



**PATIENT**

Bandit Moody

**SPECIES**

Canine

**BREED**

Chihuahua Mix

**SEX**

Neutered Male

**AGE**

12

**WEIGHT**

13.2 kgs

**INTERPRETED BY**

Andrea Nicastrò DVM  
Diplomate ACVIM  
(Sm Animal Internal Med)

**IMAGING  
PERFORMED BY**

Andrea Nicastrò DVM  
Diplomate ACVIM  
(Sm Animal Internal Med)

**HOSPITAL NAME**

Central VH  
Summerville

**REFERRING VET**

Dr. Ott

**INVOICE**

22672

**DATE**

3-12-26

**PRESENTING CLINICAL SIGNS**

Came in for a yearly examination last week. Has a history of diabetes. Is on Vetsulin and Denamarin. Bloodwork showed globulins of 3.7. ALP 1004. ALT 138. Platelet count was 1430. Fecal negative. Heartworm negative. Fructosamine norm reveals good regulation.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is mildly distended with anechoic fluid. The wall is of appropriate thickness for the level of repletion. The mucosal surface is slightly irregular. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 1.5 cm, are normal.

The prostate is normal in size (0.63 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 (4.70 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. The cortex is isoechoic relative to the spleen. A few, small, nonobstructive mineralized foci are visualized. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (4.87 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. The cortex is isoechoic relative to the spleen. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is mildly enlarged (0.56 cm at cranial pole) (0.63 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 mildly enlarged (0.55 cm at cranial pole) (0.63 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 (0.78 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.

**Liver**

The liver is subjectively enlarged, with swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly mottled in appearance. A 1.20 cm cyst is observed on the fluid therapy side. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A moderate- to large amount of aggregated, echogenic, suspended sludge in a stellate pattern is observed within the lumen. The cystic and common bile ducts are normal/not seen.



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**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 ileoceocolic junction and colonic wall are 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 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**

The abdominal lymph nodes are normal/not visible.

**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 gallbladder changes are consistent with a fully-formed mucocele.
- 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. The right hepatic cyst likely represents a benign incidental finding, with a low possibility of an emerging vascular tumor.
- Mild bilateral adrenomegaly

**Secondary Findings**

- Bilateral nonspecific age-related renal changes with right nonobstructive nephrocalcinosis
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- Regarding the gallbladder changes, consider a prophylactic cholecystectomy due to the potential risk for gallbladder rupture at some point in the future. Liver biopsies should also be obtained at the time of surgery. If a cholecystectomy is not pursued at this time, Ursodiol therapy should be initiated with close sonographic monitoring (i.e., every 4 weeks) to assess for progression. Serial monitoring (i.e., every 3-4 months) of the patient's liver values is also recommended.
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.



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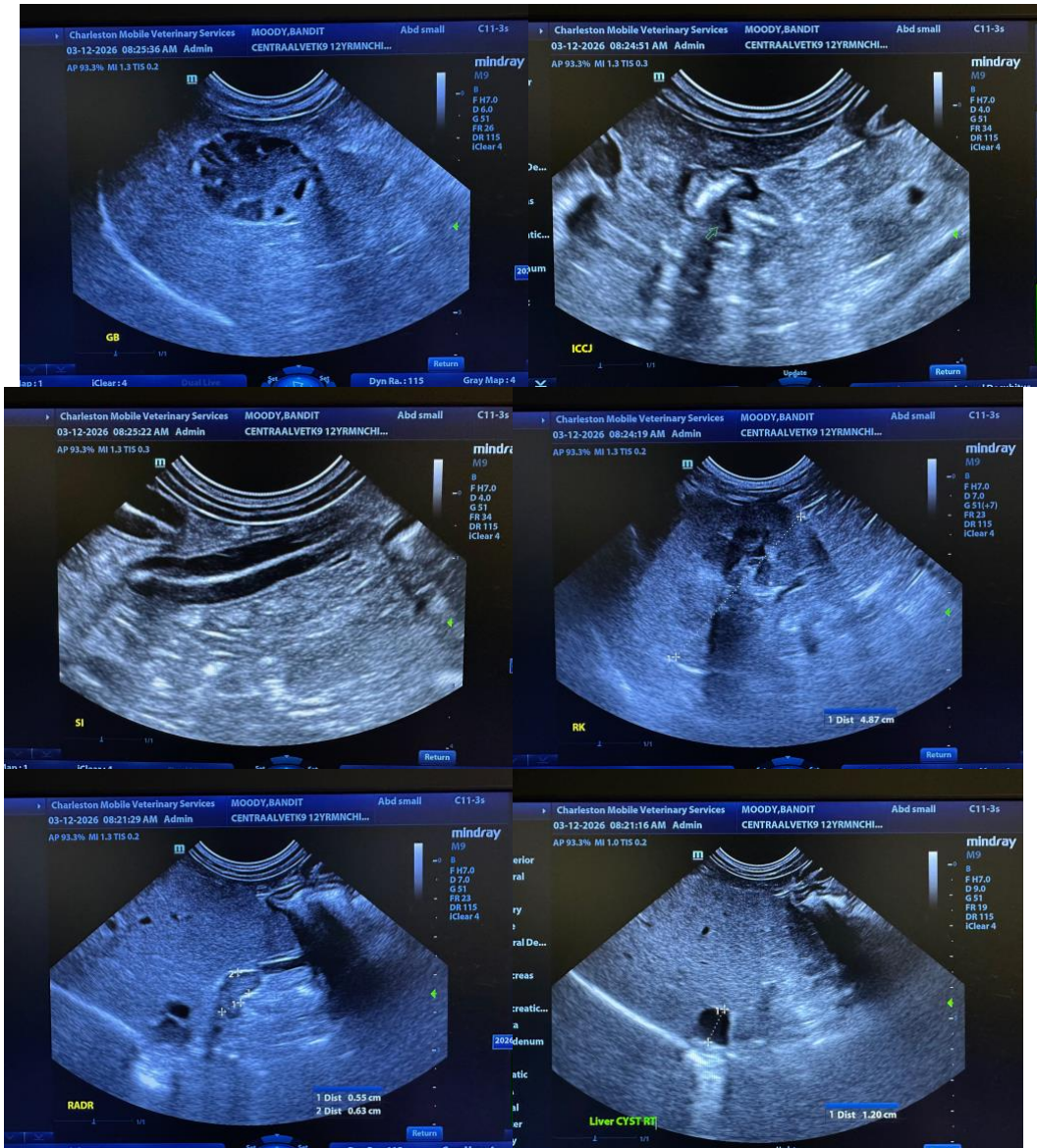
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- Regarding the marked thrombocytosis, consider the following:
  - Three-view thoracic radiographs to assess for occult neoplasia in the chest
  - +/- bone marrow aspirate





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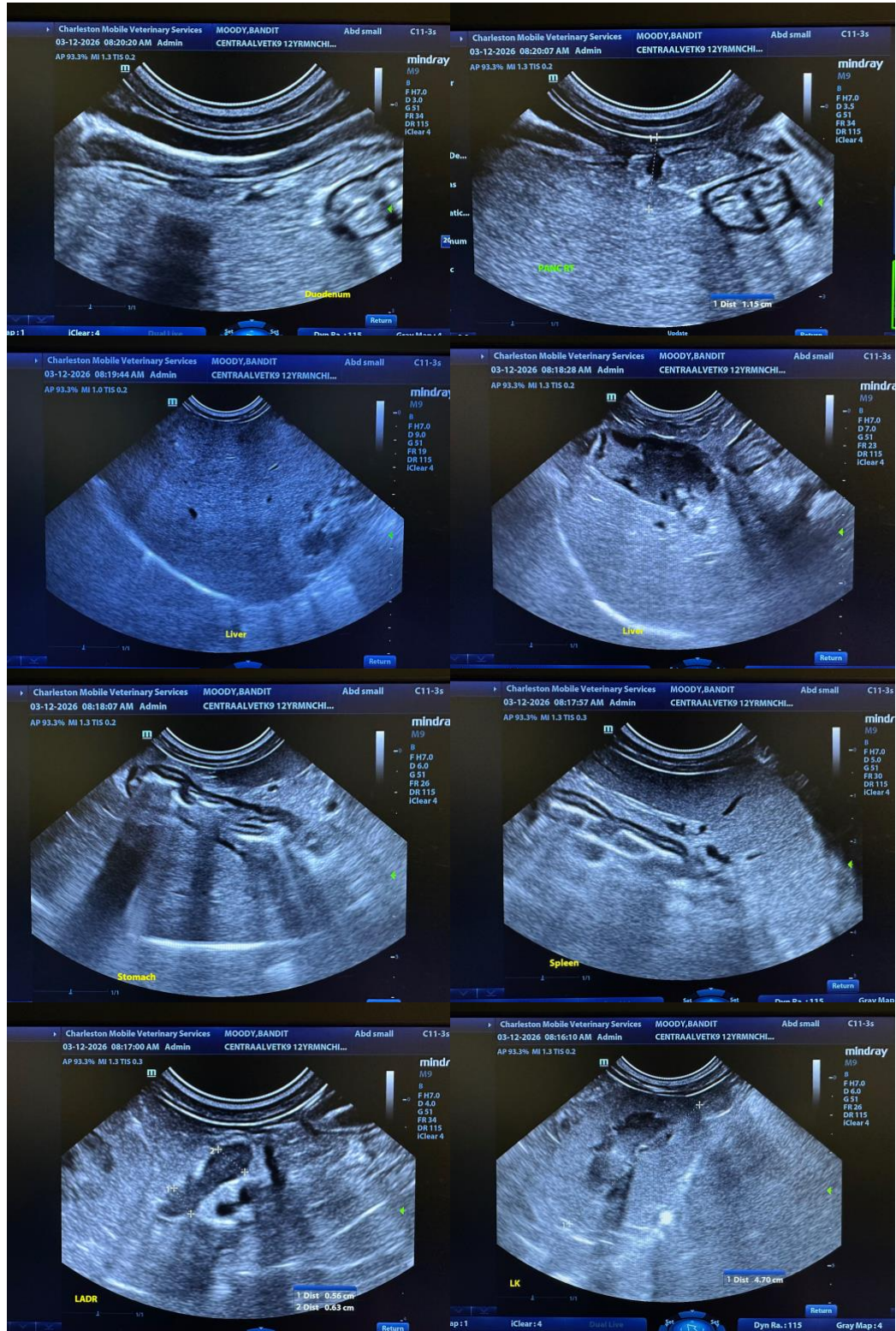
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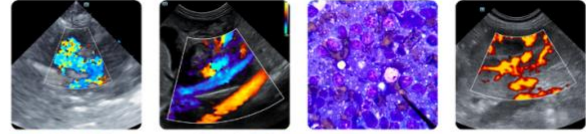
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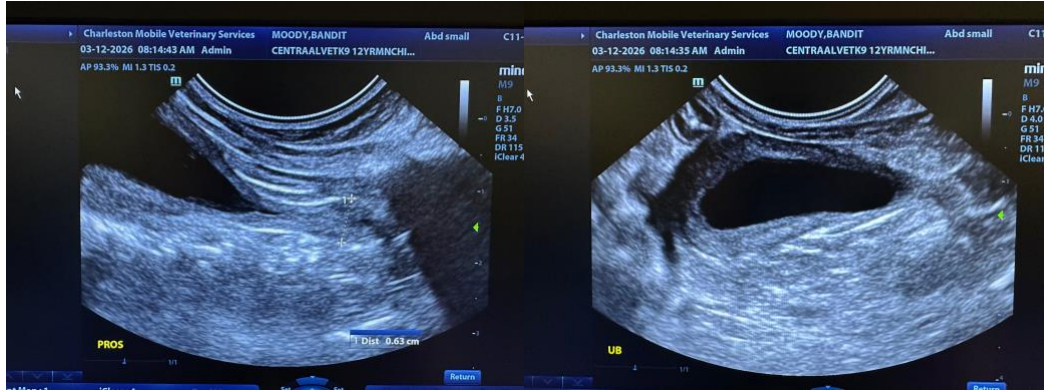
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)**  
[info@SonoPath.com](mailto:info@SonoPath.com)