

**DATE PRESENTING CLINICAL SIGNS**

11/24/25

**Patient History:** presents for acute lethargy, anorexia, and abdominal discomfort. Patient History: - Rapid decline in energy, markedly lethargic past 1.5 days - Progressive decreased appetite x 1 week, complete anorexia x 1.5 days despite preferred foods - Withdrawn behavior, isolating from family - Not eating or drinking x 1.5 days - No urination today; prior frequency unknown - Decreased defecation; last bowel movement hard, pellet-like, minimal amount - Persistent excessive licking of front paws x several weeks (no prior history) - Periodic hind limb lameness; stifle “stumping” noted during walks - No reported coughing, sneezing, vomiting, or diarrhea. USG 1.052, no proteinuria, 1+ ketonuria, inactive sediment, PCV 37%, total solids 8.2, ALP 292.

**PATIENT**

Kingston Baltazar

**SPECIES**

Canine

**BREED**

Toy Poodle

**SEX**

Male, intact

**AGE**

1/1/2012

**WEIGHT**

10.5 lbs.

**INTERPRETED BY**

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

**HOSPITAL NAME**

Animal Emergency  
Hospital

**REFERRING VET**

Dr. Ruby

**INVOICE**

13369

**Current Medications:** Methocarbamol, maropitant, ondansetron, buprenorphine, baytril

**Labwork Results:** Labwork attached.

**Date of Previous IntraPet Ultrasound:** No previous.

**Sedation:** Not required to complete full diagnostic ultrasound.

**Stat Report:** Not requested.

**Imaging Performed by:** Rachel Brillhart, RDMS.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are mostly anechoic. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is enlarged (2.12 cm in width) with smooth peripheral contours. The parenchyma is isoechoic to hyperechoic relative to surrounding omental and subtly heterogeneous in appearance. The prostatic urethra is not overtly dilated.

The left kidney is normal in size (3.84 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate 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 (3.97 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate 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 normal in size (0.50 cm at cranial pole) (0.48 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 (0.54 cm at cranial pole) (0.47 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 (0.68 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.62 cm ill-defined hypoechoic nodule is observed near the caudal pole. Splenic vasculature is normal.

**Liver**

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature 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 to large amount of aggregated, echogenic to mineralized, partially dependent debris/sludge/sand 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 duodenum and jejunal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern. A several cm segment of bowel in the cranial abdomen, thought to be ileum, is fluid distended and hypomotile. The colonic wall is normal. The colonic lumen contains shadowing fecal material. There is no obvious evidence of an obstructive pattern.

### ***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.

### ***Lymph nodes***

The abdominal lymph nodes are normal/not visible.

### ***Free Abdomen***

There is no obvious evidence of free fluid.

### ***Other***

The testicles are subjectively normal in size and symmetrical with homogeneous parenchyma.

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

## **ULTRASONOGRAPHIC FINDINGS**

### **Primary Findings:**

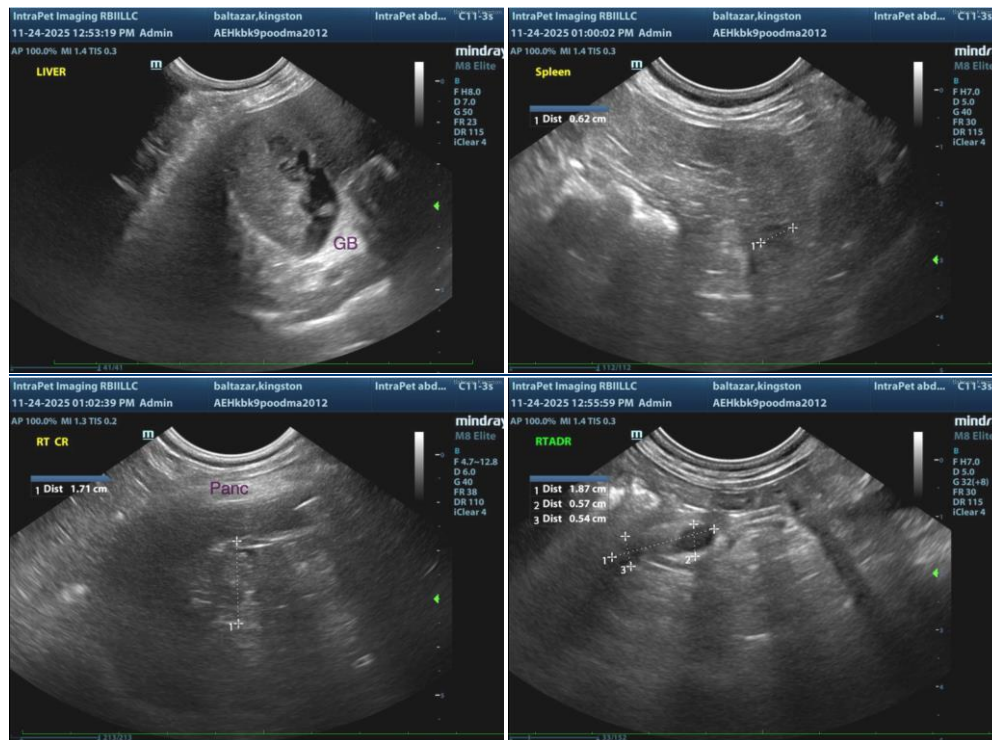
- Focal bowel dilation, thought to represent ileum. Considerations include focal ileus (i.e., secondary to enteritis) or less likely, mechanical obstruction (none seen).
- The gallbladder changes are most consistent with a developing mucocele.
- The splenic nodule could be consistent with a benign focus (i.e., lymphoid hyperplasia or similar). Alternatively, an emerging tumor is possible.

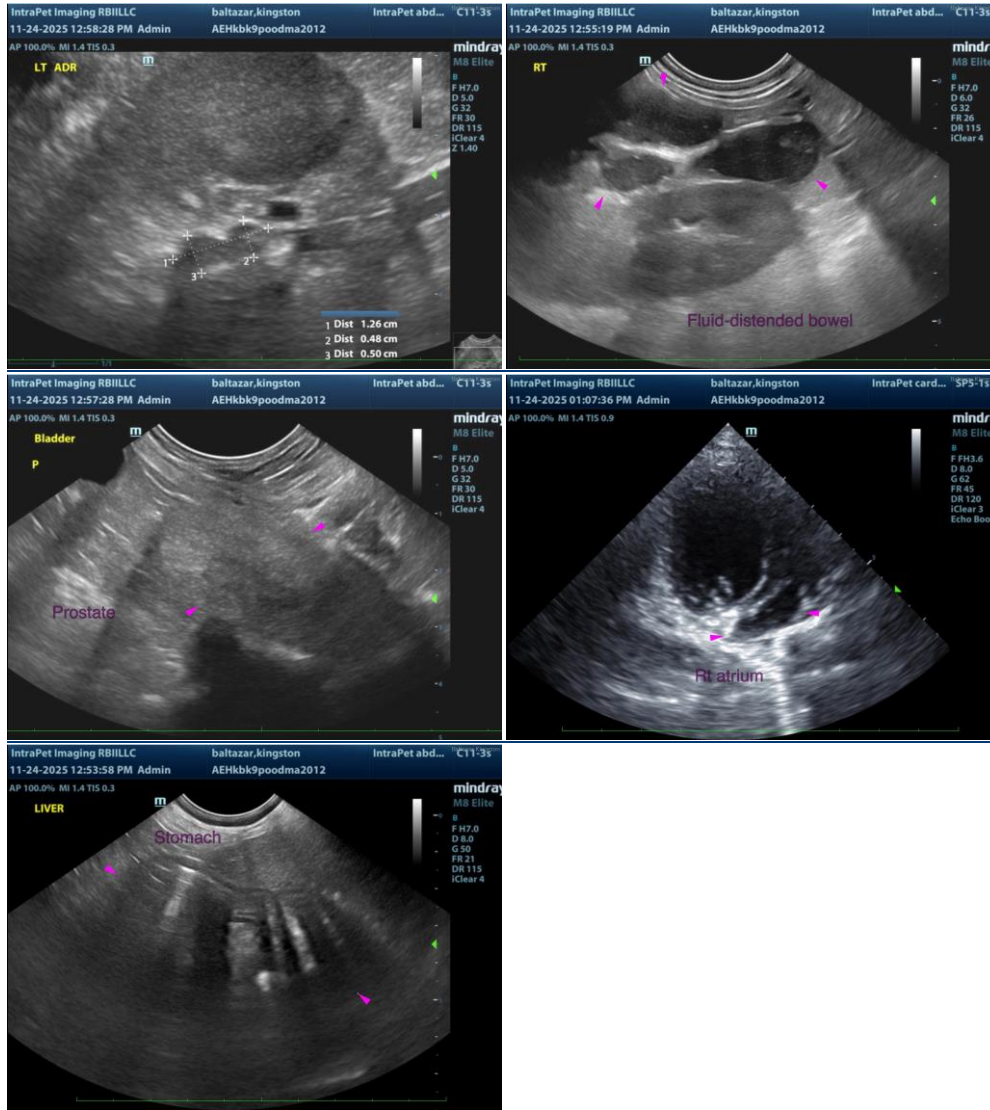
### **Secondary Findings:**

- Bilateral nonspecific, age-related renal changes
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- 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 prostate changes are most consistent with benign prostatic hyperplasia. Bacterial prostatitis is also a differential but considered unlikely in the absence of lower urinary tract signs.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. 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.
2. Given the prostate changes, a urinalysis with a culture and sensitivity are recommended to assess for infection.
3. Regarding the splenic nodule, consider three-view thoracic radiographs to assess for metastatic disease.
4. Given the splenic lesion is likely not accessible for aspiration, consider a recheck ultrasound in 1-2 months to assess for growth.
5. Regarding the dilated bowel, supportive care for enteritis is recommended along with a fecal evaluation for ova and Giardia. Consider a recheck ultrasound in 24-48 hours to reevaluate the bowel for persistent dilation. If clinical signs persist, further GI workup (i.e., GI panel including serum cobalamin, folate, TLI, PLI and resting cortisol level) +/- surgical GI biopsies may be indicated.





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)