



**DATE**

11-24-25

**PATIENT**

Brady Johnson

**SPECIES**

Canine

**BREED**

Bernese

**SEX**

Neutered Male

**AGE**

2/22/2018

**WEIGHT**

104lbs

**INTERPRETED BY**

Andrea Nicastro DVM  
Diplomate ACVIM  
(Sm Animal Internal Med)

**HOSPITAL NAME**

AMC of Bel Air

**REFERRING VET**

Dr. Chaudhry

**INVOICE**

22310

**PRESENTING CLINICAL SIGNS**

**Patient History:** Vomiting, lethargic, not eating.  
**Current Medications:** None listed.  
**Labwork Results:** Labwork not attached.  
**Date of Previous IntraPet Ultrasound:** No previous.  
**Sedation:** Not required to complete full diagnostic ultrasound.  
**Stat Report:** DVM requested STAT.  
**Imaging Performed by:** Rachel Brillhart, RDMS.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. A few, small cystic calculi are observed (one of the larger stones measuring 0.25 cm in diameter). A scant amount of mineralized sand is also seen. The region of the trigone and visible portion of the proximal urethra are normal.

The prostate is normal in size (1.46 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 (8.08 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (7.78 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal in size (0.66 cm at cranial pole) (0.65 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 (0.68 cm at cranial pole) (0.62 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.

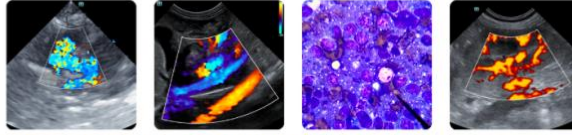
**Spleen**

The spleen is normal in size (2.24 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 gallbladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of aggregated, echogenic, partially dependent sludge is observed within the lumen. The cystic and common



**DATE** bile ducts are normal/not seen.

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**Gastrointestinal**

The gastric lumen is mildly to moderately distended with gas and fluid. Some irregular, shadowing material is observed within the gastric lumen. The gastric wall is normal to mildly thickened (up to 0.67 cm) with retention of the normal layering pattern. The pyloric outflow tract is visualized. It is difficult to determine whether foreign material is present within the pyloric lumen. A cluster of small intestinal segments are plicated and mildly fluid-distended. A hyperechoic linear shadow is observed within the lumen in these segments. The wall in this region is mildly thickened (up to 0.57 cm) with retention of the normal layering pattern. The mesentery effacing the serosal surface in this region is hyperechoic. In the remaining small intestinal segments, the wall is normal in thickness with a normal layering pattern and appropriate mural detail. The ileocecolic junction and colonic wall are normal.

**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**

At least one, prominent, mesenteric lymph node is visualized (measuring 3.34 x 0.74 cm).

**Free Abdomen**

Trace free fluid is observed.

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- Suspected small intestinal linear foreign body/obstruction. Mild adjacent peritonitis is present. Gastric foreign material is also suspected.
- Small cystic calculi/urinary bladder sand

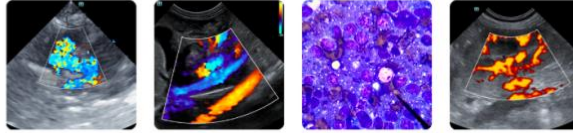
**Secondary Findings**

- The gallbladder changes are suggestive of a developing mucocele.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Mild bilateral nonspecific age-related renal changes

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- Three-view thoracic radiographs thoracic radiographs are recommended to assess for occult aspiration pneumonia.
- An abdominal exploratory with removal of any gastrointestinal foreign material is recommended. Consider obtaining GI biopsies at the time of surgery to evaluate for an underlying gastroenteropathy. If the patient is stable under anesthesia, also consider a cystotomy with stone removal, analysis and culture.

Imaging performed by



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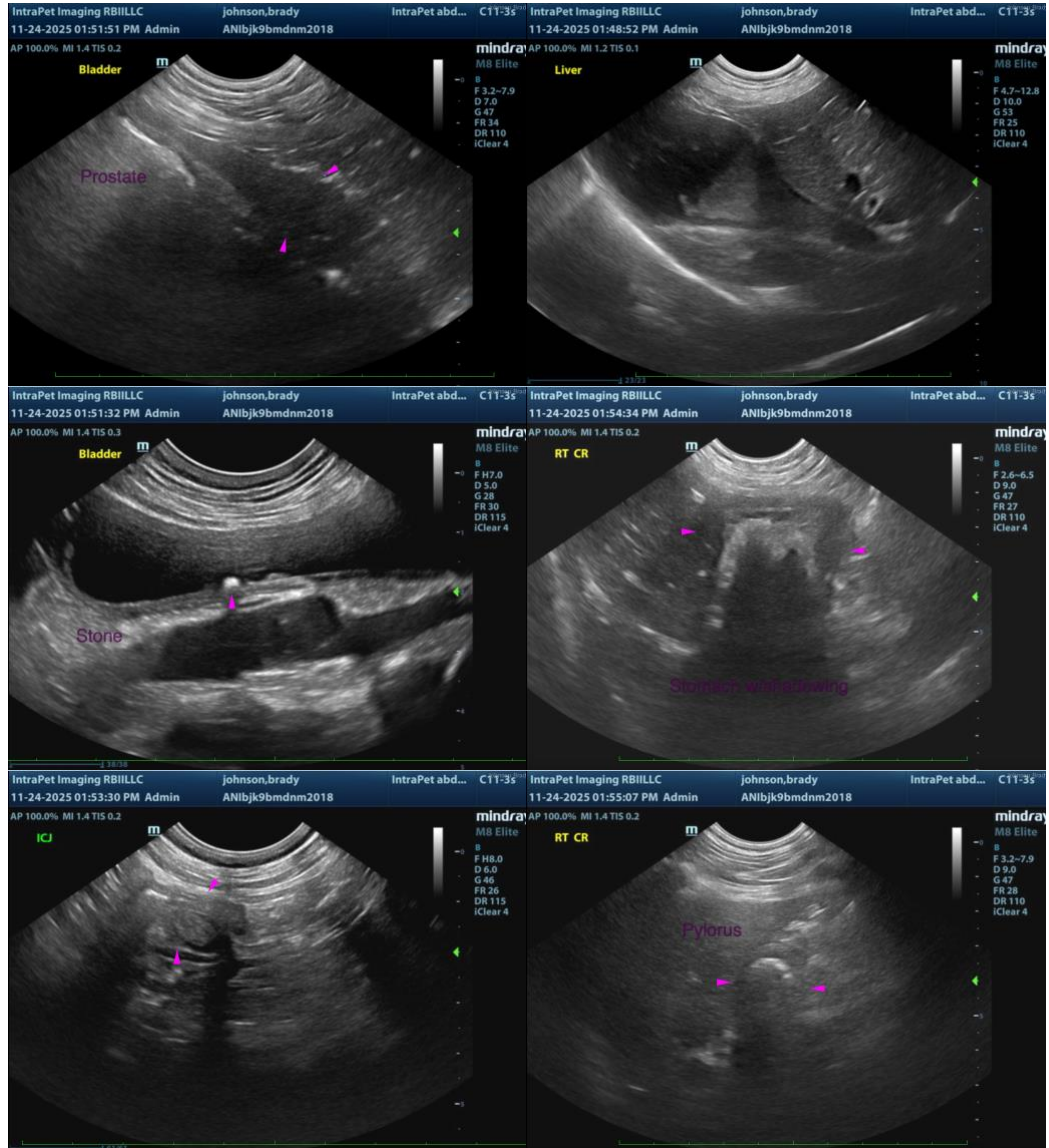
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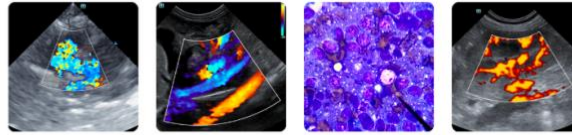
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- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) is recommended. Serial sonographic monitoring (e.g., every 6-8 weeks) of the gall bladder is recommended to assess for progression to a fully formed mucocele. If progression occurs,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



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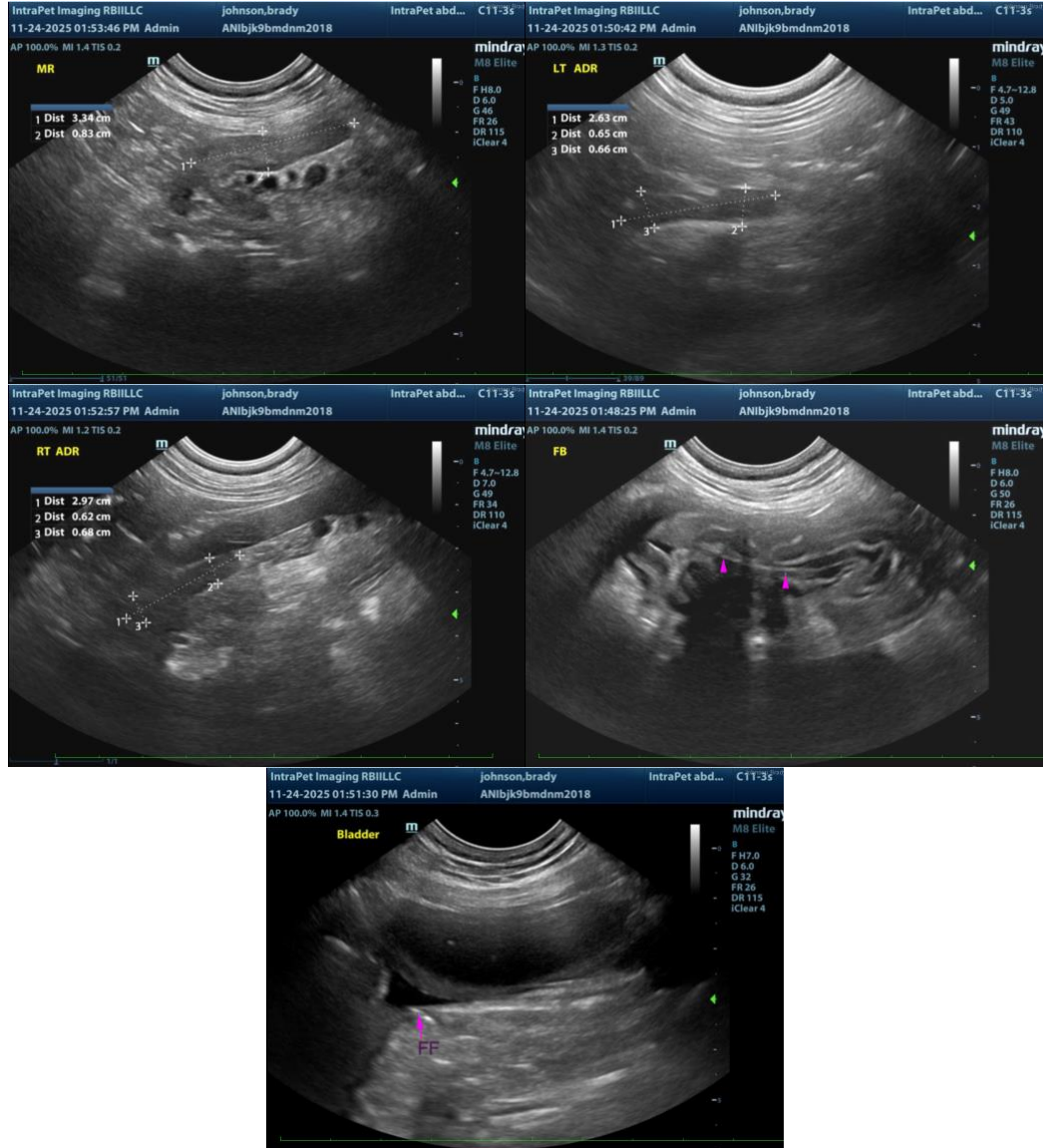
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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](mailto:info@SonoPath.com)