PATIENT

Ready Hightower

SPECIES

Canine

BREED

Boston Terrier

SEX

Male Neutered

AGE

11/04/2021

WEIGHT

5 kg

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 MP ER

REFERRING VET

Dr Christina Kitzmiller

INVOICE

22299

DATE

11-23-25

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: P has a history of perforating GI FB and septic abdomen requiring abdominal exploratory surgery and IRAA all performed in early November 2025. He recovered well from this procedure and had been doing well at home apart from developing a dermatitis at the abdominal incision recently. Treated with Convenia and topical antibiotic spray. P vomited multiple times starting 11/21 and MM appeared pale. O also reports dark stools and possible single episode of true melena at home (no melena seen in hospital). P has been mildly anemic (27%-32%) and hypoalbuminemia (2.1-2.3) has persisted. Initial AXR on 11/21 reveal suspected gastroenteritis with soft tissue material in the GI tract, r/o ingesta vs. foreign material. P was hospitalized and tx with IVF, Cerenia, ondansetron, Protonix, sucralfate. P was eating ravenously overnight. P developed a cough 11/22 am. Anemia worsened to 20-23%. Additional dx performed - normal coags, neg saline agglut, neg 4dx. POCUS revealed pulmonary B-lines left mid ventral lung fields. Radiographs were repeated 11/22 - CXR reveals suspected aspiration pneumonia. AXR revealed severe gastric distention, concerning for mechanical obstruction vs. severe functional ileus. O declined surgical explore and elected continued medical management. NGT was placed and air and fluid was suctioned overnight q2h. Rechecked AXR this morning reveal significant improvement in gastric and SI distention. High suspicion for functional ileus.

Abnormal lab-work values:
11/21: PCV/TS: 32%/6.0. CBC: HCT 29.3%, Reticulocytes 110.5, low reticulocyte hemoglobin (21.1), WBC count 17.59K (increased), neutrophilia 12.84K (increased), PLT count normal at 360K. aFAST: no free fluid any any of the 4 quadrants. Some ingesta present within the stomach.

11/22: PCV/TP: 23%/4.4. CBC: RBC 3.1 (L), HCT 20.2% (L), HGB 7.0 (L), Retic-HGB 19.5 (L), Mono 1.38k (H), Eos 0.03k (L), rest WNL. PT: 11 sec (11-17 sec). PTT: 91 sec (72-102 sec). Chem17: BUN 5 (L), Cl 105 (L), rest WNL. Slide agglutination: No agglutination observed. Blood type: DEA 1.1 positive. 4Dx: Negative x 4. Fecal float: NPS
Current MedicationsL Plyte, Cerenia, Ondansetron, Protonix, Unasyn, Methadone
Radiographic Findings

11/21 Radiograph consult report:
Findings: Radiographs of the thorax and abdomen
Conclusions 1. Normal limited thorax. Likely positional over pathologic reflux or esophagitis. 2. Concern for gastroenterocolitis with possible foreign material although cannot be confirmed. Dilation difficult to confirm as cannot entirely distinguish the small and large bowel. Recommend US evaluation to confirm. Megan Maclellan, DVM, DACVR

CXR + AXR (3-view) with Keystone review (AXR performed before and after NG tube placement and suctioning of the stomach):

Assessment: Heterogenous material throughout the gastrointestinal tract could represent residual normal ingesta, foamy fluid, or foreign material. The progressive distension of the stomach, duodenum, and a few additional small intestinal segments seen on the latest images are most concerning for a developing small intestinal mechanical obstruction, however given the clinical history a severe non-specific functional ileus or aerophagia cannot be definitively excluded. Emergency abdominal ultrasound should ideally be considered for further evaluation
A definitive cause for progressive anemia is not identified at this time. Emergency abdominal ultrasound should ideally be considered given the clinical history
Reduced abdominal serosal detail; differential diagnosis includes incidental minimal intra-abdominal fat, post-operative change, scant peritoneal fluid, edema/inflammation/peritonitis, and less likely other. Consider abdominal ultrasound for further evaluation.
Mild intermittent patchy unstructured interstitial pattern, lungs. Differential diagnosis includes early

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pneumonia, incidental atelectasis, and less likely other. Clinical correlation is required. Serial radiographs could be considered to monitor this finding
Otherwise, unremarkable thorax
Likely incidental congenital vertebral malformations, spine

11/23 Recheck CXR + AXR (3-view) with STAT Keystone review/Findings:
6 images of the thorax and abdomen are available for interpretation and compared with that done yesterday.

Assessment: Progressive alveolar consolidation of the cranioventral lung fields consistent with pneumonia. Nasal esophageal tube. The tube may have been withdrawn slightly and extends to the level of the diaphragm. Correlation with the function of the tube may be helpful.
Decreased gas distention of the GI tract with a normal-appearing abdomen at this time. No gastric outflow obstruction or mechanical obstruction is seen. Concurrent gastroenteritis or pancreatitis cannot be excluded. A cause for the progressive anemia is not otherwise identified. GI ulceration cannot be excluded.

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. Luminal contents are 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 normal in size (0.61 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 (3.75 cm in length) with a normal shape, architecture and 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 hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.36 cm in length) with a normal shape, architecture and 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 hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.45 cm at cranial pole) (0.42 cm at caudal pole) with a normal shape and 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 normal in size (0.49 cm at cranial pole) (0.32 cm at caudal pole) with a normal shape and 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 normal in size (0.90 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

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portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is mildly-to-moderately distended with fluid and gas. The gastric wall is normal is normal to mildly thickened (up to 0.66 cm) with retention of the normal layering pattern The pyloric outflow tract is patent. The small intestinal lumen is segmentally dilated with chyme (mild). 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 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.

Lymph Nodes
A few prominent mesenteric lymph nodes are visualized (one measuring 1.01 x 0.49 cm).

Free Abdomen
There is no obvious evidence of free fluid.

Other
A brief echocardiogram reveals no obvious evidence of right atrial or auricular mass. There is no obvious evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

- The gastric wall changes are suggestive of gastritis with a lower possibility of hypertrophy or emerging neoplasia. There is no obvious evidence of gastric ulceration. However, superficial gastric ulcers or erosions may not be identified sonographically.

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

*An obvious cause for the patient's anemia is not definitively identified in this study. Considerations depend on whether or not the anemia is regenerative. Causes of regenerative anemia include blood loss (i.e., GI) and hemolysis. Nonregenerative anemias could be secondary to bone marrow disease, chronic disease, occult neoplasia, low-grade GI bleeding, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A repeat CBC with clinical pathology review (send to a diagnostic lab) and a reticulocyte count are recommended.
- Also consider further testing for tick-borne disease.
- Three-view thoracic radiographs should also be considered (if not already performed) to assess for occult pathology in the chest.
- Depending on the results of the above diagnostics, an upper GI endoscopy with biopsies and/or a bone marrow aspirate may be warranted.
- In the meantime, empirical treatment for gastric ulceration (i.e., proton pump inhibitor, sucralfate, bland diet) is recommended.

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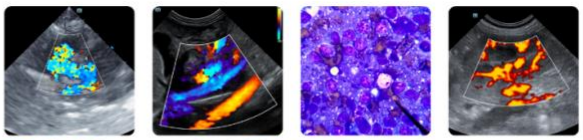

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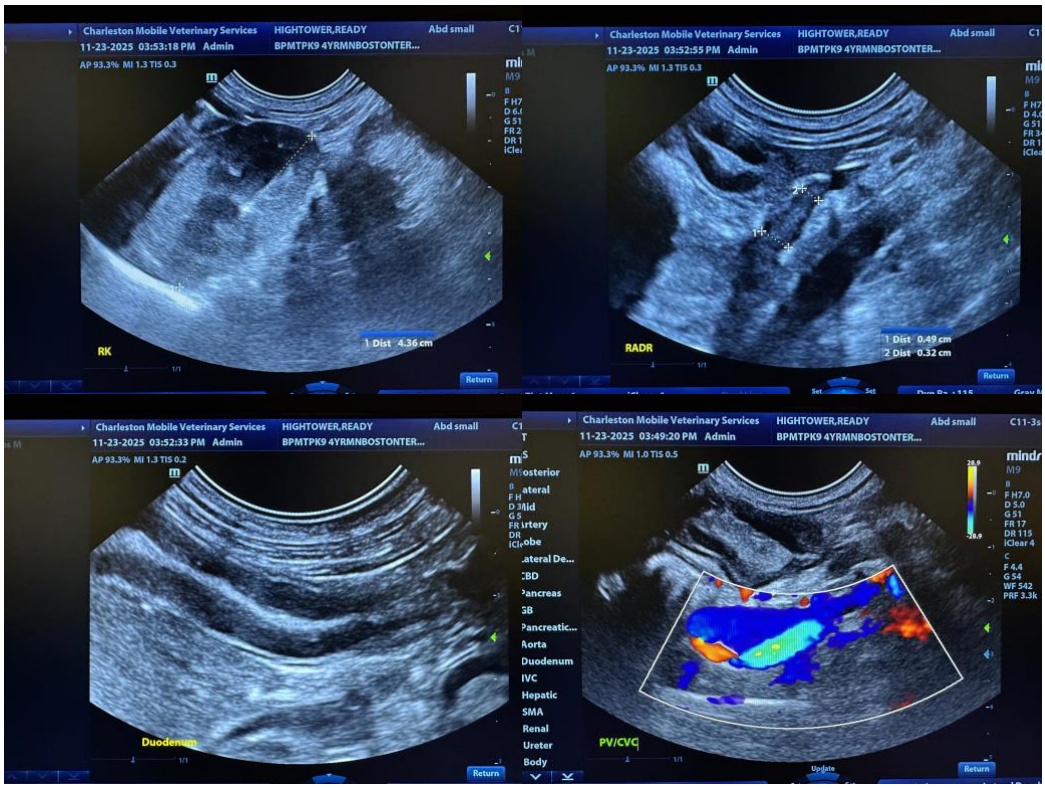

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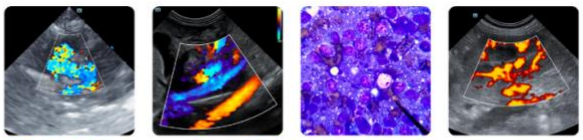

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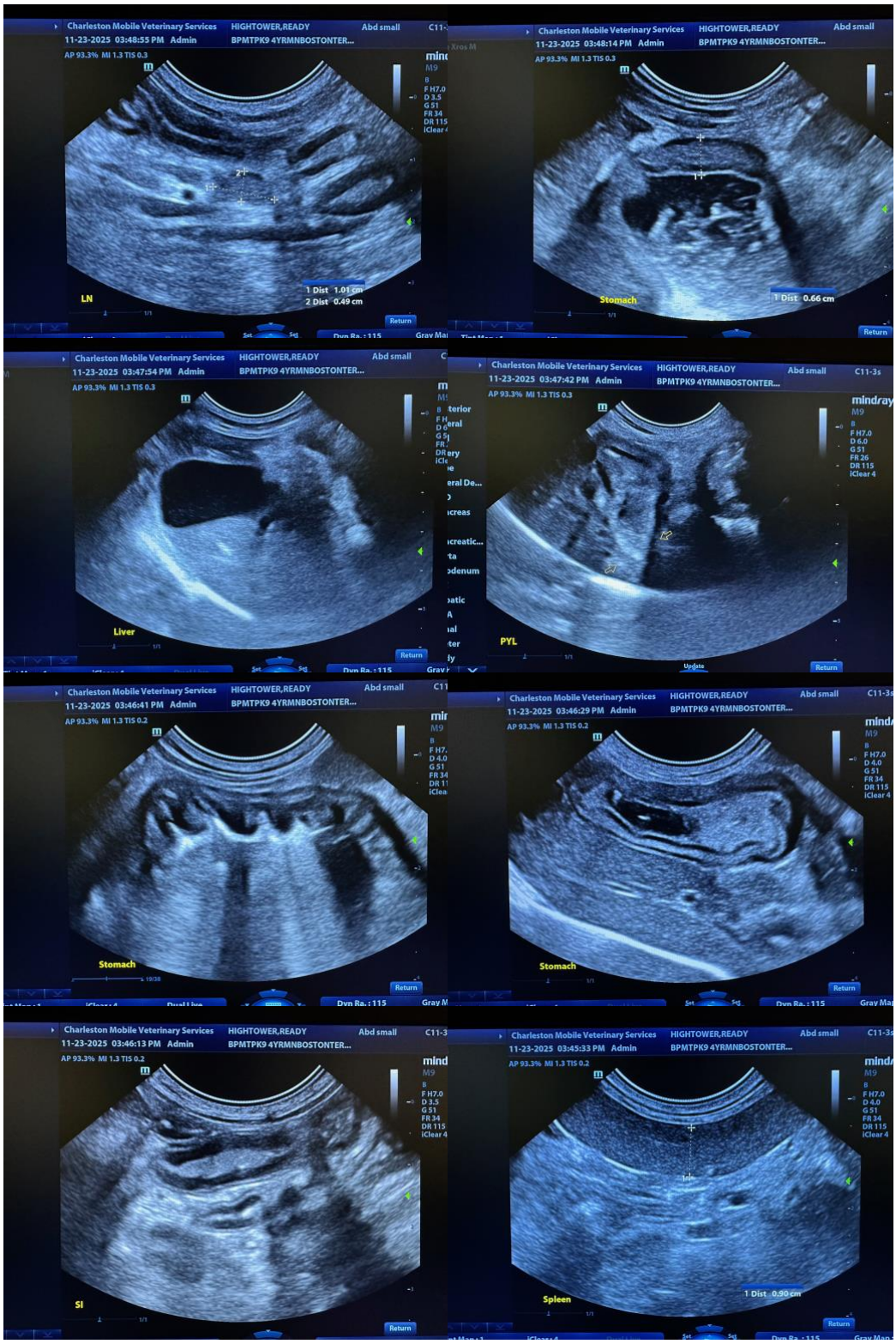

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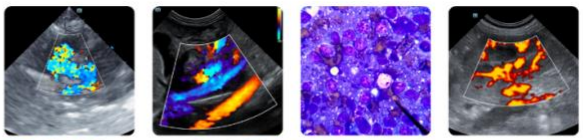

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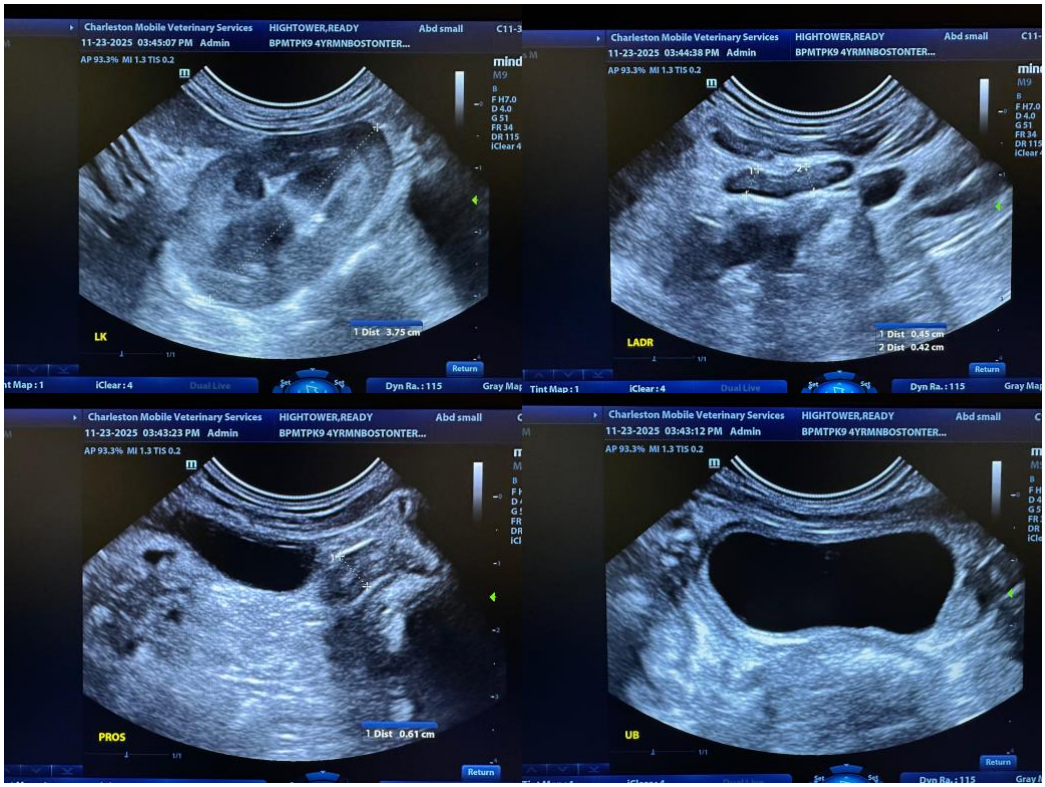

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com