

**PATIENT**

Rascal McGrady

**SPECIES**

Canine

**BREED**

Yorkshire Terrier

**SEX**

Neutered Male

**AGE**

9.22.13

**WEIGHT**

5.3 kg

**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**

PawMed VUC W Ashley

**REFERRING VET**

Dr. Erin Watts

**INVOICE**

22700

**DATE**

3-16-26

**PRESENTING CLINICAL SIGNS**

Clinical Exam Findings: Sweet Rascal is a 12 ½ yo neutered male Yorkie presenting for loose stool and lethargy. He has a chronic history of gastrointestinal upset. The current episode began with jelly stool, which was followed by vomiting on the 10th of the month. Vomiting has since resolved. Rascal's stool is consistently loose, and a sample was brought for evaluation. His appetite is poor, and he will only consume food if it is topped with chicken. Water intake is normal. His energy level is significantly decreased; he shows no interest in his usual routines such as mealtime or going outside. Rascal has had three veterinary visits in the past three weeks for similar issues. He is currently receiving ProHeart 12 for heartworm prevention and Omeprazole. He recently finished a course of Metronidazole and other prescribed medications. 14 weeks post-op from CCL repair

Abnormal lab-work values: Chem/CBC/PCV/Cortisol/cPLI performed: BUN and cPL elevated. CVC normal. Normal resting cortisol.  
Current Medications: Omeprazole 20 mg (1/4) tab po BID  
Radiographic Findings: Radiographs taken at Patrick Vet on 3/10/26 available for review.  
rDVM records only note: X-ray: rugal folds visualized, lots of stool in colon

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary is moderately distended. The wall is normal in thickness with a smooth mucosal surface. A few, tiny cystic calculi are observed within the lumen. The remaining luminal contents are mostly anechoic. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.73 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction. A scant amount of urethral sand is observed within the lumen.

The left kidney is normal in size (4.27 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. At least one, small, cortical cyst is seen. A few nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.62 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. A few nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal in size (0.44 cm at cranial pole) (0.47 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 normal in size (0.86 cm at cranial pole) (0.51 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. A few, small, myelolipomas are observed in the region of the hilus. Splenic vasculature is normal.



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**Liver**

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and slightly mottled in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A small- to moderate moderate amount of gravity-dependent, echogenic- to mineralized debris/sand is observed within the lumen. The cystic and common bile ducts are normal/not seen.

**Gastrointestinal**

The gastric lumen is not 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 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 obvious evidence of an obstructive pattern.

**Pancreas**

The base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is slightly isoechoic- to hyperechoic relative to surrounding omental fat and slightly heterogenous 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**

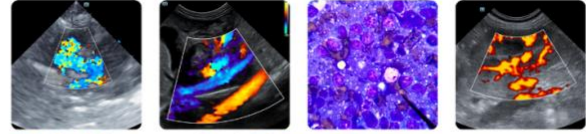
**Primary Findings**

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Tiny cystic calculi with prostatic urethral sand

**Secondary Findings**

- Bilateral nonspecific age-related renal changes with nonobstructive nephrolithiasis
- Minor geriatric hepatic parenchymal changes
- Gallbladder debris/sand, non-mucocele

\*An obvious cause for the patient's clinical signs is not definitively identified in this study. Considerations include a microscopic enteropathy (i.e., food allergy/intolerance, inflammatory bowel disease,



**PATIENT** infectious/parasitic disease), underlying metabolic issue, other.

Rascal McGrady

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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The following diagnostics/treatment recommendations can be considered:

Canine

1. Texas GI panel including serum cobalamin, folate, PLI, and TLI
2. A fecal evaluation for ova/Giardia, if not already performed
3. Prophylactic deworming with fenbendazole.
4. A 3-4-week hypoallergenic or hydrolyzed protein diet trial
5. Also consider initiating a probiotic with a high colony count +/- fiber supplement (i.e., psyllium).
6. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.
7. Three-view thoracic radiographs should be performed prior to any anesthetic event.

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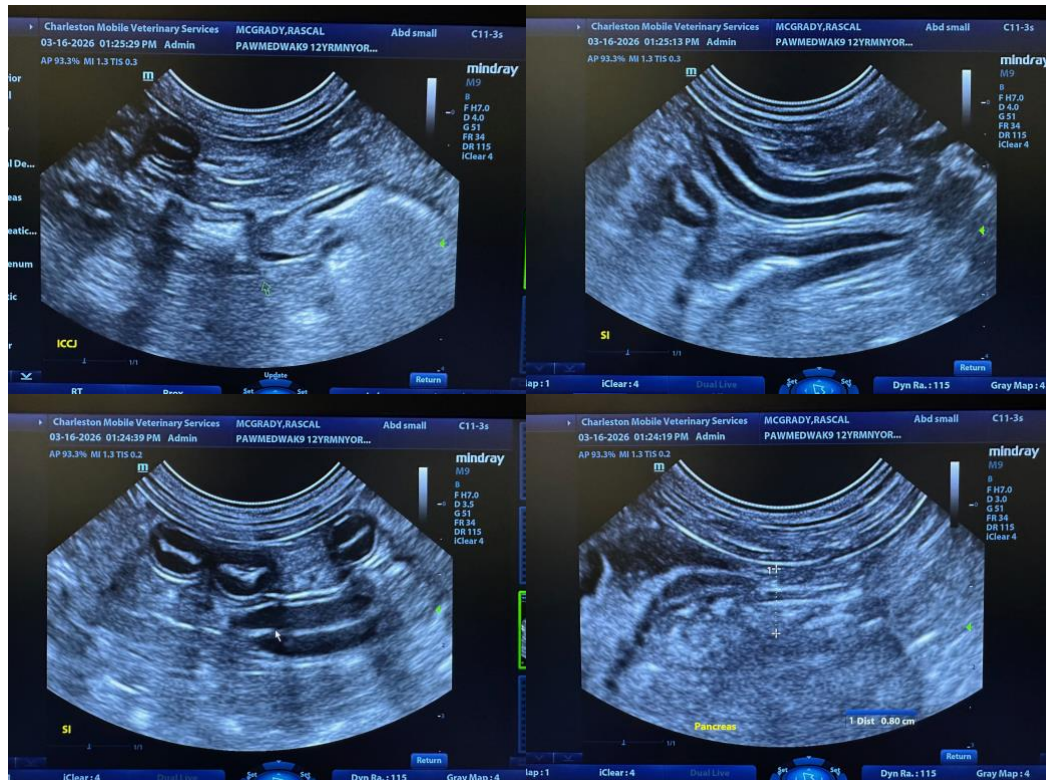
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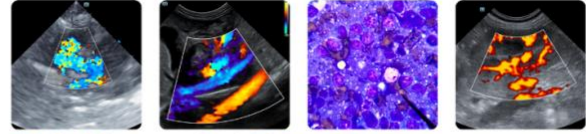
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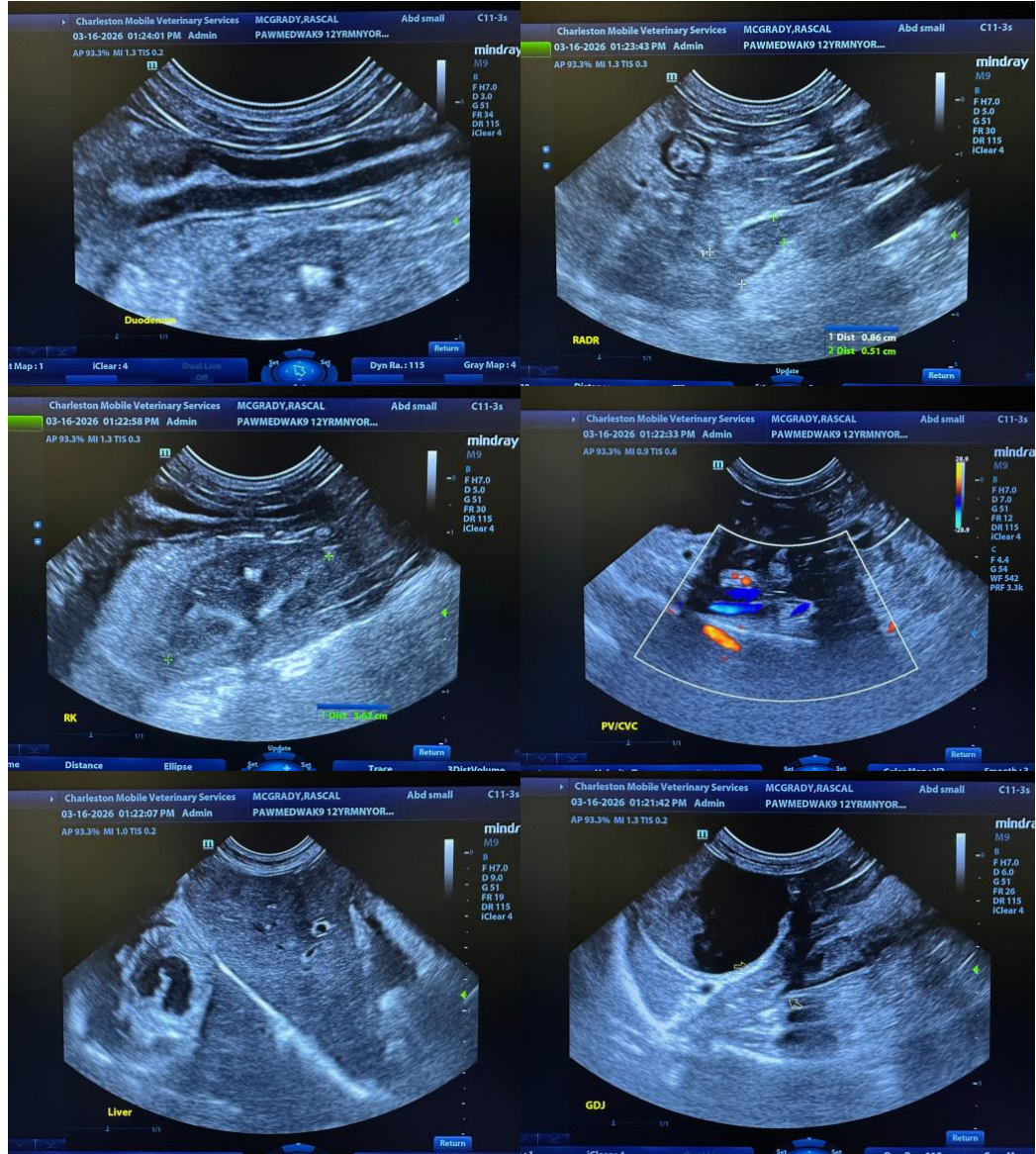
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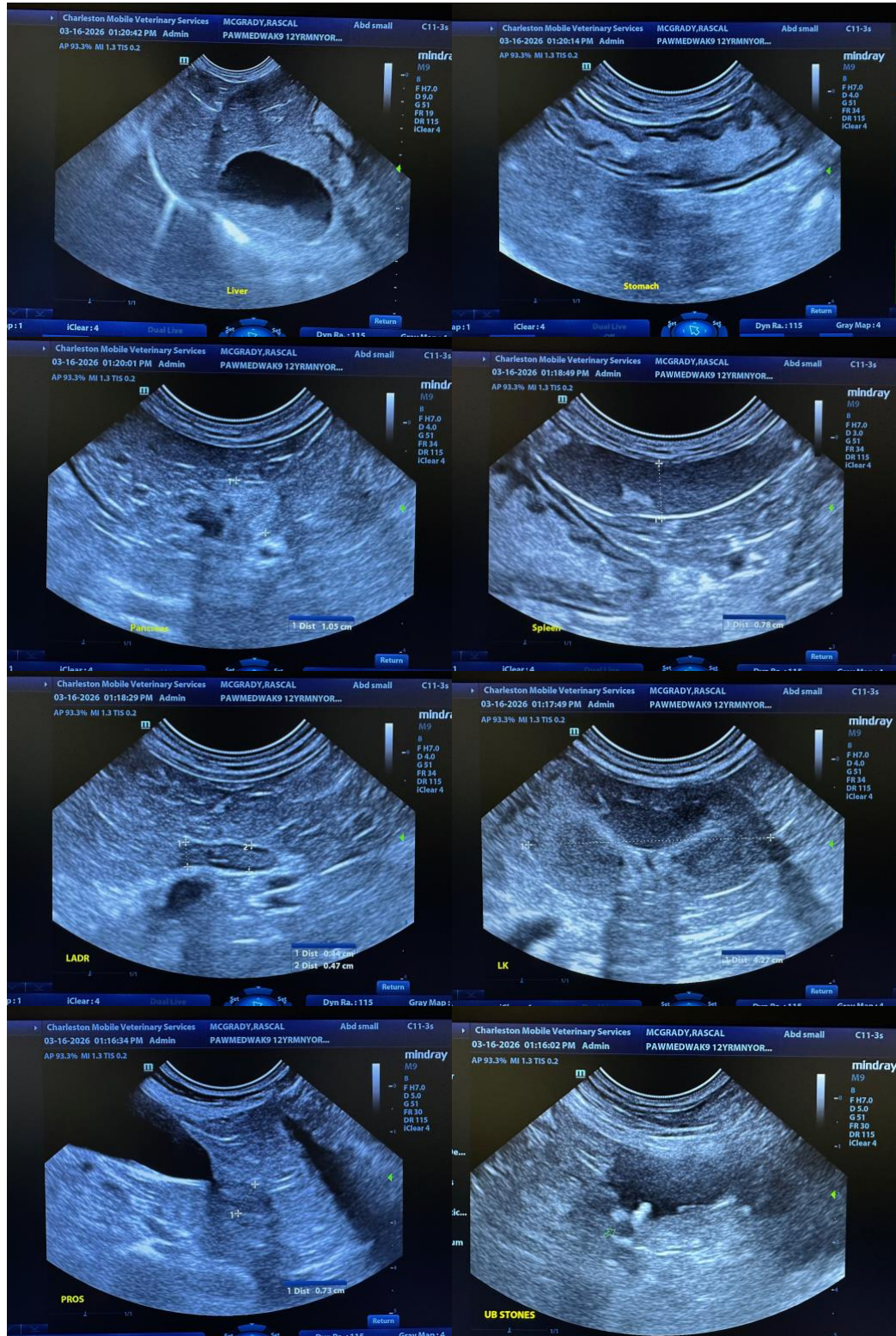
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

**SPECIES**

Canine

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

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