

**PATIENT**

Jake Gomez

**SPECIES**

Canine

**BREED**

Yorkiepoop

**SEX**

Neutered Male

**AGE**

14 Years

**WEIGHT**

12.6 Pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Shari Reffi, CVT

**HOSPITAL NAME**

Andover AH

**REFERRING VET**

Dr. Vanderbogart

**INVOICE**

14058

**DATE**

10/29/21

**PRESENTING CLINICAL SIGNS**

History: On-off diarrhea since Labor Day. V+ once yesterday. Current meds: Pepto 1/2-tab bid. Abnormal PE/Chem/CBC/UA Results: Pending

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (0.77 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney presented normal size (3.89 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney presented normal size (3.82 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. 1-2 small cortical cysts are observed at the lateral aspect. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is mildly enlarged (0.85 cm at cranial pole) (0.83 cm at caudal pole) (2.09 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is upper limits of normal size (0.80 cm at cranial pole) (0.56 cm at caudal pole) (1.66 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

**Spleen**

The spleen is subjectively prominent in size (1.22 cm at the level of the hilus) with slightly swollen peripheral contours. The parenchyma is subtly mottled in appearance. No distinct focal lesions are observed. Splenic vasculature is normal with no evidence of thrombosis.

**Liver**

The liver is subjectively enlarged with slightly swollen 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 gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic partially dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

The gall bladder is of normal contours and contains a moderate amount of aggregated echogenic debris is observed within the lumen, most of which is gravity dependent and some of which is adhered



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to the mucosal surface. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen.

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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 small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern. There is evidence of mucosal fogging in some segments. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains granular appearing fecal material. There is no evidence of obstruction.

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**Pancreas**

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic 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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**Free Abdomen**

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

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**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- The small intestinal wall changes are suggestive of an inflammatory process (i.e., inflammatory bowel disease).

**Secondary Findings**

- Borderline bilateral adrenomegaly
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered unlikely.
- Gallbladder debris- incidental
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The following diagnostics/treatment recommendations can be considered:

1. Serum cobalamin, folate, PLI and TLI
2. A fecal evaluation for ova/Giardia



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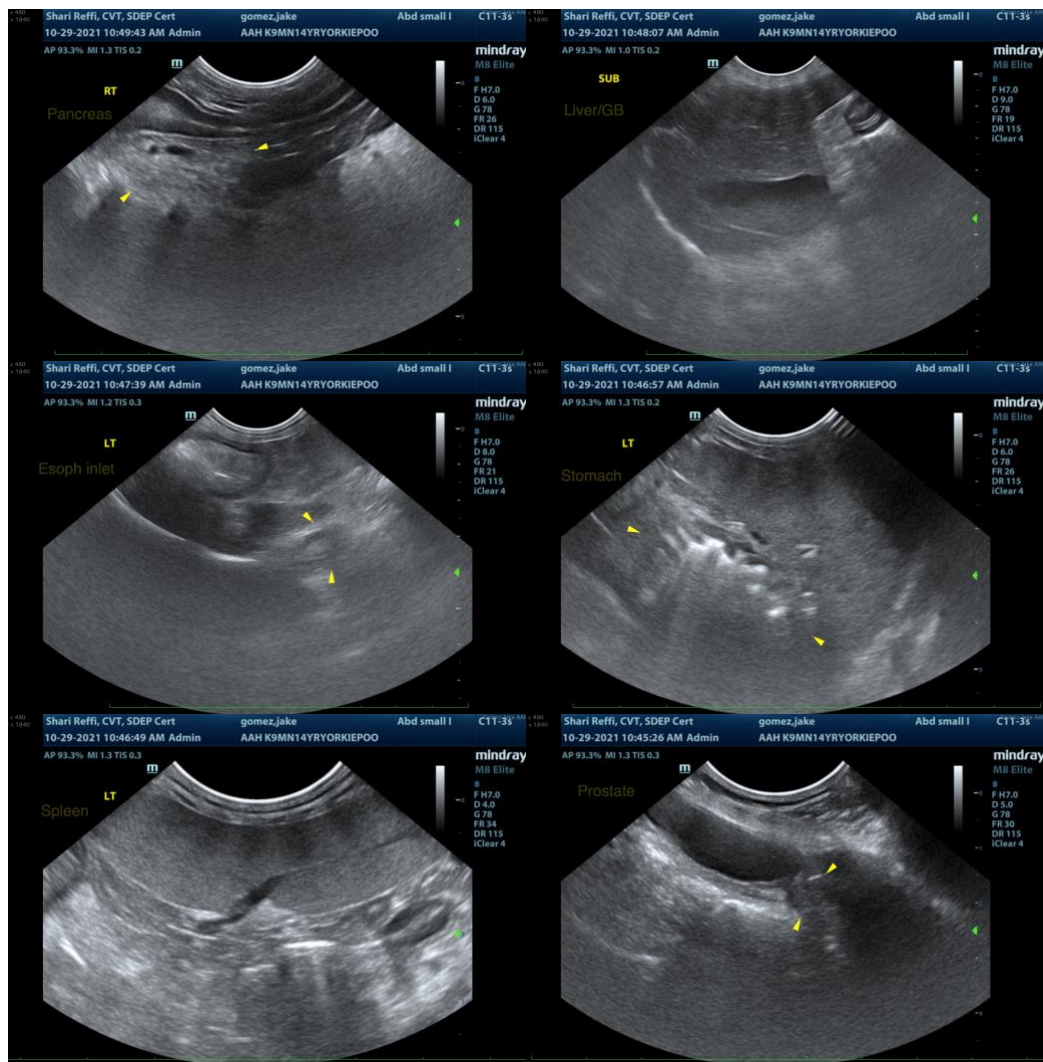
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3. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
4. A 6-week limited antigen diet trial to assess for food allergies.
5. Consider a 4-week course of Tylosin at 15-20 mg/kg by mouth every 12 hours as empirical treatment for small intestinal bacterial overgrowth.
6. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.
7. Three-view thoracic radiographs should be performed prior to any anesthetic event.



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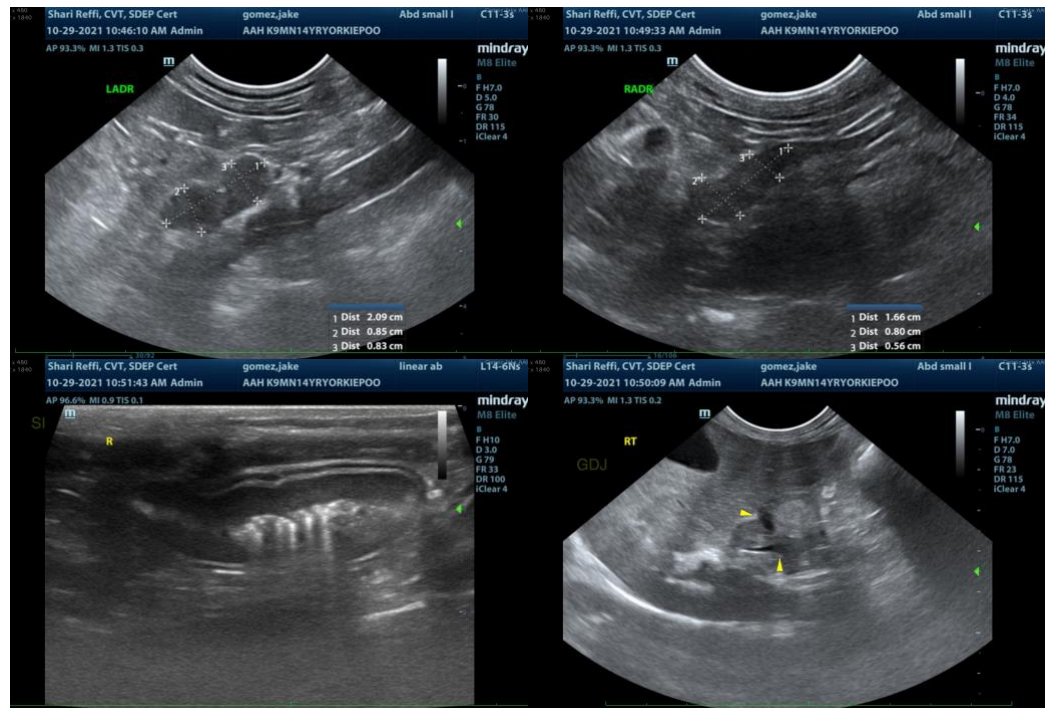
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**, DVM, Diplomate DACVIM (Small Animal Internal Medicine)  
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