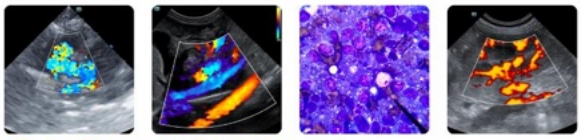




**DATE**

1/20/26

**PATIENT**

Little Dog Applefeld

**SPECIES**

Canine

**BREED**

Poodle mix

**SEX**

Male, neutered

**AGE**

1/19/2014

**WEIGHT**

13 lbs.

**INTERPRETED BY**

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

**HOSPITAL NAME**

Animal Emergency Hospital

**REFERRING VET**

Dr. Shannahan

**INVOICE**

13404

## PRESENTING CLINICAL SIGNS

**Patient History:** Little Dog presents for chronic intermittent vomiting and diarrhea Patient History: - Adopted at 5 years old, now 12.5 years - History of pancreatitis diagnosed 7+ years ago following ingestion of Chinese food; hospitalized in ICU for 3 days - Long-term diet: Hill's i/d low-fat (canned and kibble) with boiled chicken tenders - Recent dental procedure (November 13, 2025): - Full mouth extraction recommended - Client elected to save canine teeth with commitment to maintain dental hygiene - Post-operative course complicated by anorexia and vomiting - Presented to ER same night; treated with anti-nausea medication, appetite stimulant, and injectable pain medication (gabapentin, carprofen) - Prescribed Royal Canin digestive high fiber and low-fat formulas - Diet history: - Did well on Royal Canin in Texas for several months - Upon return to Maryland in December, new batch of Royal Canin caused foul-smelling diarrhea - Switched back to Hill's i/d; initial batch well-tolerated – Subsequent batch of Hill's caused vomiting - Clinical course since December: - Multiple 4-day episodes of vomiting - Seen at primary veterinarian (Falls Road Veterinary Hospital); no diagnostics performed, visual exam only - Fall down full flight of wooden stairs; suspected fracture - Examined at Falls Road: no fractures identified, oral laceration noted, hematemesis attributed to swallowed blood from oral injury – Episode of severe lethargy lasting almost 2 days following neighborhood walk: - Completely recumbent, minimally responsive - Ataxic when attempting to ambulate - Anorexic and adipsic for nearly 2 days - Inappropriate urination noted during bath - Client concerned about possible leptospirosis exposure (area has wildlife including raccoons, foxes, deer) - Brief improvement with return of appetite for 1.5 days- Last night: profuse diarrhea throughout house (soft, foul-smelling, non-bloody) - This morning: anorexic, adipsic, lethargic with enophthalmos per client, vomited - Associated signs: - Loud borborygmi preceding and during GI episodes - Progressive weight loss (13lbs today, described as thinner than usual with prominent spine) - Current medications/supplements: - Fish oil: 1 capsule 3x weekly (started after fall for arthritis) - Carprofen: given for approximately 10 days post-dental; client notes patient seemed reluctant to take toward end of course - No access to toxins, rat bait, or ant traps - Possible exposure to coffee grounds on kitchen floor - Does not chew toys excessively; carries stuffed squirrel toy - No recent travel outside Maryland/Texas - Lives in area with significant wildlife presence

**Current Medications:** None listed, reported as above.
**Labwork Results:** CBC WNL, ALT 205
**Date of Previous IntraPet Ultrasound:** No previous.
**Sedation:** Not required to complete full diagnostic ultrasound.
**Stat Report:** STAT requested.
**Imaging Performed by:** Rachel Brilhart, RDMS.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is contracted. The wall is of appropriate thickness for the level of repletion. There is no obvious evidence of cystic calculi. A Foley catheter is observed within the bladder lumen.

The prostate is normal in size (0.94 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (4.48 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. At least one small cortical cyst is seen. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (4.47 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

### *Adrenal Glands*

The left adrenal gland is enlarged (0.87 cm at cranial pole) (0.96 cm at caudal pole) with swollen peripheral contours and a slightly irregular shape. A 0.84 x 0.79 cm hyperechoic nodule is observed at the cranial pole.. The remaining parenchyma is slightly heterogeneous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature appear normal.

The right adrenal gland is mildly enlarged (0.79 cm at cranial pole) (0.70 cm at caudal pole) with swollen peripheral contours. The parenchyma is slightly mottled with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

### *Spleen*

The spleen is normal in size (1.12 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 enlarged with swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly heterogeneous in appearance with a few small ill-defined hypoechoic nodules. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of aggregated, echogenic, partially dependent to suspended sludge in a partially stellate pattern is observed within the lumen. The cystic and common bile ducts are normal/not seen.

### *Gastrointestinal*

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 not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

### *Pancreas*

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is slightly hyperechoic 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*

The abdominal lymph nodes are normal/not visible.

### *Free Abdomen*

There is no obvious evidence of free fluid.

## ULTRASONOGRAPHIC FINDINGS

**Primary Findings:**

- The gallbladder changes are consistent with a developing mucocele

- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease, infiltrative neoplasia and other hepatopathies are considered less likely.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

**Secondary Findings:**

- Bilateral nonspecific, age-related renal changes with dystrophic mineralization
- Bilateral adrenomegaly. The left adrenal nodule could be consistent with focal nodular hyperplasia, adenoma, emerging adenocarcinoma, pheochromocytoma, other.

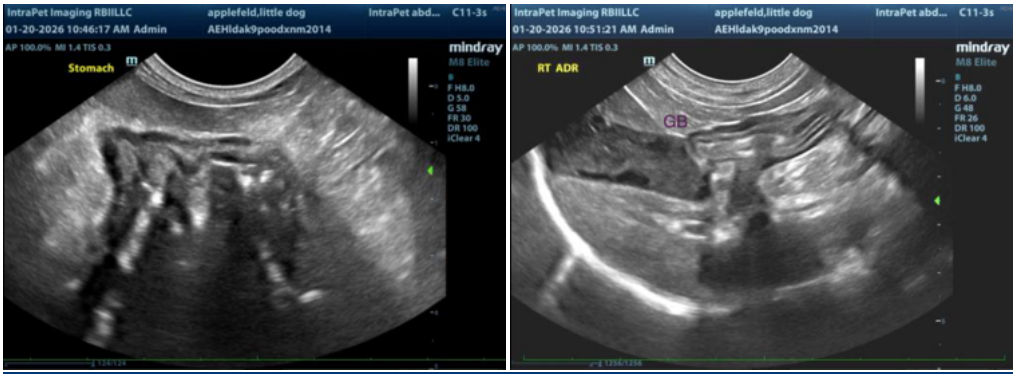
*An obvious cause for the patient's clinical signs is not definitively identified in this study. Considerations include a microscopic enteropathy (i.e., food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease), underlying metabolic issue, other.

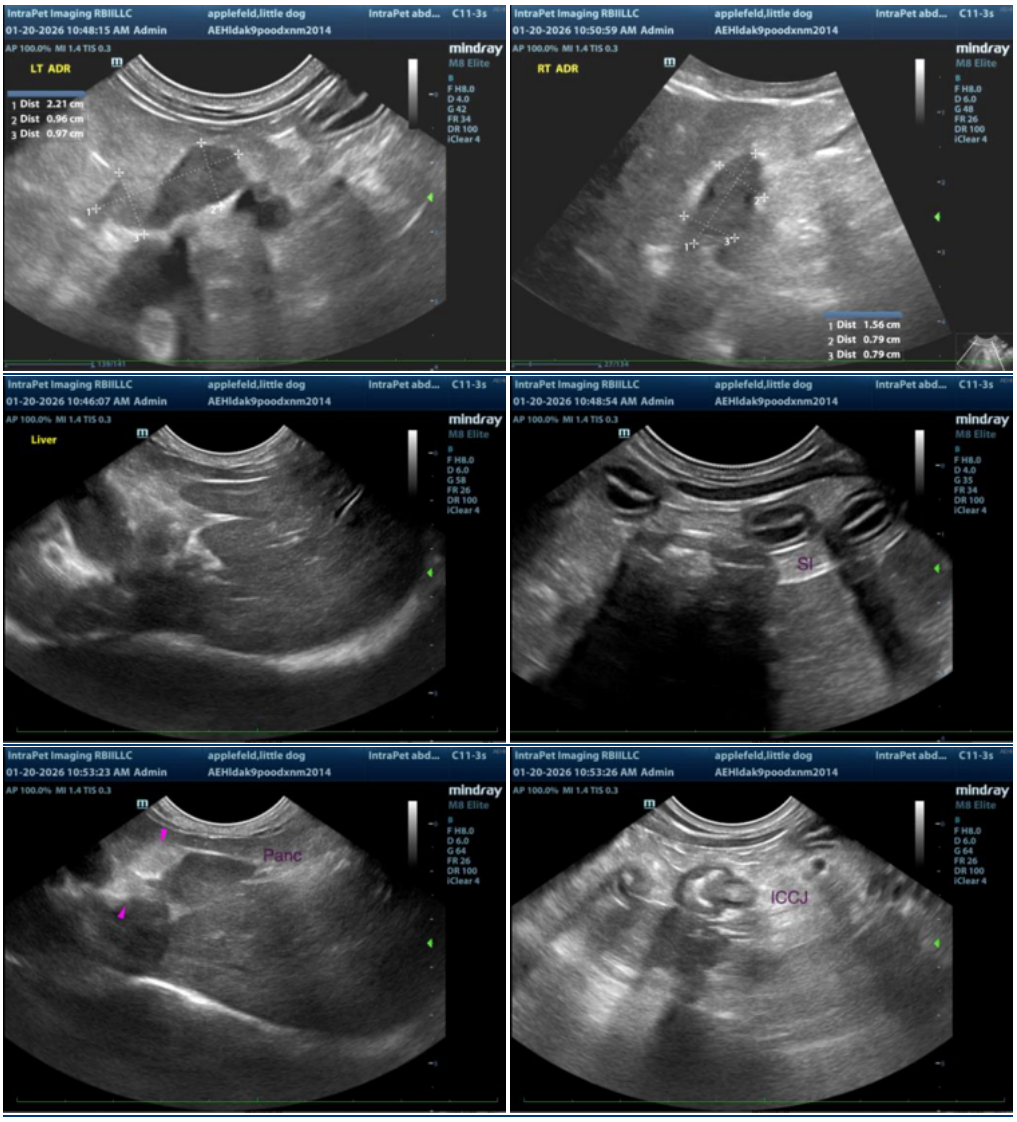
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- The following diagnostics/treatment recommendations can be considered:
  1. Texas GI panel including serum cobalamin, folate, PLI, TLI and resting cortisol level
  2. Fecal evaluation for ova/Giardia
  3. Prophylactic deworming with Fenbendazole.
  4. 3-4 week hypoallergenic or hydrolyzed protein diet trial
  5. Initiation of a probiotic with a high colony count +/- fiber supplement (i.e., psyllium).
  6. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted. Three-view thoracic radiographs should be performed prior to any anesthetic event.

- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) is recommended. Serial sonographic monitoring (e.g., every 6-8 weeks) of the gall bladder is recommended to assess for progression to a fully formed mucocele. If progression occurs, a cholecystectomy may be warranted.

- Regarding the bilateral adrenomegaly and left adrenal nodule, consider the following:
  1. Further testing for Cushing's disease if clinical signs emerge.
  2. Baseline blood pressure measurement
  3. Recheck ultrasound in 2-3 months to assess for growth of the left adrenal nodule






**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) info@SonoPath.com