


**PATIENT**

Gala Garcia

**SPECIES**

Canine

**BREED**

Goldendoodle

**SEX**

Intact Female

**AGE**

9 mos

**WEIGHT**

9.4 lbs

**PRESENTING CLINICAL SIGNS**

History: 12/15/22 Patient was presented for vomiting and anorexia. Patient had been 3 weeks at training. Trainer told owner she had not eaten since Thursday (4 days prior to presenting at the clinic). Patient was picked up 2-14-22. Had 1 vomiting episode with the trainer. Vomited yellow liquid yesterday at home. She was given treats and peanut butter at training. Does not have diarrhea; defecated a small amount of normal feces 2-14-22 and it was dark and pasty (melena liked). Recommended hospitalizing with IVF, cerenia, famotidine, gastro diet and repeat radiographs - owner declined hospitalization. Administered IVF, cerenia 0.4 ml IV and famotidine 0.4 ml IV - patient left in the afternoon 12/16/22 Presented to recheck from yesterday. NO more vomiting or diarrhea but decrease appetite. Recheck exam Abd rads: no obvious GI FB, or intestinal distension, some feces see on large intestine. The PE showed that pt is lethargic but responsive and dehydrated. The diagnostics did not show any major abnormalities. We gave IV fluids, gave cerenia injection and started Panacur just in case for intestinal parasites. Offered Recovery. Pt did not eat but at the end of the hospitalization, pt seems more active. Recommended to cont hospitalization, but declined. Told if not better then need to come to for diagnostics like ABD u/s and continue QAR, dehydrated 5% NO FB tacky MM Historical vomiting and decrease appetite. rectal, no masses and very pasty and sticky black feces. 2/17/22 Last vomiting was Monday 2-14-22 and Tuesday 2-15-22. Hasn't eaten since last Thursday 2-10-22. Currently on Cerenia, Famotidine, fluids. Started on Mirtazapine and Panacur.

Abnormal PE/Chem/CBC/UA Results: A complete physical examination was performed on Gala. Vital signs, hydration status and color and refill time were mildly delayed and tacky. Fecal - negative Parvo: Negative CBC - WNL Chemistry - hypocholesterolaemia 72, decreased amylase 380 radiographs - WNL

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Dr. Ferrer DVM

**HOSPITAL NAME**

Paseos VC

**REFERRING VET**

Dr. Maria Celeste  
 Martes

**INVOICE**

10405

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2/17/22

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**
**Urinary System**

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A small to moderate amount of suspended echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney presented normal size (3.79 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney presented normal size (4.27 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

**Adrenal Glands**

The left adrenal gland is normal size (0.33 cm at cranial pole) (0.38 cm at caudal pole) (1.89 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.



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The right adrenal gland is normal size (0.91 cm at cranial pole) (0.47 cm at caudal pole) (1.98 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

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**Spleen**

The spleen is normal in size (1.02 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 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. No pathological hepatic lymphadenopathy observed.

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The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal.

**Gastrointestinal**

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern. There is slight mucosal fogging in the proximal duodenal mucosa. In the remaining small intestinal segments, there is appropriate mural detail. Discreet masses are not identified. The ileocecolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

**WEIGHT**

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Medicine)

**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.

**IMAGING PERFORMED BY**

Dr. Ferrer DVM

**Free Abdomen**

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. Several prominent mesenteric lymph nodes are visualized, the largest measuring 2.03 cm in length. In addition, a 1.12 cm medial ileac lymph node is seen.

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**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- The abdomen lymphadenopathy could be consistent with immunologic immaturity and/or reactive change. Infiltrative neoplasia is possible but considered unlikely in this young patient.
- The slight mucosal fogging of the duodenal mucosa may represent an inflammatory process or may be a normal variant for this patient.
- The urinary bladder debris could be consistent with cells, crystal and/or exfoliated material

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\*\*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include dietary indiscretion, toxin exposure, infectious/parasitic disease, other microscopic gastrointestinal disorder, low-grade pancreatic disease, underlying metabolic issue, other.

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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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- GI Panel (send to Texas A&M)
- A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
- Also consider pre-and postprandial serum bile acids to assess for occult hepatic dysfunction.
- Consider three-view thoracic radiographs to assess for occult esophageal disease.
- Supportive care for gastric ulceration is recommended, including a proton pump inhibitor (i.e, omeprazole), as well as sucralfate. The patient should be treated for 10-14 days. If the patient's diagnostic workup is inconclusive and clinical signs do not resolve with supportive care, an upper GI endoscopy with biopsies may be warranted.
- Given the urinary bladder debris, a urinalysis +/- urine culture and sensitivity should also be considered.

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## IMAGING PERFORMED BY

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## REFERRING VET

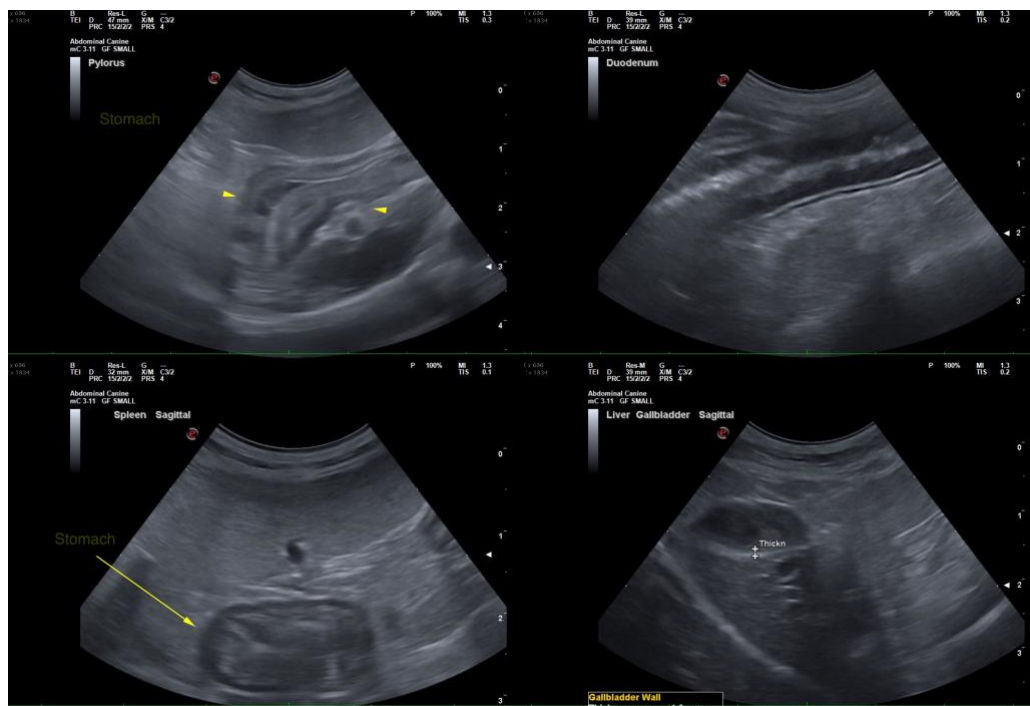
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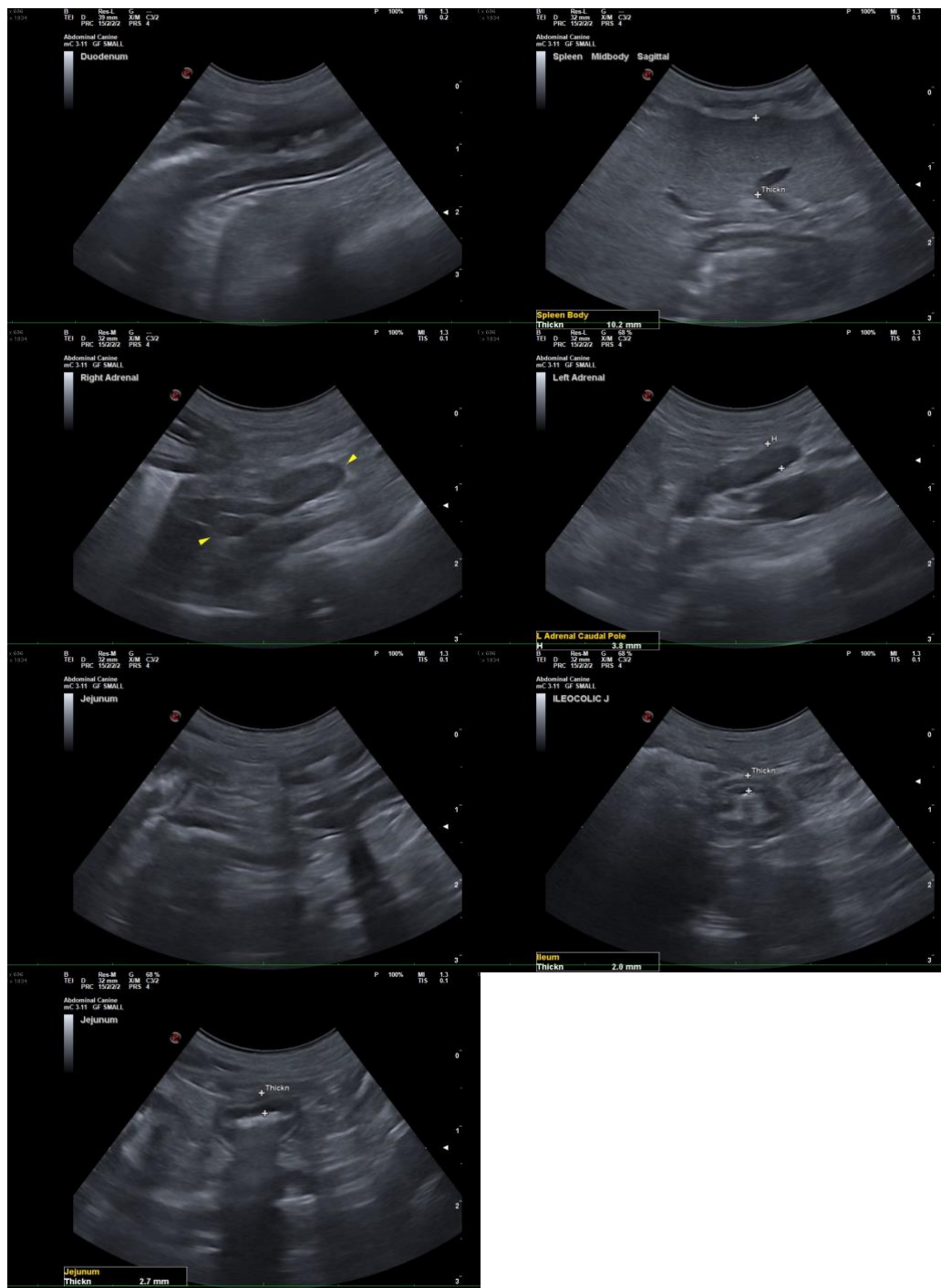
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I



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can be of any further assistance, please contact me.

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**Andrea Nicastro, DVM, Diplomate DACVIM (Small Animal Internal Medicine)**  
info@SonoPath.com

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