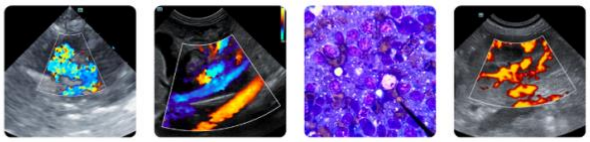




**PATIENT**

Cooper Koppenhaver

**SPECIES**

Canine

**BREED**

Yorkshire Terrier Mix

**SEX**

Neutered Male

**AGE**

13

**WEIGHT**

6 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Mary Pearce

**HOSPITAL NAME**

Chambersburg AH

**REFERRING VET**

Tanya Miller

**INVOICE**

22561

**DATE**

2-16-26

## PRESENTING CLINICAL SIGNS

History: Presented 1/19/26 for eval d/t weight loss. Vomiting 5-6x/wk, with vomit sometimes containing food or appearing as yellowish bile or white foam. Increased sleeping/lethargy. Drinking more water, urinating in the house. Changed to GI low fat diet d/t concerns for pancreatitis end of January.
r/o pancreatitis, infiltrative GI disease, IBD, neoplasia, CKD, urolithiasis, open

Abnormal PE/Chem/CBC/UA Results:
1/23/26: spec cPL 1,208 (H), TLI >50 (H), B12 451, Folate >24.0 (H)
1/19/26: 4Dx neg. HCT 44.1%, normal CBC. SDMA 16 (0-14), BUN 67 (7-27), Creat 1.5, phos 2.0, lipase 2089, K 3.3. Rads: thoracic wnl abd: feces in colon, on v/d slight increase opacity in fundus of stomach (ingesta vs open), some GI seems bunched and w/ some degree of decrease serosal detail mid abd
6/27/25: Creat 1.2, BUN 46, otherwise unremarkable CBC/Chem 17.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. Gravity-dependent mineralized sand/tiny calculi are observed within the lumen. The region of the trigone and visible portion of the proximal urethra are normal.

The prostate is normal in size (0.62 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 (2.67 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. Several nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (2.77 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. Several nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

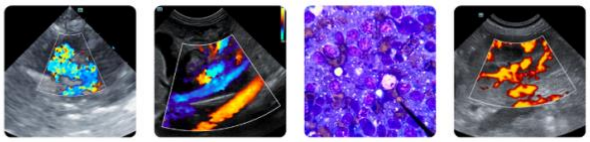
### *Adrenal Glands*

The left adrenal gland is normal in size (0.32 cm at cranial pole) (0.37 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 (0.52 cm at cranial pole) (0.45 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 (0.80 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.





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***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 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.

***Gastrointestinal***

The gastric lumen is not distended. The gastric wall is normal to moderately thickened (up to 0.76 cm) with questionable retention of the normal layering pattern in the thickened regions. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

***Pancreas***

The right limb is visible, with minimal deviation from the normal peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated.

***Lymph Nodes***

The abdominal lymph nodes are normal/not visible.

***Free Abdomen***

The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

- The gastric wall changes could be consistent with gastritis or emerging neoplasia.
- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.

### Secondary Findings

- Bilateral nonspecific age-related renal changes with nonobstructive nephrocalcinosis
- Urinary bladder sand/small, cystic calculi
- 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.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the patient's history of vomiting, consider the following:

1. Fecal evaluation for ova and Giardia
2. Three-view thoracic radiographs to assess for occult pathology in the chest

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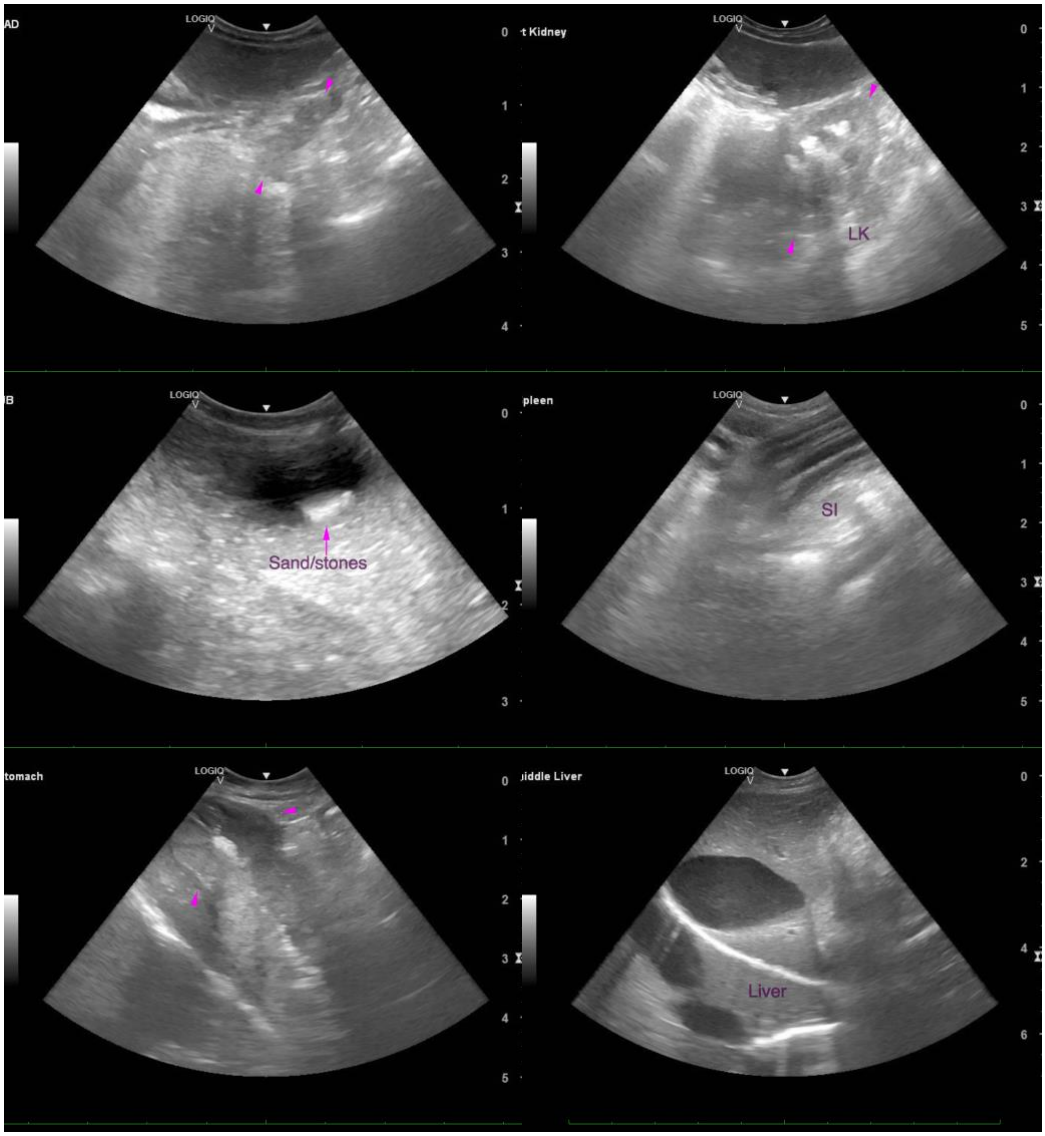
3. Endoscopic or surgical GI biopsies, along with particular attention to the thickened portion of the stomach wall.

- Regarding the azotemia, consider the following:

1. Urinalysis with culture and sensitivity
2. UPC if proteinuria is present in the absence of infection
3. Baseline blood pressure measurement
4. Serial monitoring of the patient's renal values to assess progression of the azotemia

- Regarding the urinary bladder sand/cystic calculi, as cystotomy with stone removal, analysis and culture can be considered, particularly if the patient undergoes surgical GI biopsies. Alternatively, an attempt at medical dissolution can be considered.



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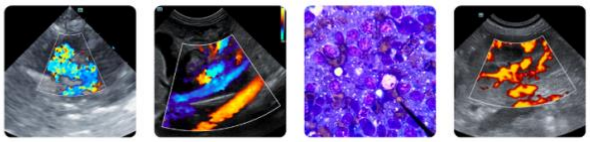

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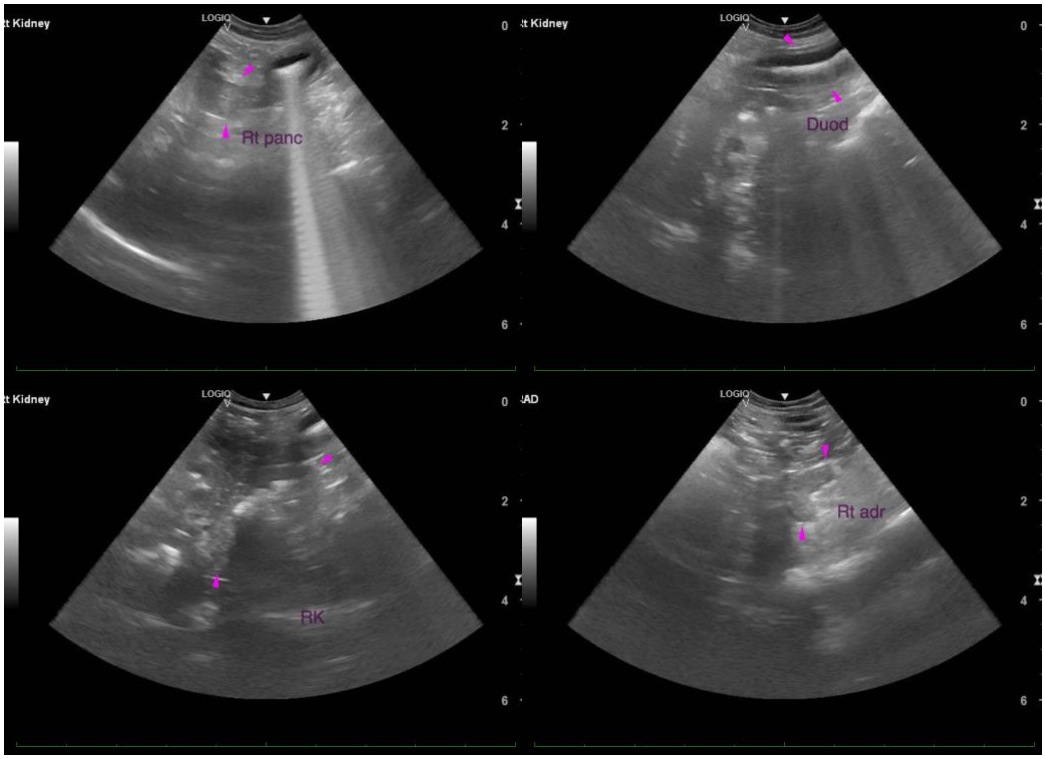


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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