



**PATIENT**

Bama Wilkerson

**SPECIES**

Canine

**BREED**

Lab

**SEX**

Male Neutered

**AGE**

01-13-2019

**WEIGHT**

55lb

**INTERPRETED BY**

Andrea Nicastro DVM  
Diplomate ACVIM  
(Sm Animal Internal Med)

**IMAGING  
PERFORMED BY**

Andrea Nicastro DVM  
Diplomate ACVIM  
(Sm Animal Internal Med)

**HOSPITAL NAME**

BluePearl Summerville ER

**REFERRING VET**

Dr Kelsey Harris

**INVOICE**

22380

**DATE**

1-15-2026

**PRESENTING CLINICAL SIGNS**

Patient was diagnosed with heartworm disease 5 years ago and treated with Immiticide. Since then, has had intermittent exercise intolerance and a cough. Presented for acute vomiting/regurgitation, with subsequent labored breathing. Radiographs revealed a mild broncointerstitial pattern.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder wall is normal in thickness. The mucosal surface in the region of the apex is slightly irregular. The bladder is moderately distended. Luminal contents are mostly anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is enlarged (2.30 cm in width) with smooth peripheral contours. The parenchyma is mildly heterogenous in appearance. No focal lesions are observed. The prostatic urethra is not overtly dilated.

The left kidney is normal in size (6.66 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (7.21 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is enlarged (1.31 cm at cranial pole) (0.99 cm at caudal pole) with an irregular shape. A 1.39 x 1.31 cm hyperechoic-to-heterogenous nodule is observed at the cranial pole. Glandular echogenicity and detail at the caudal pole are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is enlarged (0.73 cm at cranial pole) (0.96 cm at caudal pole) with smooth peripheral contours. The parenchyma is subtly heterogenous, with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

**Spleen**

The spleen is normal in size (1.16 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 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. 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 polypoid-like lesions is arising from the mucosal surface. Some mobile echogenic debris is observed within the lumen.

**Gastrointestinal**

The gastric lumen is not distended. Gastric wall thickness is difficult to determine due to rugal folds, but appears subjectively thickened. Layering is intact. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and



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appropriate mural detail. Discreet masses are not identified. The ileoceocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

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**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.

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**Lymph Nodes**

One-to-two prominent mesenteric lymph nodes are visualized (one measuring 1.06 x 0.45 cm).

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**Free Abdomen**

There is no obvious evidence of free fluid.

**ULTRASONOGRAPHIC FINDINGS**

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**Primary Findings**

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- Prostatomegaly. This could be consistent with late-in-life neutering (if applicable), neoplasia (i.e., prostatic adenocarcinoma, transitional cell carcinoma), prostatitis, hyperplasia, other. Correlation with the patient's clinical history is recommended.
- Bilateral adrenomegaly. The left adrenal nodule could be consistent with focal nodular hyperplasia, adenoma, or emerging adenocarcinoma, pheochromocytoma, other.

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- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The prominent mesenteric lymph node is likely reactive, with a lower possibility of emerging neoplasia.

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**Secondary Findings**

- The gastric wall thickening may be a normal variant for this patient or could be secondary to gastritis. Correlation with the patient's clinical history is recommended.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- Regarding the prostate changes, consider a urine BRAF test to further evaluate for lower urinary tract neoplasia. A positive test confirms neoplasia. However, a negative test does not rule out the possibility of cancer, and further testing (i.e., biopsies) may be necessary to get a definitive diagnosis.
- Regarding the adrenomegaly, consider further testing for Cushing's disease (i.e., low-dose dexamethasone suppression test) if the patient develops clinical signs. Also consider a baseline blood pressure measurement. A recheck ultrasound is also recommended in 2-3 months to assess for growth of the left adrenal nodule.
- Further recommendations should be based on the echocardiogram report.

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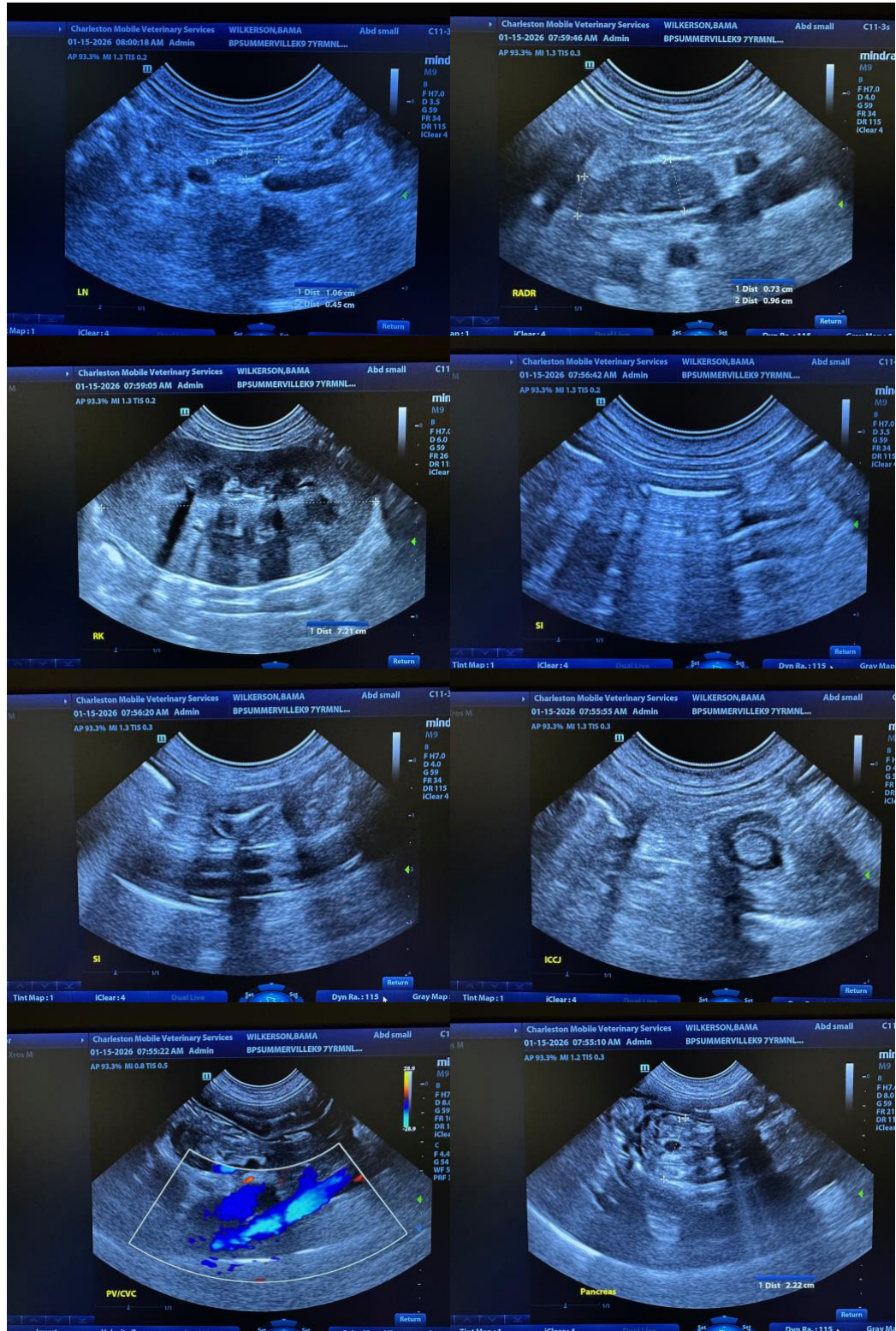
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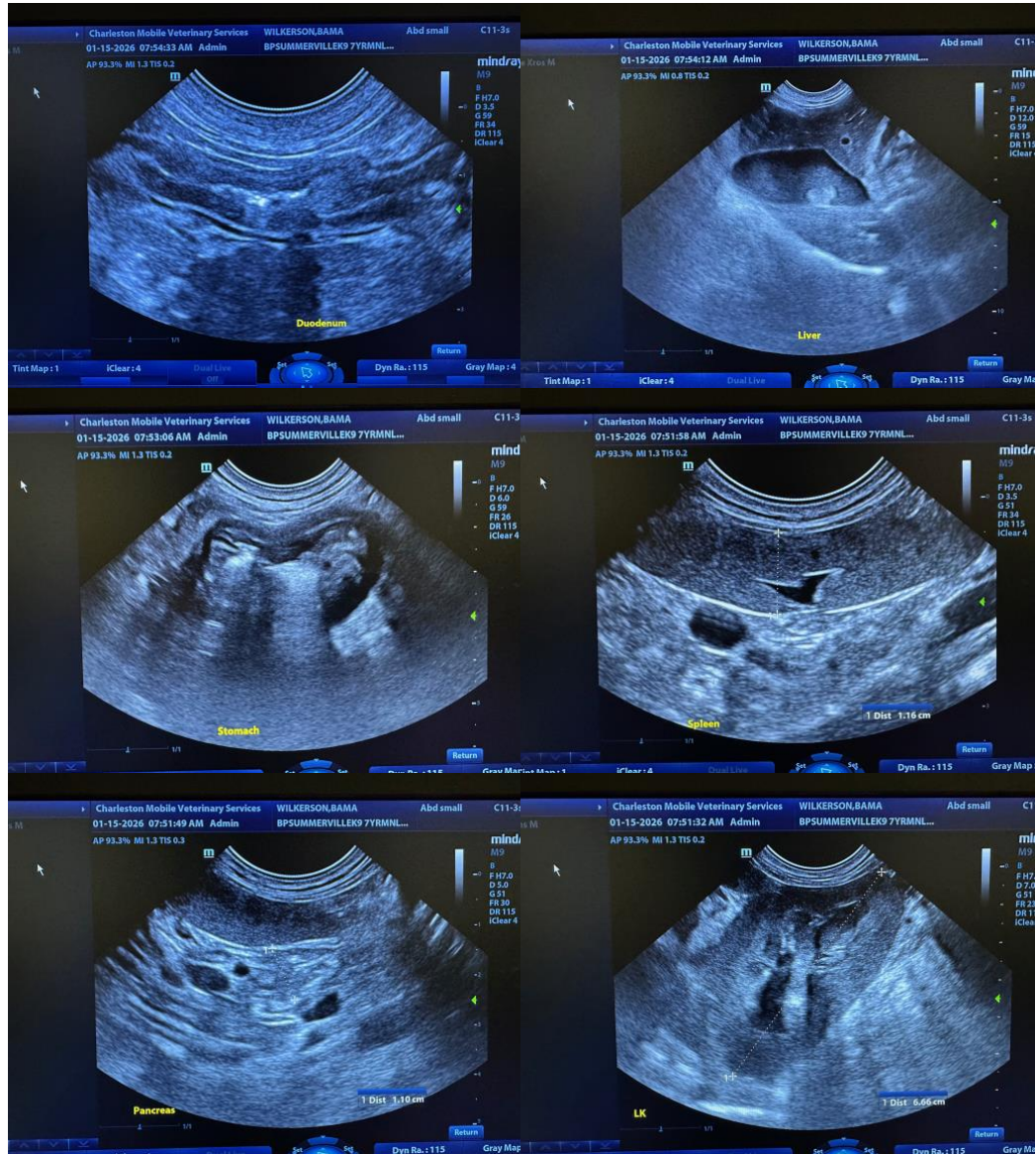
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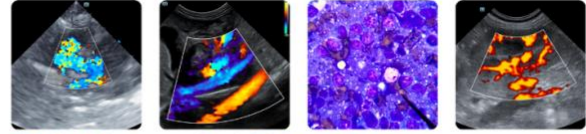
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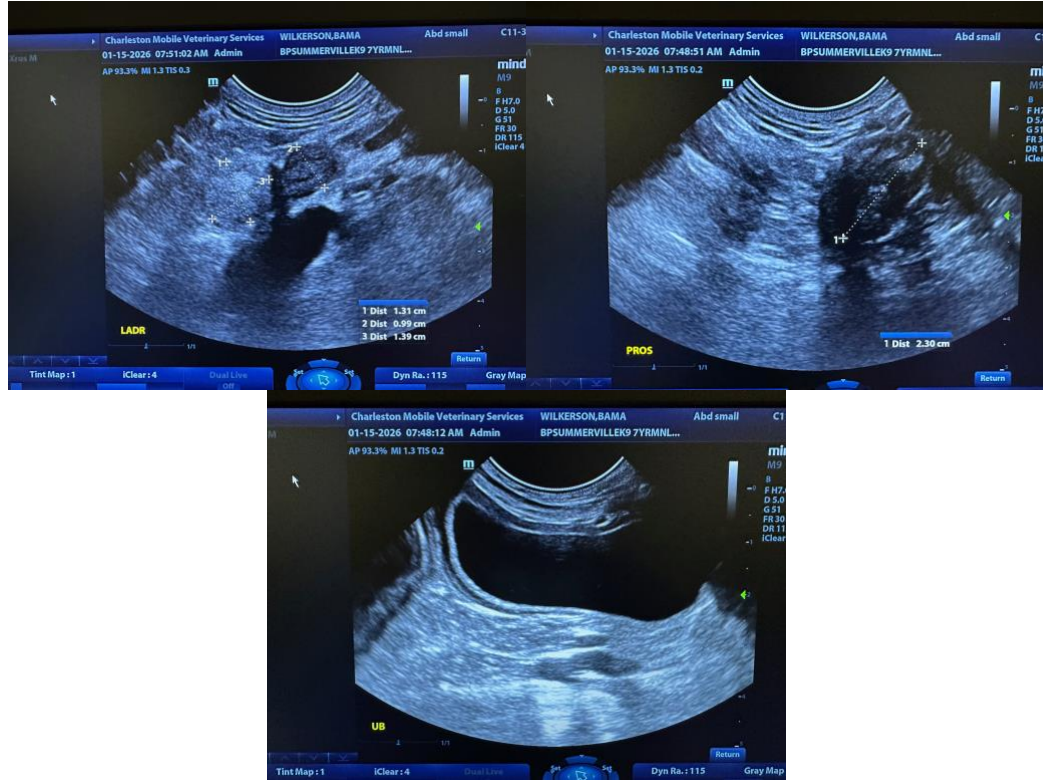
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)**  
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