



PATIENT PRESENTING CLINICAL SIGNS

Oshka Crowel
SPECIES History: 4-day history of vomiting and inappetence. No improvement on supportive treatments, severe azotemia. Patient presented for reevaluation of vomiting. O reports P has not eaten since initial consult Thursday, did not vomit yesterday but vomited a large quantity of bile and water this morning at 3 am. P has been lethargic. Small bowel movement appreciated at home, appeared normal. No potential reported for toxin exposure, P does not typically rummage for food or other items.
Canine

BREED Bloodwork from March 20: Creatinine 14.2. BUN 70. SDMA 63. Elevated phosphorus. Hematocrit: 34%. USG 1.012. Trace proteinuria, inactive sediment.
Pitbull Terrier Mix Bloodwork from March 21: Creatine 12.3. BUN >140. Elevated phosphorus.

SEX ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Female Spayed
Urinary System

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

AGE

7

WEIGHT

44

The left kidney is normal in size (6.02 cm in length) with a slightly irregular shape. The cortex is hyperechoic relative to the spleen, and variably thickened, with moderate loss of corticomedullary distinction. Mild- to moderate pyelectasia is present (0.31 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter.

INTERPRETED BY

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

The right kidney is normal-in-size (7.02 cm in length), with a slightly irregular shape. The cortex is hyperechoic relative to the spleen, and variably thickened, with moderate loss of corticomedullary distinction. At least one, small, cortical cyst is seen. Mild- to moderate pyelectasia is present (0.29 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter.

IMAGING PERFORMED BY

Celia Galanti, DVM

Adrenal Glands

The left adrenal gland is normal in size (0.60 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.

HOSPITAL NAME

Craig Road AH

The right adrenal gland is normal in size (0.90 cm at cranial pole) (0.67 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.

REFERRING VET

Emanuel DeJesus DVM

Spleen

The spleen is normal in size with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.86 cm ill-defined hypoechoic nodule is observed at the craniomedial aspect. 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

3-21-26

The gallbladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of aggregated, echogenic, partially dependent, debris/sludge 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 is normal- to mildly-thickened (up to 0.97 cm) with apparent retention of the 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 colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic 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

The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

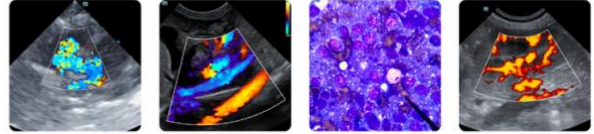
- Bilateral nonspecific chronic renal changes. The bilateral pyelectasia may be secondary to pyelonephritis, parenchymal remodeling, PU/PD (if applicable), fluid therapy (if applicable), or some combination thereof.

Secondary Findings

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The gallbladder changes could be consistent with cholestasis, fasting, or an emerging mucocele.
- The hypoechoic splenic nodule trends toward the benign (i.e., focus of lymphoid hyperplasia or similar). However, an emerging tumor cannot be completely excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the azotemia, consider the following:
 1. Urine culture and sensitivity
 2. UPC if proteinuria persists in the absence of infection
 3. Baseline blood pressure measurement
 4. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
 5. Leptospirosis testing (i.e., blood and urine PCR, serology)
 6. IV fluid diuresis and supportive care with close monitoring of the patient's renal values to assess progression of the azotemia
 7. Once the patient is eating again, consider transitioning to a prescription renal diet.



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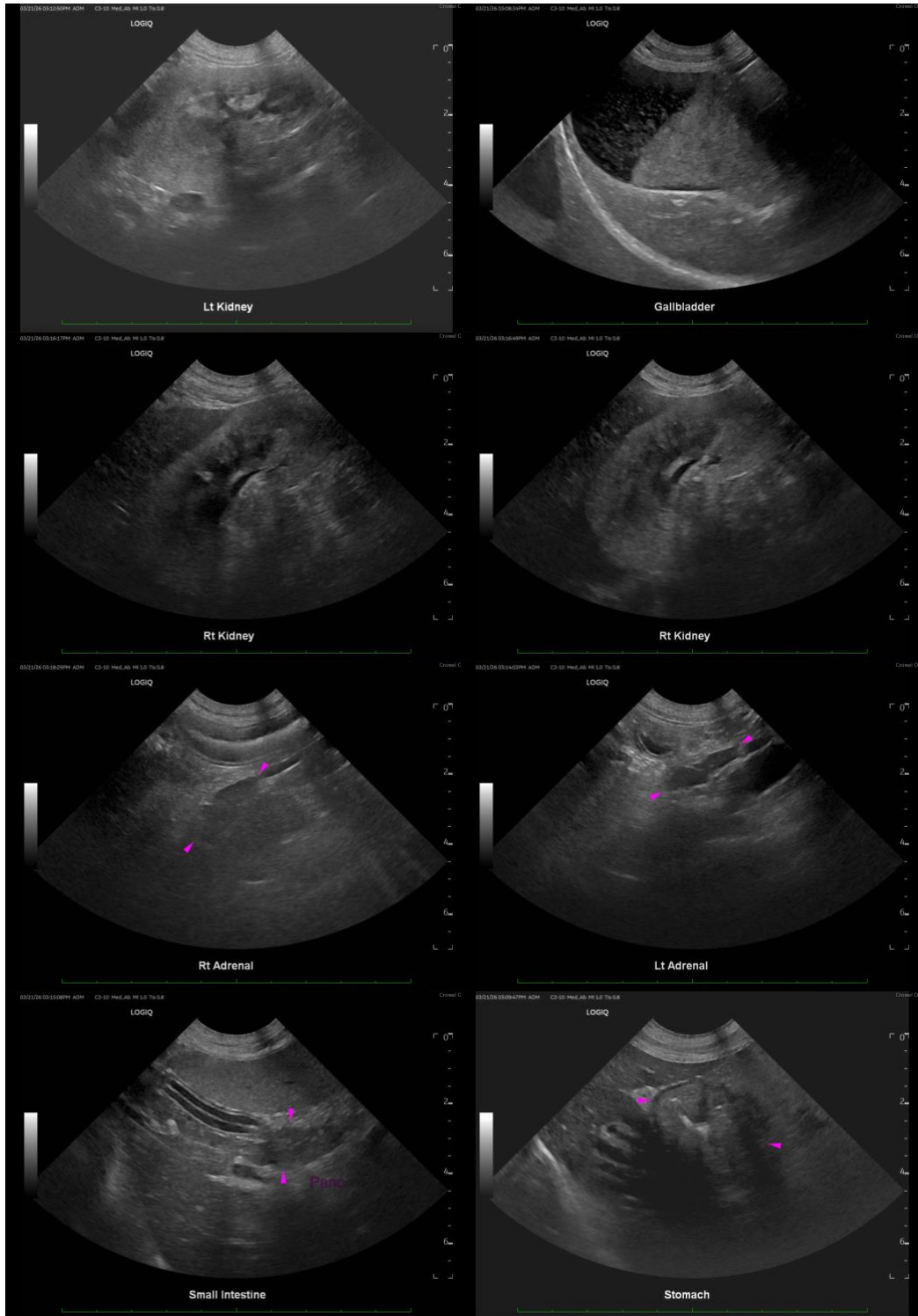
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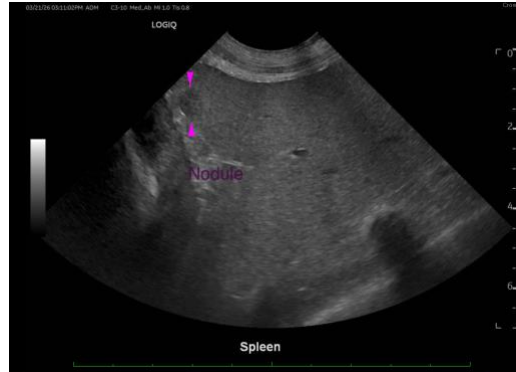
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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