**PATIENT PRESENTING CLINICAL SIGNS**

Jerry Pickett  
 History: Vomiting, weight loss, Pu/Pd, and high lipase and spec cpl. Currently on Pepcid.  
 Abnormal PE/Chem/CBC/UA Results: Cpl 270

**SPECIES**

Canine

**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 lumen is moderately distended with anechoic urine. 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.

**BREED**

Beagle mix

**SEX**

Neutered Male

The prostate is normal in size (2.53 cm in length; 1.06 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

**AGE**

12 Yrs.

The left kidney is normal size (5.75 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. Moderate pyelectasia is present (0.62 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

**WEIGHT**

35 Pounds

The right kidney is normal size (5.93 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

**INTERPRETED BY**

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

***Adrenal Glands***

The left adrenal gland is normal size (0.44 cm at cranial pole) (0.56 cm at caudal pole) (2.27 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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PMVU

The right adrenal gland is normal size (0.45 cm at cranial pole) (0.64 cm at caudal pole) (2.13 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.

**HOSPITAL NAME**

Silver Spring AH

***Spleen***

The spleen is normal in size (1.39 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.

**REFERRING VET**

Dr. Cathy Jarrett

***Liver***

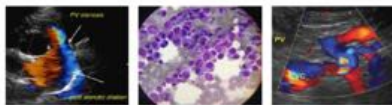
The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is normal in thickness. A small polypoid like lesion is arising from the luminal surface near the gallbladder neck. A small amount of suspended echogenic debris is also present within the lumen. The cystic and common bile ducts are normal/not seen.

**INVOICE**

13064

**DATE**

3/1/22

**PATIENT*****Gastrointestinal***

Jerry Pickett

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**REFERRING VET**

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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 pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal to borderline thickened (up to 0.38 cm) with a normal layering pattern and appropriate mural detail. There is slight disruption in the normal 1:3 muscularis: mucosal ratio in some segments. Discreet masses are not identified. The colonic wall is normal to borderline thickened (up to 0.31 cm) with a normal layering pattern. No obstructive disease is noted.

***Pancreas***

The base and both limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic 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.

***Free Abdomen***

Trace free fluid is observed. A 1.15 x 0.60 cm right medial iliac lymph node is visualized. The node is normal in shape and echogenicity.

**ULTRASONOGRAPHIC FINDINGS****Primary Findings:**

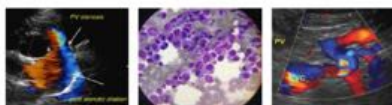
- Bilateral, degenerative renal changes with left pyelectasia.
- The small intestinal wall changes are suggestive of inflammatory bowel disease. There is some potential for emerging lymphoma. However, neoplasia is considered unlikely at this time.
- The significance of the trace ascites is unclear. It is likely secondary to increased vascular permeability, increased hydrostatic pressure or low oncotic pressure (if applicable).

**Secondary Findings:**

- Suspected benign hepatopathy (i.e., regenerative nodular hyperplasia and/or vacuolar hepatopathy).
- Age-related pancreatic remodeling +/- fibrosis. Mild pancreatitis may also be present, particularly if the patient exhibits discomfort on cranial abdominal palpation.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- Regarding the patient's weight loss and vomiting, consider the following:
  1. Three-view thoracic radiographs to assess for occult neoplasia and esophageal disease.
  2. Fecal evaluation for ova and Giardia.
  3. GI panel (send to Texas A&M).
  4. GI biopsies (i.e., endoscopic or surgical) may be necessary to get a definitive diagnosis.
- Regarding the PU/PD, consider the following:
  1. Urinalysis with a urine specific gravity.
  2. Urine culture and sensitivity.
  3. +/- Leptospirosis testing.



**PATIENT**

Jerry Pickett

4. Pre and post prandial serum bile acids to assess for occult hepatic dysfunction.
5. Depending on the results of these diagnostics, a more advanced PU/PD workup may be warranted.

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**HOSPITAL NAME**

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**REFERRING VET**

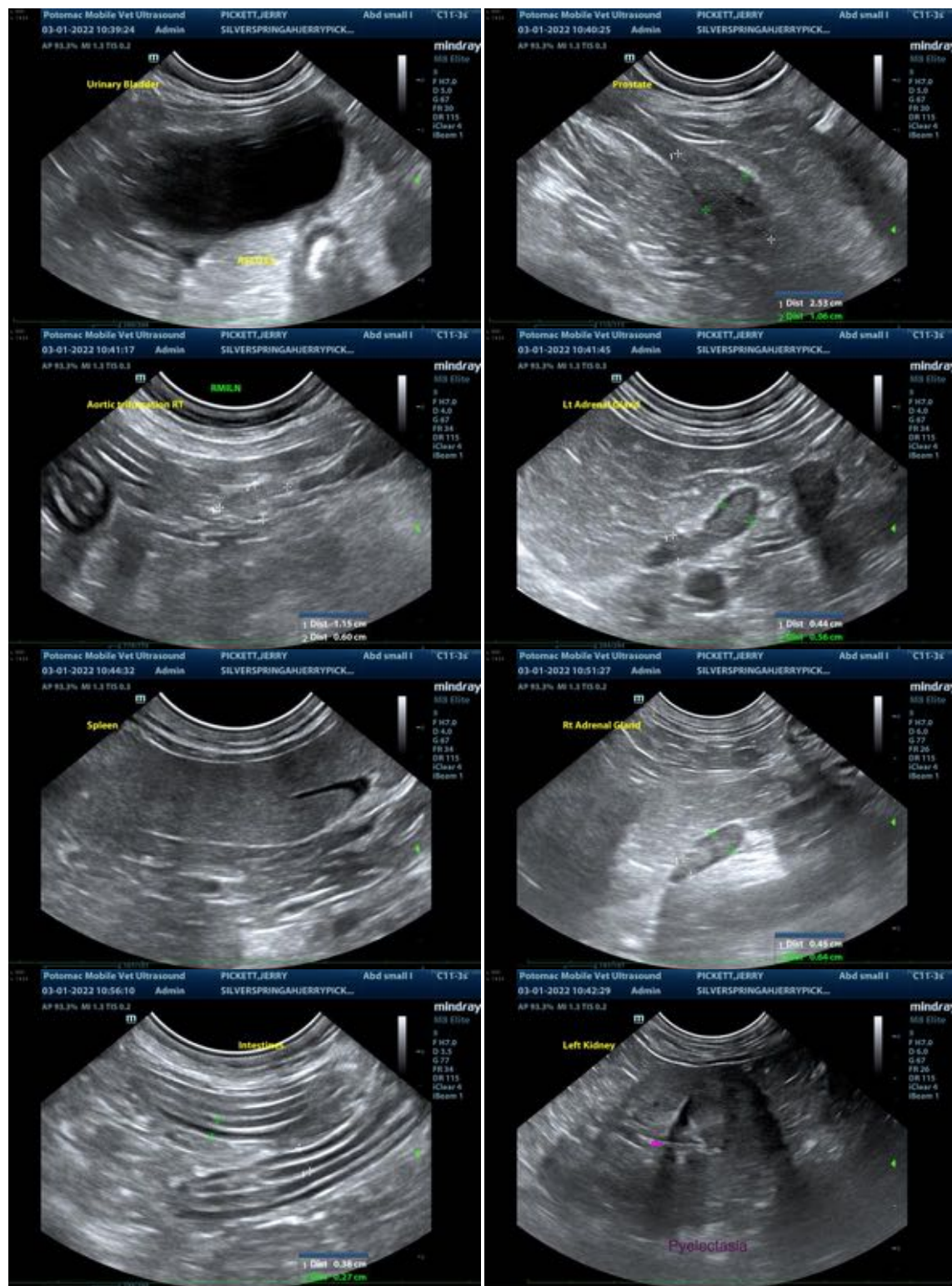
Dr. Cathy Jarrett

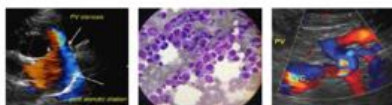
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**PATIENT**

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**SPECIES**

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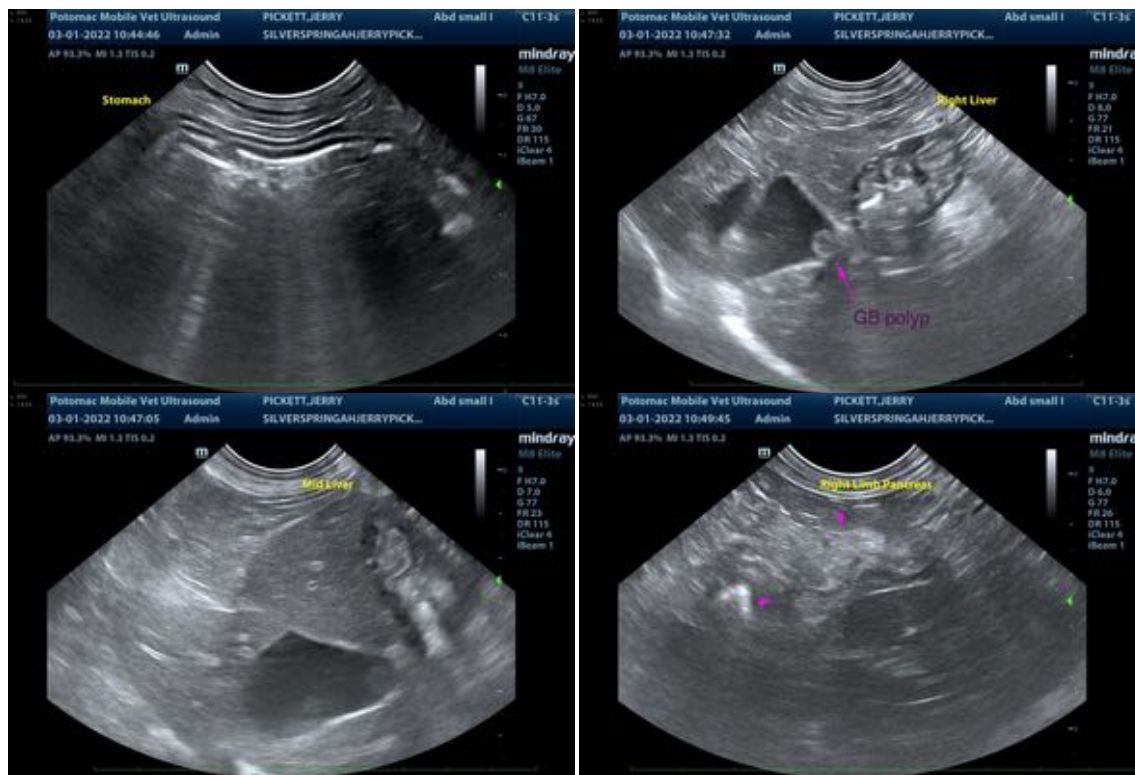
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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