

PATIENT PRESENTING CLINICAL SIGNS

Fozzy Malinoff

History: Hx of chronic vomiting, used to be intermittent (once every 2-3 months) then increased to a range of 1x a week to 3x a week. Vomiting started 2/13/2020, has become more frequent since 10/15/2021. Hx of pancreatitis that has been stable and IBD. Ultrasound previously performed and sent in on 8/20/2020 (report attached). Patient has been managed well on cerenia 24mg (1/4 tab SID prn) but needed it more often starting around 10/2021. Performed Texas A&M Panel on Had been eating RCVD Gastrointestinal/High Energy from 2/2020 to 9/2020. 9/2020 started him on Hill's z/d which he has been on since. Weight has been decreasing as well. Patient becomes EXTREMELY agitated and angry when at the clinic and usually comes after getting 100mg of gabapentin the evening before, currently on fluoxetine 10mg (1/2 tab SID) since 2019. No gabapentin was given today but butorphanol was given IM prior to ultrasound. Presented today d/t vomiting food 15 mins after eating. Owner has been monitoring the vomiting lately and his usual is vomiting bile. Vomiting food is not normal for his vomiting episodes. Administered SQF and cerenia SQ prior to sending home today.

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

Abnormal PE/Chem/CBC/UA Results: 8/20/2020: PLI - 5.5 8/21/2021 PLI - 3.6 1/17/2022 Cobalamin - 998 Folate - 28.6 Pancreatic Lipase Immunoreactivity - 3.9 TLI - 32.7 Weight History: 2/13/2020 - 14.63lbs 8/12/2020 - 14lbs 10/19/2020 - 13.96lbs 1/29/2021 - 14.62lbs 8/12/2021 - 11.4lbs 8/17/2021 - 11.2lbs 10/1/2021 - 11.2lbs 10/15/2021 - 10.9lbs 1/17/2022 - 10.4lbs 2/9/2022 - 9.8lbs Vomiting Log 2022: 1/27 - 2 times - Bile 1/29 - 1 time - Bile 2/3 - 1 time - Bile 2/6 - 1 time - Bile 2/8 - 1 time - Food and Bile

AGE

9 years

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

WEIGHT

9.8 lbs

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A scant amount of suspended echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 1 cm, are normal.

INTERPRETED BY

Andrea Nicastro, DMV,
Diplomate DACVIM
(Small Animal
Internal Medicine)

The left kidney is borderline small in size (3.00 cm in length); with a slightly irregular shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

IMAGING PERFORMED BY

Dr. Goodman

The right kidney is normal size (3.98 cm in length); normal shape and architecture with smooth peripheral margins. Hyperechoic shadowing diverticular foci are visualized. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. A few small nonobstructive nephroliths are present. There is no evidence of pyelectasia or hydroureter.

HOSPITAL NAME

Evandale-Blue Ash
Pet Hospital

Adrenal Glands

The region of the adrenal glands is evaluated. No obvious pathology is observed.

REFERRING VET

Dr. Gogluizza

Spleen

The spleen is subjectively normal in width (0.65 cm in width at the level of the hilus) with an elongated contour and scalloping of the medial margin. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

INVOICE

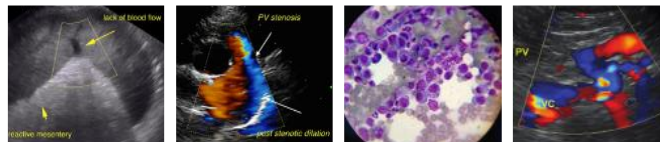
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Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.

DATE

2/9/22



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The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal.

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Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. 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 normal to mildly thickened (up to 0.32 cm), with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis to mucosal ratio with a >1: 1 ratio in some segments. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

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DSH

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

SEX

Neutered Male

Free Abdomen

There is no evidence of free fluid. A few prominent mesenteric lymph nodes are visualized, the largest measuring 1.03 cm in length.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bowel pattern consistent with inflammatory bowel disease with potential for emerging lymphoma. Changes are similar to the previous sonogram. It is possible that the inflammatory bowel disease is progressing microscopically, resulting in the worsening clinical signs.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.
- Mild splenomegaly – previously observed.

Secondary Findings

- Bilateral degenerative renal changes with right nonobstructive nephrolithiasis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to rule out occult esophageal disease.
- Repeat baseline lab work, including a CBC Chemistry panel, urinalysis and T4 is recommended, to assess overall metabolic function.
- Depending on the results of the above diagnostics, endoscopic or surgical gastrointestinal biopsies may be warranted. Surgical biopsies are more likely to yield a definitive diagnosis. If biopsies are not to be pursued, initiation of anti-inflammatory medications (i.e., metronidazole or prednisolone), can be considered as long as the client understand the risk of treatment without a definitive diagnosis.

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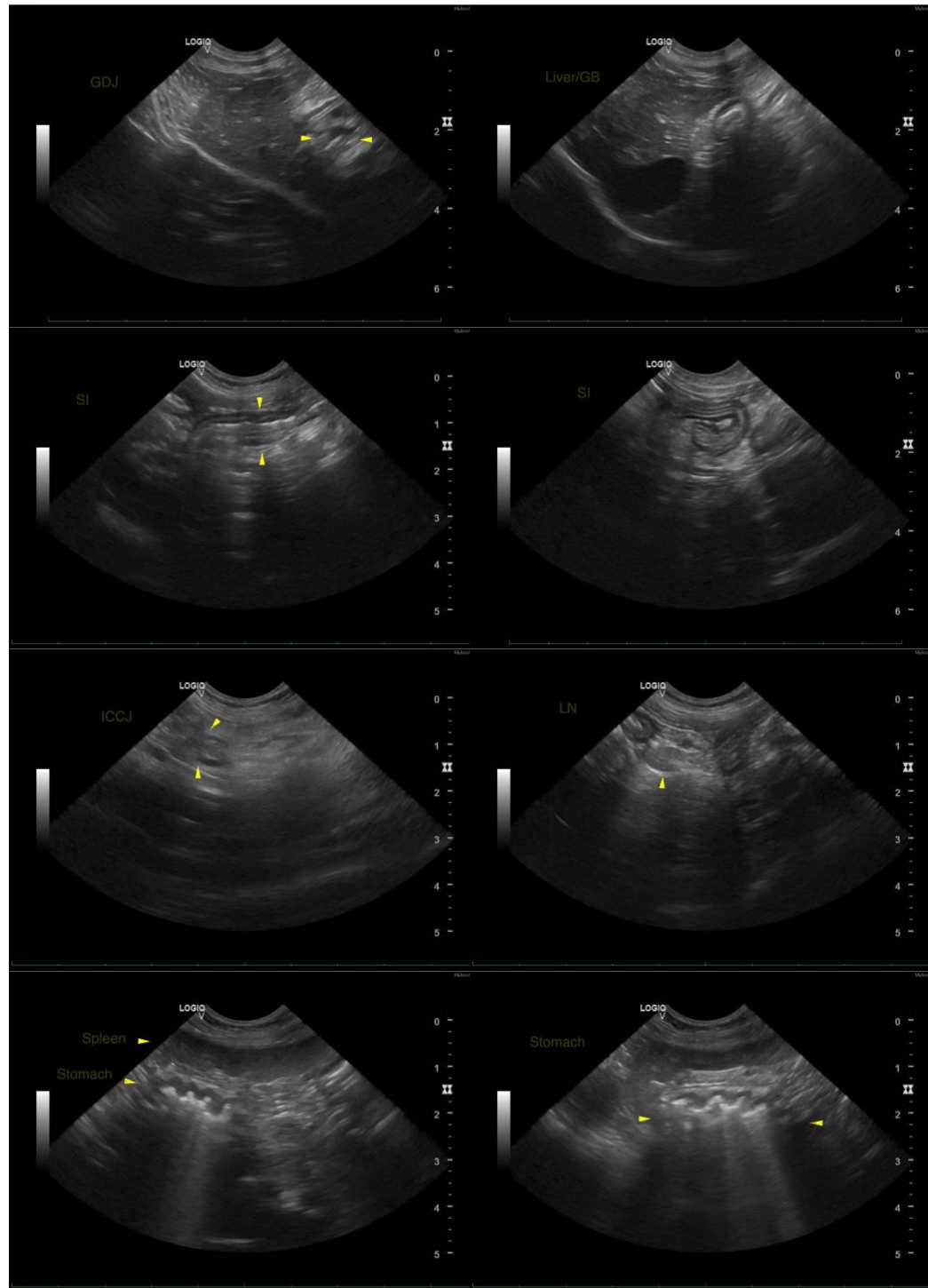
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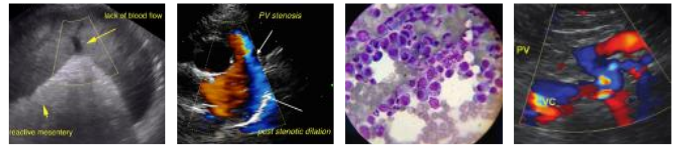


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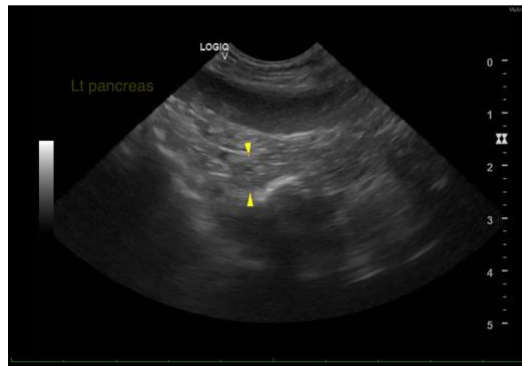
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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