



PATIENT PRESENTING CLINICAL SIGNS

Sophie Rivera

History: Px presented as a referral for an abdominal ultrasound due to Hx of Pancreatitis and bloody diarrhea since last week. Px has a mass on the left perianal region. Previously Dx with pancreatitis (September/Nov 2025). Px has had some episodes of vomiting. Normal appetite per owner. Nephroliths were observed in abdominal radiographs a few months ago, but no further Tx was pursued due to normal laboratory values and the lack of symptoms

SPECIES

Canine

BREED

Yorkshire Terrier

Abnormal PE/Chem/CBC/UA Results: Leukocytosis with a neutrophilia. Thrombocytosis. Elevated cPL. (Bloodwork and abdominal radiographs attached below for your reference).

SEX

Female Spayed

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone is normal.

AGE

13

The left kidney is normal in size (3.74 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. A few, small, nonobstructive mineralized foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter.

WEIGHT

9.4 lbs

The right kidney is normal in size (3.08 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Several nephroliths are visualized. Trace pyelectasia is present. There is no evidence of infarcts. The ureter is diffusely dilated (measuring 0.42 cm in diameter proximally and 0.19 cm distally). A 0.19 cm hyperechoic- to mineralized structure is observed within the distal right ureteral lumen, just proximal to the ureteral papilla.

INTERPRETED BY

Andrea Nicastro, DVM,
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(Small Animal Internal
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Adrenal Glands

The left adrenal gland is normal in size at the cranial pole and enlarged at the caudal (0.43 cm at cranial pole) (0.63 cm at caudal pole). Glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

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The right adrenal gland is normal in size at the cranial pole and enlarged at the caudal pole (0.44 cm at cranial pole) (0.67 cm at caudal pole). Glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

REFERRING VET

Dr Ricardo Fernandez

Spleen

The spleen is normal in size (1.20 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 1.64 x 0.88 cm irregular, hypoechoic nodule is observed at the lateral aspect, approximately mid-body. 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.

DATE

2-25-26

The gallbladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen. The duodenal papilla is normal-in-size (0.28 cm in width).



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Gastrointestinal

The gastric lumen is mildly 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 is not dilated. The small intestinal wall is normal in thickness. There is slight disruption in the normal 1:3 muscularis: mucosal ratio in some segments. Discreet masses are not identified. The ileoceocolic junction and colonic wall are normal. 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

One-to-two prominent medial iliac lymph nodes are visualized (one measuring 1.68 x 0.42 cm). A few prominent mesenteric lymph nodes are also seen (one measuring 1.62 x 0.46 cm).

Free Abdomen

There is no obvious evidence of free fluid.

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The small intestinal wall changes could be consistent with inflammatory bowel disease or may be a normal variant for this patient.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Bilateral nephrolithiasis with right hydroureter and a possible ureterolith in the right distal ureter
- The splenic nodule could be consistent with an emerging tumor or a benign focus (i.e., lymphoid hyperplasia or similar).

*An obvious cause for the patient's GI signs is not definitively identified in this study. Considerations include a microscopic enteropathy (i.e., food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease), underlying metabolic issue, other.

Secondary Findings

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Bilateral adrenomegaly



PATIENT **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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- The following diagnostics/treatment recommendations can be considered:

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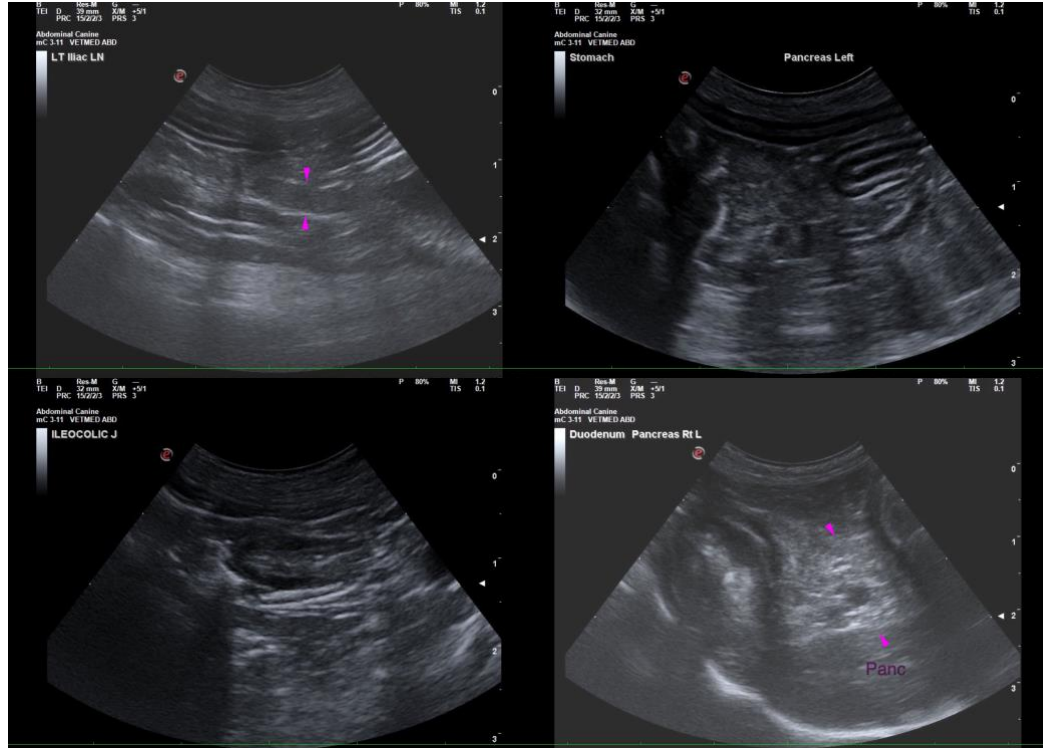
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- Texas GI panel including serum cobalamin, folate, PLI, TLI and resting cortisol level
 - A fecal evaluation for ova/Giardia
 - Prophylactic deworming with Fenbendazole.
 - A 3-4-week hypoallergenic or hydrolyzed protein diet trial
 - Also consider initiating a probiotic with a high colony count +/- fiber supplement (i.e., psyllium).
 - Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.
 - Three-view thoracic radiographs should be performed prior to any anesthetic event
- Regarding the splenic nodule, further recommendations should be based on cytology results.
 - Regarding the possible ureterolith in the right distal ureter, consider the following:
 - Urine culture and sensitivity
 - Serial sonographic monitoring to assess progression





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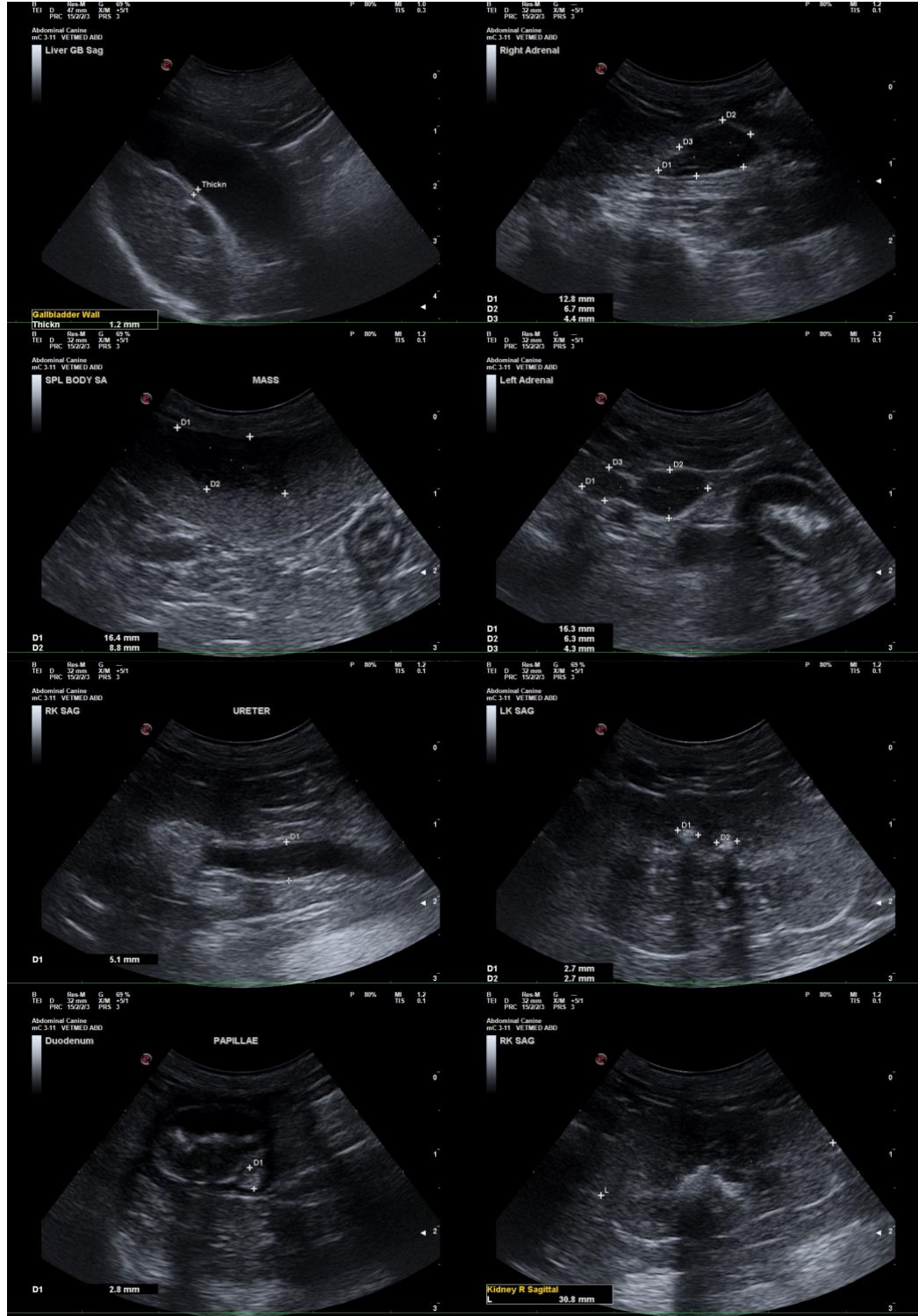
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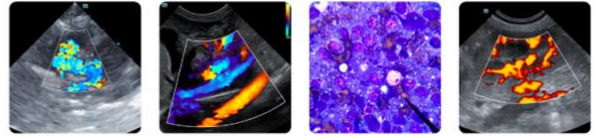
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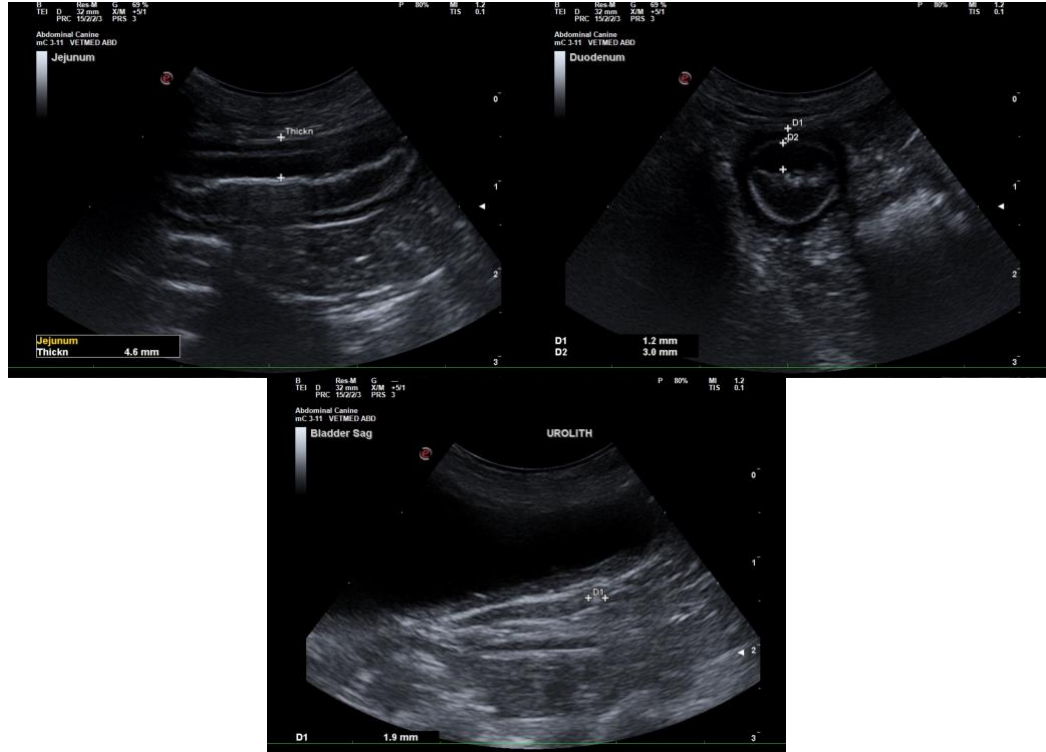
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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