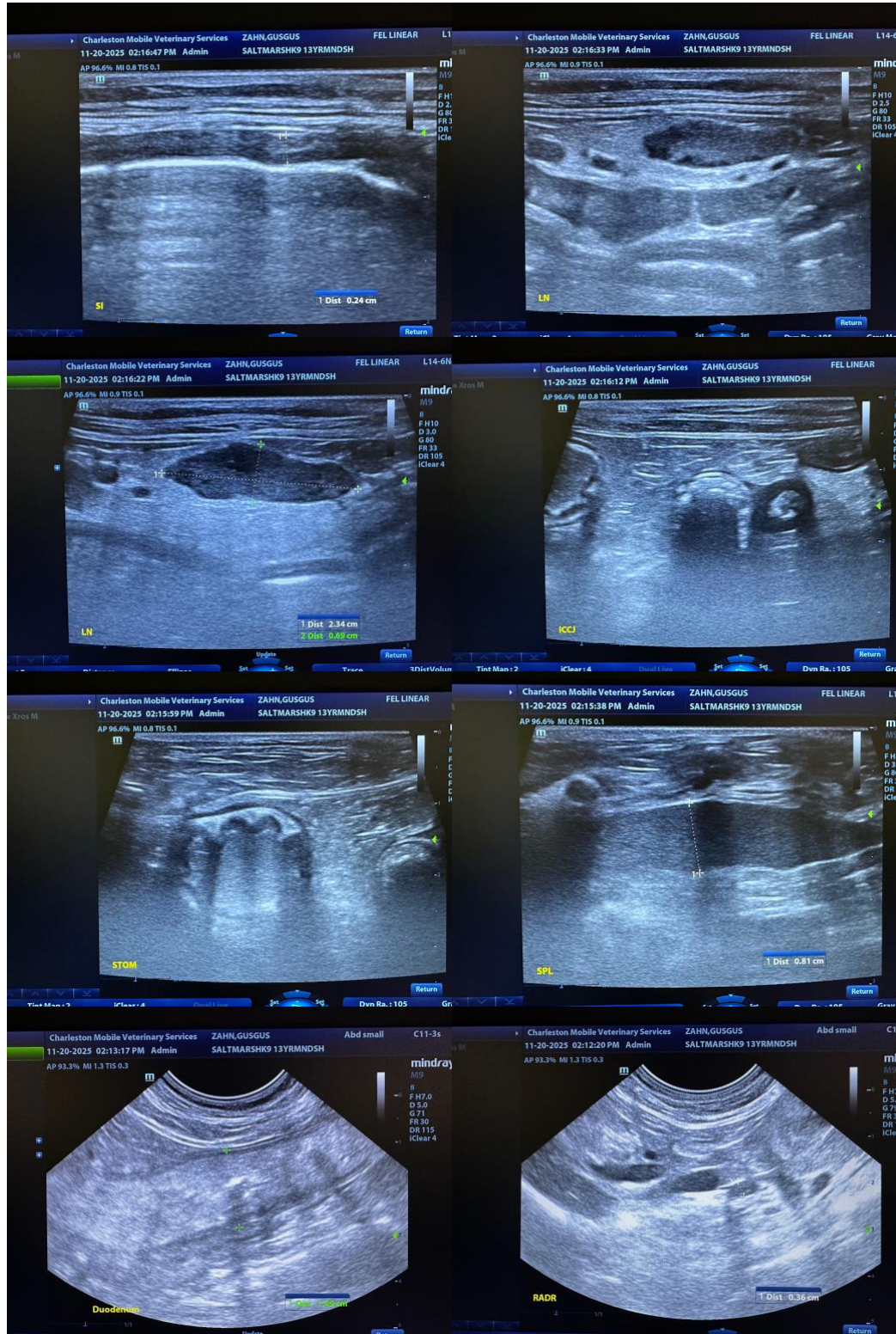
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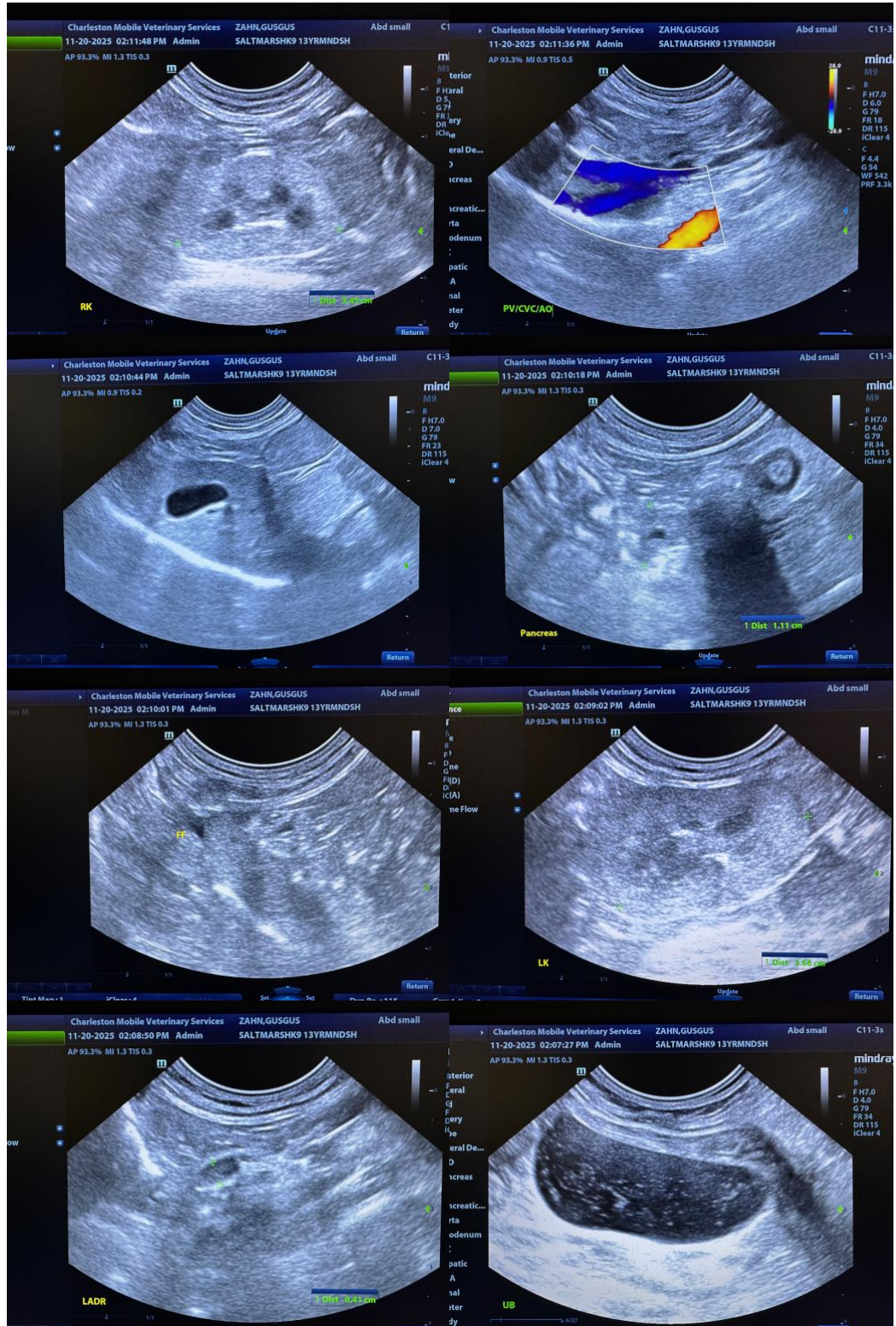
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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**Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)**  
[info@SonoPath.com](mailto:info@SonoPath.com)

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