



**PATIENT**

Lilypad Augustine

**SPECIES**

Canine

**BREED**

Standard Schnauzer

**SEX**

Female Spayed

**AGE**

06/01/2014

**WEIGHT**

16 lb

**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**

Kind Care AH

**REFERRING VET**

Dr Adri Casagrande

**INVOICE**

22224

**DATE**

12-5-25

**PRESENTING CLINICAL SIGNS**

Clinical Exam Findings: Frequent pancreatitis flare ups, vomiting, and diarrhea  
Abnormal lab-work values: ALT 22. ALP 584.  
Current Medications: Gabapentin  
Radiographic Findings: none

**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 left kidney is normal in size (4.67 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 hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (4.70 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 hydronephrosis. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal in size (0.46 cm at cranial pole) (0.50 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 (1.19 cm at cranial pole) (0.39 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 (0.96 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 prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic to hyperechoic 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 portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen. The distal common bile duct is mildly dilated (up to 0.45 cm). However, it can be followed to the level of the duodenal papilla. No obvious intraluminal obstruction is seen.

**Gastrointestinal**

The gastric lumen is minimally distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen segmentally



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dilated with chyme (mild). The small intestinal wall is normal in thickness with retention of normal layering. There is evidence of mucosal speckling in some segments. Discreet masses are not identified. The ileocecolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

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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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**Lymph Nodes**

The abdominal lymph nodes are normal/not visible.

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**Free Abdomen**

There is no obvious evidence of free fluid.

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**Other**

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

**ULTRASONOGRAPHIC FINDINGS**

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**Primary Findings**

- The diffuse hepatic changes are nonspecific 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.
- Gallbladder debris, non-mucocele

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**Secondary Findings**

- The small intestinal mucosal speckling can be associated with enteritis, inflammatory bowel disease, or may be a normal variant for this patient.
- 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.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- If an aggressive approach is desired, consider hepatic tissue sampling (i.e., aspirates or biopsies). If biopsies are pursued, aerobic and anaerobic bile cultures and hepatic copper quantitation should also be performed. Alternatively, consider serial monitoring (i.e., every 3-4 months) of the patient's liver values. If values continue to increase, consider a recheck ultrasound +/- hepatic tissue sampling at that time.
- Regarding the GI signs, consider the following:
  1. Texas GI panel including serum cobalamin, folate, PLI, TLI and resting cortisol level
  2. A fecal evaluation for ova/Giardia
  3. Prophylactic deworming with Fenbendazole.

**REFERRING VET**

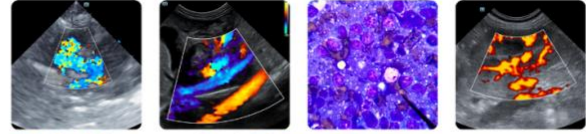
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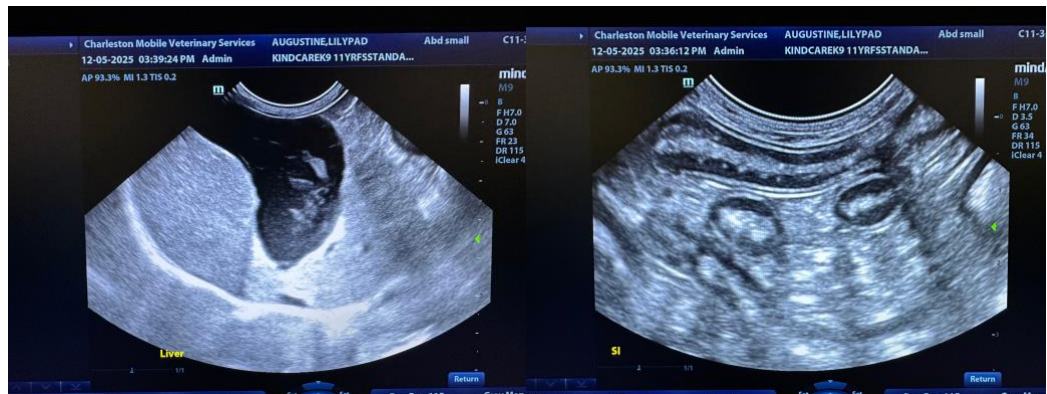
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4. Consider a low-fat hypoallergenic or hydrolyzed protein diet to address potential pancreatitis and inflammatory bowel disease.
5. Also consider initiating a probiotic with a high colony count +/- fiber supplement (i.e., psyllium).
6. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.
7. Three-view thoracic radiographs should be performed prior to any anesthetic event.





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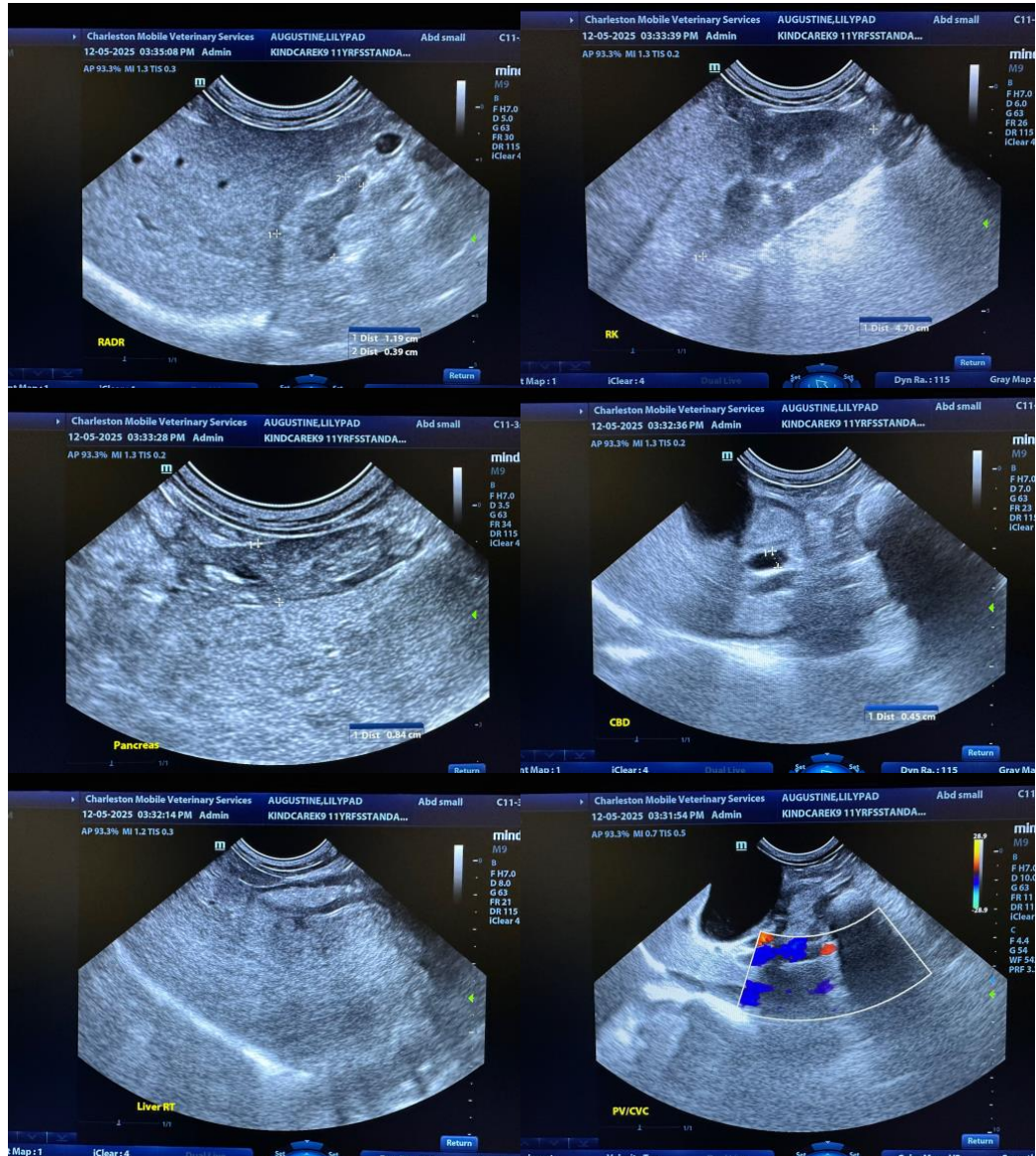
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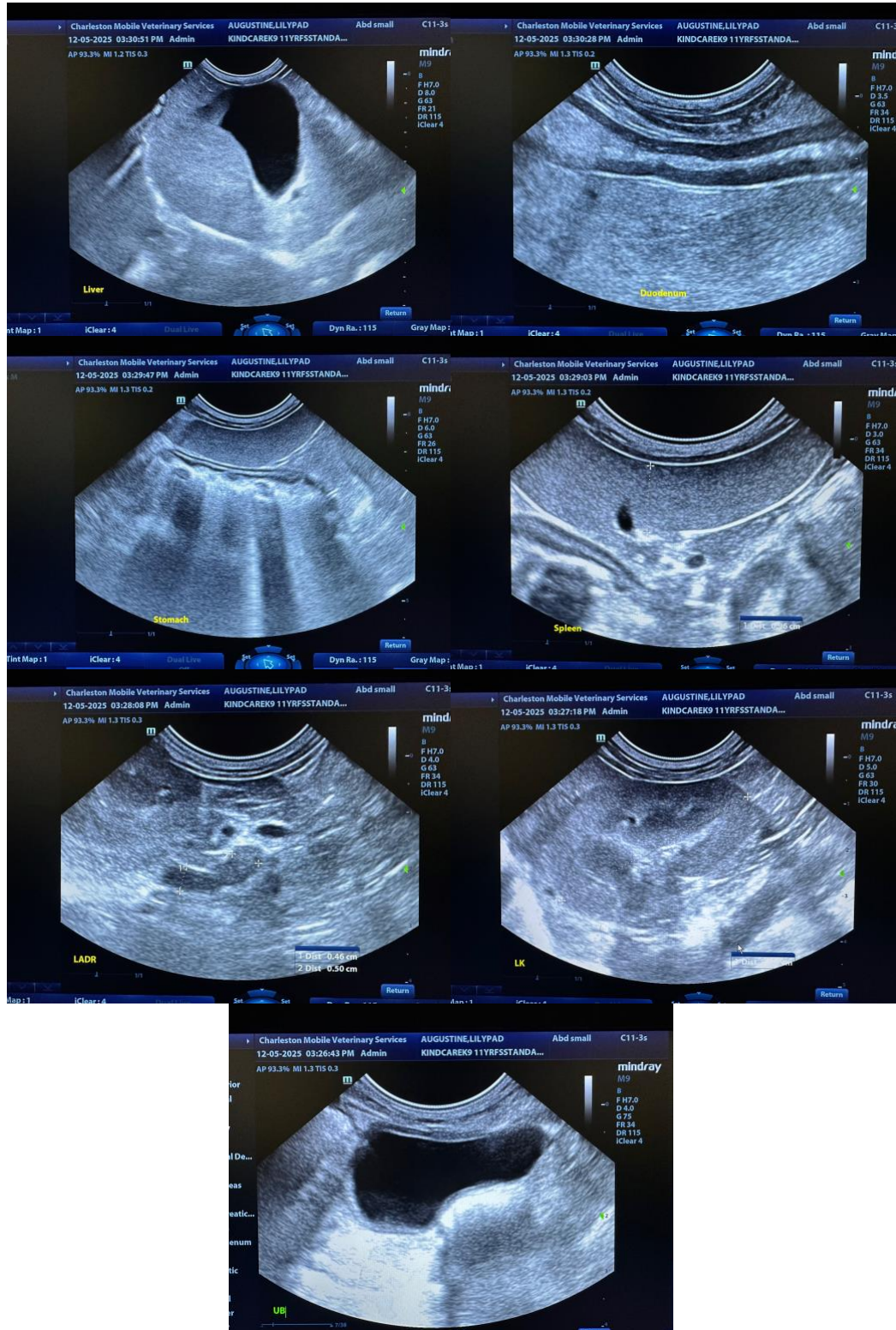
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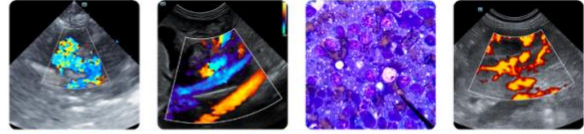
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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[info@SonoPath.com](mailto:info@SonoPath.com)

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