


DATE **PRESENTING CLINICAL SIGNS**

2/16/26

PATIENT

Scruffy Parkhurst

SPECIES

Canine

BREEDWest Highland white
terrier**SEX**

Male, neutered

AGE

16+ Yrs.

WEIGHT

13.04 lbs.

INTERPRETED BY
 Andrea Nicastro, DVM,
 Diplomate ACVIM
 (*Small Animal Internal
 Medicine*)
HOSPITAL NAMEAnimal Emergency
Hospital**REFERRING VET**

Dr. Shannahan

INVOICE

13478

Patient History: Sunday saw Urgent Care diagnosed with pancreatitis/heart murmur --was vomiting, diarrhea and not eating. Did BW, Panoquell along with Cerenia, Entyce Monday went back and gave Panoquell, Ondancetron, SQ fluids Cerenia inj. Ate a little bit Monday. Radiographs done as well Midweek O noticed blood in urine went to RDVM with urine only diagnosed bladder infection and started antibiotics but he will not eat it. Vomited today and VERY limited eating on his own. Date: 02-16-2026 Notes: Signalment: 16+ yo male dog Presenting Complaint: Scruffy presents for continued signs of pancreatitis and bladder infection despite treatment Patient History: - Rescue dog, owned for approximately 16 years - Current medications: - Denamarin (liver supplement) - 1-2 years - Fluoxetine - 2 years - Enrofloxacin (Baytril) - started yesterday evening - Gabapentin - 1-2 doses given - Methocarbamol - prescribed but not yet started - Monthly heartworm preventative - Cosequin joint supplement - Diagnosed with pancreatitis last Sunday (2026-02-09) at First State Veterinary Hospital - Treated with Panaquil injections (2 doses) - Initially showed some appetite improvement after Panaquil, then declined - Initial urinalysis last Sunday negative for infection - Developed hematuria and urinary incontinence mid-week (Wednesday) - Urine sample collected Friday, bladder infection confirmed yesterday (Saturday) - Anorexia throughout past week - Last ate yesterday morning (small amount) - Refused food including highly palatable items (ribs) - Vomited once today (white foamy material) several hours after receiving enrofloxacin - Last bowel movement Wednesday: soft, mucoid stool with blood - Progressive lethargy and weakness over past week - More alert in mornings, increasingly lethargic throughout day - Reluctant to move, standing at top of stairs without descending - Heart murmur newly discovered last Sunday at First State - Never previously on cardiac medications - Plan to start pimobendan (Vetmedin) after resolving pancreatitis - Chronic allergies (unknown allergen): - Self-trauma: pulls hair from tail and feet - History of urticaria - Scooting behavior - Rubs belly on surfaces - Receives Cytopoint injections every few months as needed - Possibly worse in spring, though client uncertain if truly seasonal - Left eye cataract (chronic, non-visual) - Severe dental disease (chronic, not treated due to anesthesia concerns given age) - History of mammary neoplasia 1-2 years ago, surgically excised- Cutaneous masses present for extended period - Previous blood work from First State showed: - Mild lymphopenia - Elevated BUN - Elevated protein - Elevated liver enzyme (one value) - Elevated amylase and lipase - Chest radiographs at First State showed mild cardiac enlargement - Previous patient at this hospital: Daisy (Cavalier King Charles Spaniel with heart disease, deceased)

Current Medications: Protonix, Buprenorphine, Ondansetron.**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 proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.84 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 (3.96 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is moderate loss of corticomedullary distinction. A few small cortical cysts are seen. Several hyperechoic shadowing diverticular foci are observed. Moderate pyelectasia is present (0.42 cm in the longitudinal plane). There is no evidence of infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (3.95 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is moderate loss of corticomedullary distinction. A few small cortical cysts are seen. Several hyperechoic shadowing diverticular foci are observed. Mild pyelectasia is present (0.25 cm in the longitudinal plane). There is no evidence of infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.66 cm at cranial pole) (0.78 cm at caudal pole) with swollen peripheral contours. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is mildly enlarged (0.75 cm at cranial pole) (0.58 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 (1.12 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.57 cm x 0.65 cm hypoechoic nodule is observed near the hilus. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size. The parenchyma is isoechoic relative to the spleen and heterogeneous with diffuse varying sized hypoechoic nodules, one of the larger nodules measuring 1.5 cm in its longest dimension. Vascular 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 amount of aggregated, echogenic to mineralized partially dependent debris/sludge 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 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 of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic relative to surrounding omental fat and heterogeneous 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

In the visible portion of the thorax, several B-lines are suspected.

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The hepatic parenchymal changes could be consistent with infiltrative neoplasia (i.e., round cell tumor, carcinoma). Alternatively, a benign process (i.e., inflammatory disease, hepatotoxicosis (i.e., copper), regenerative nodular hyperplasia, vacuolar hepatopathy, fibrosis and/or other hepatopathy) may be present.
- The gallbladder changes are suggestive of a developing mucocele.
- Bilateral adrenomegaly
- Suspected B-lines in the thorax are suggestive of pulmonary parenchymal disease.

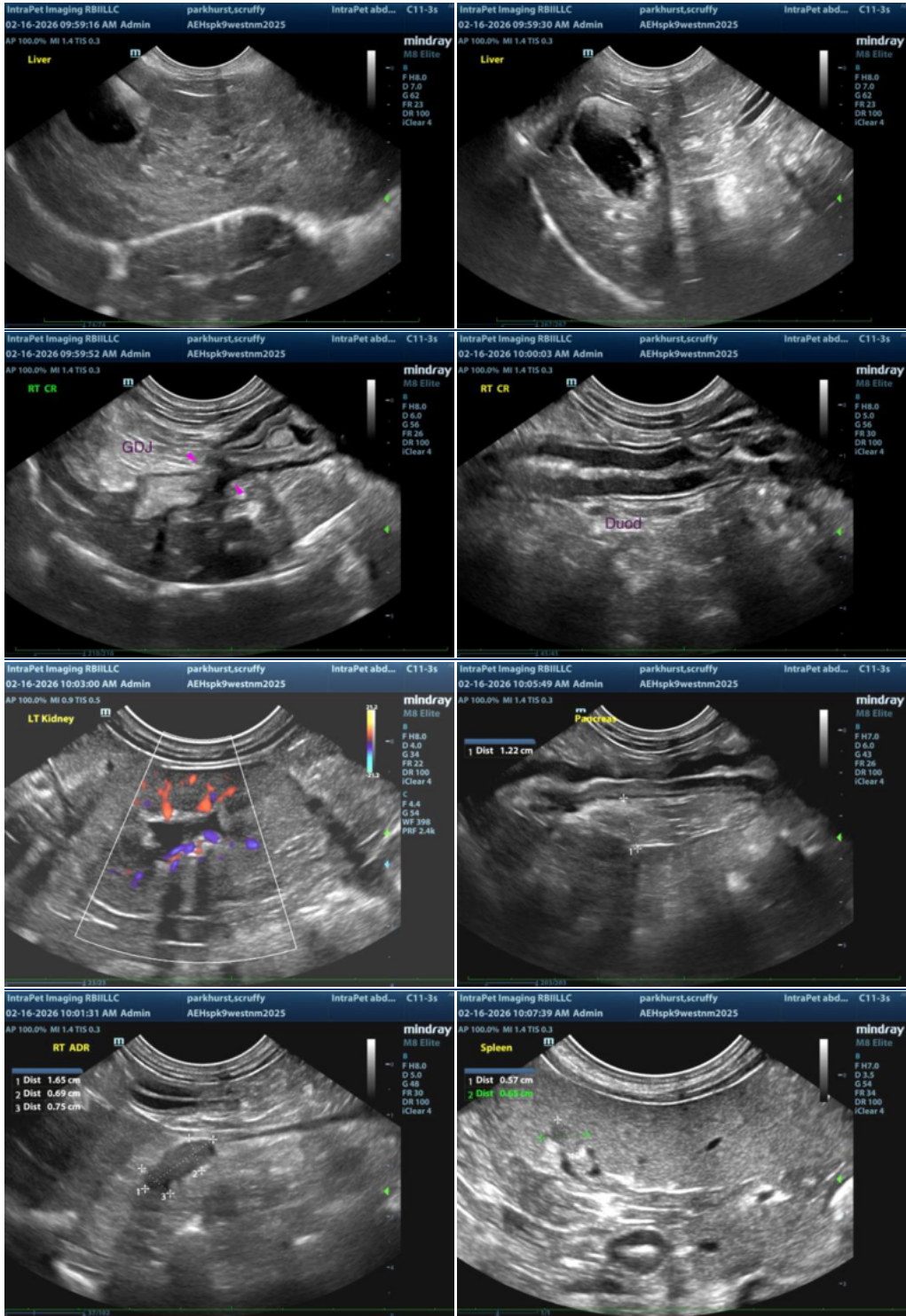
Secondary Findings:

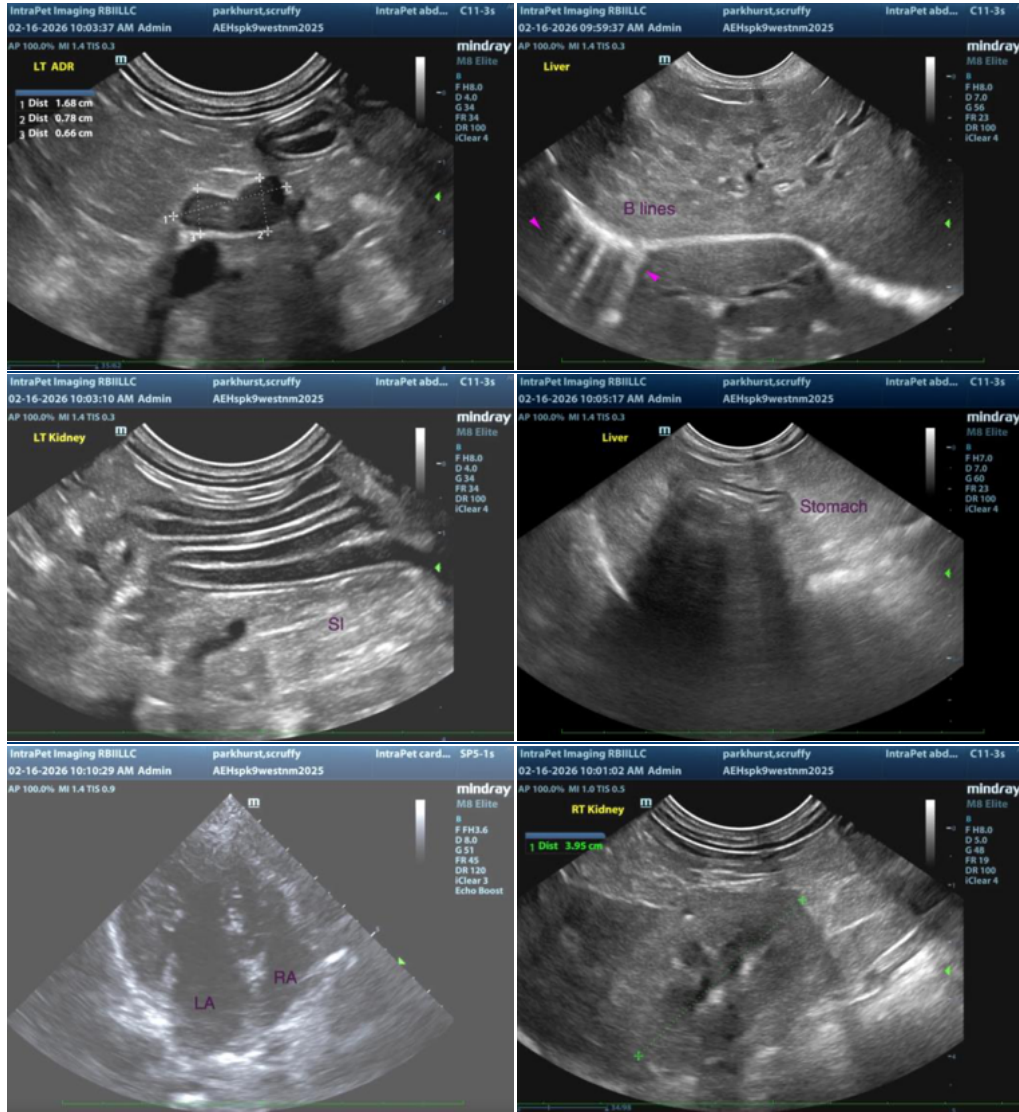
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Bilateral nonspecific, age-related renal changes with cortical cysts and pyelectasia. The pyelectasia may be secondary to pyelonephritis, parenchymal remodeling, PU/PD (if applicable), fluid therapy (if applicable) or some combination thereof.
- The splenic nodule trends toward the benign (i.e., focus of lymphoid hyperplasia or similar). However, emerging neoplasia cannot be completely excluded.

*An obvious cause for the patient's GI signs is not definitively identified in this study. Considerations include dietary indiscretion, toxicity, food allergy/intolerance, inflammatory bowel disease, mild pancreatitis, underlying metabolic issue (i.e., hepatobiliary disease), other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A fecal evaluation for ova and Giardia is recommended (if not already performed).
- Consider a GI panel including serum cobalamin, folate, TLI and PLI.
- Regarding the hepatic changes, consider the following:
 1. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
 2. Hepatic tissue sampling (i.e., aspirates or biopsies) assuming normal clotting status.
- While awaiting test results, symptomatic care is recommended.





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.

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