



PATIENT

Tobias Sanchez

SPECIES

Canine

BREED

Border Collie

SEX

Male Neutered

AGE

9

WEIGHT

89.7 lbs

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

River Oaks AH

REFERRING VET

Dr Pennington

INVOICE

22852

DATE

4-8-26

PRESENTING CLINICAL SIGNS

Presenting Complaint: Tobias is being referred for an in-house abdominal ultrasound due to a flare-up of chronic, recurrent gastroenteritis. Current clinical signs include persistent liquid diarrhea, historical vomiting, abdominal discomfort, and lethargy, which have not fully resolved with initial dietary and symptomatic management.

Current/Relevant History: Tobias has a long-standing history of chronic gastritis and a sensitive stomach. He also has osteoarthritis managed with Librela and gabapentin.

04/02/2026: Presented as an urgent care for vomiting (2 episodes, ~3 days prior) followed by bloody, mucoid stools. He was also reported to be burping frequently. Physical exam revealed abdominal tenderness on palpation. His weight was 90.2 lbs and temperature was 102.3°F. A plan was made to switch his diet to Purina EN. Sucralfate was dispensed for as-needed use. A Bravecto Quantum injection was administered.

04/08/2026: Presented for a recheck due to persistent signs. The owner reports he vomited once on

04/06/2026. The diarrhea is ongoing and liquid, though no longer bloody. He is defecating SID but is straining. His appetite is good on the new diet, but he is drinking less and is more lethargic. His mobility remains decreased despite receiving his monthly Librela injection on 04/07/2026. Physical exam today revealed a tense abdomen and a normal temperature of 101.6°F. Pancreatitis is a concern. Previous diagnostics, including blood work and radiographs, have reportedly been unremarkable.

Medications:

- Librela injection: Given monthly for osteoarthritis, last administered 04/07/2026.
- Gabapentin: For osteoarthritis pain.
- Provable: As a probiotic supplement.
- Sucralfate 1 g tablets: 1 tablet by mouth q 12 hours as needed for gastroenteritis.
- Metronidazole: To be started 04/08/2026.
- Cerenia: To be started 04/08/2026.
- ProHeart 12: Administered in June 2025.
- Bravecto Quantum injection: Administered 04/02/2026.

Diagnostics:

- Abdominal Ultrasound: Requested for today, 04/08/2026.
- Fecal analysis (send-out): Pending sample collection.
- Canine diarrhea panel (send-out): Pending sample collection.

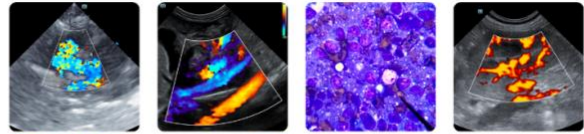
Handling notes: There is an alert for nervousness around men. A Calmer Collar and a towel have been effective in the past. The owner has consented to light sedation if required for the ultrasound procedure.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is distended. The wall is normal in thickness with a smooth mucosal surface. A small amount of gravity-dependent mineralized sand +/- tiny calculi are observed within the lumen. The region of the trigone and the proximal urethra, visible to a depth of 5.5 cm, are normal.

The prostate is mildly enlarged (1.93 cm in width) with smooth peripheral contours. The parenchyma is homogenous. No focal lesions are observed. The prostatic urethra is not overtly dilated.



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The left kidney is normal in size (7.50 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 corticomedullary distinction. The cortex is isoechoic- to hyperechoic relative to the spleen. Trace pyelectasia is present. A few nonobstructive mineralized foci are visualized. There is no evidence of infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (7.03 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 corticomedullary distinction. The cortex is isoechoic- to hyperechoic relative to the spleen. Mild pyelectasia is present (0.34 cm in the longitudinal plane). A few nonobstructive mineralized foci are visualized. There is no evidence of infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.67 cm at cranial pole) (0.74 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 (0.81 cm at cranial pole) (0.52 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 (1.55 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. A 0.79 x 0.48 cm hypoechoic nodule is observed at the mid- to caudal aspect. Splenic vasculature is normal.

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 portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen.

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 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

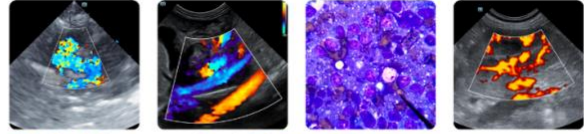
The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

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



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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bilateral nonspecific age-related renal changes with nonobstructive nephrocalcinosis and pyelectasia. The pyelectasia may be secondary to pyelonephritis, parenchymal remodeling, PU/PD (if applicable), or some combination thereof.
- Urinary bladder sand +/- tiny calculi
- Mild prostatomegaly. This may be a normal variant for this large-breed patient or may be secondary to late-in-life neutering (if applicable) or emerging neoplasia (i.e., adenocarcinoma, transitional cell carcinoma). Correlation with the patient's clinical history is recommended.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Minor geriatric hepatic parenchymal changes
- Gallbladder debris, non-mucocele
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia). The hypoechoic splenic nodule trends toward the benign (i.e., focus of lymphoid hyperplasia or similar) with a lower possibility of emerging neoplasia.

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

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Depending on fecal evaluation results, prophylactic deworming with fenbendazole may be indicated. Consider a GI panel including serum cobalamin and folate, TLI, PLI and resting cortisol level.
- Also consider a 3-4-week limited antigen or hydrolyzed protein diet trial.
- Ultimately, endoscopic or surgical GI biopsies may be indicated. If pursued, three-view thoracic radiographs should be performed prior to anesthesia.
- In the meantime, symptomatic care (including a probiotic as well as a fiber supplement) is recommended.
- Regarding the prostatomegaly, consider a Urine BRAF test to further evaluate for lower urinary tract neoplasia.
- Regarding the urinary bladder sand +/- calculi, consider a urinalysis +/- culture and sensitivity. A cystotomy with stone/sand removal, analysis and culture can be considered. Alternatively, an attempt at medical dissolution can be considered.



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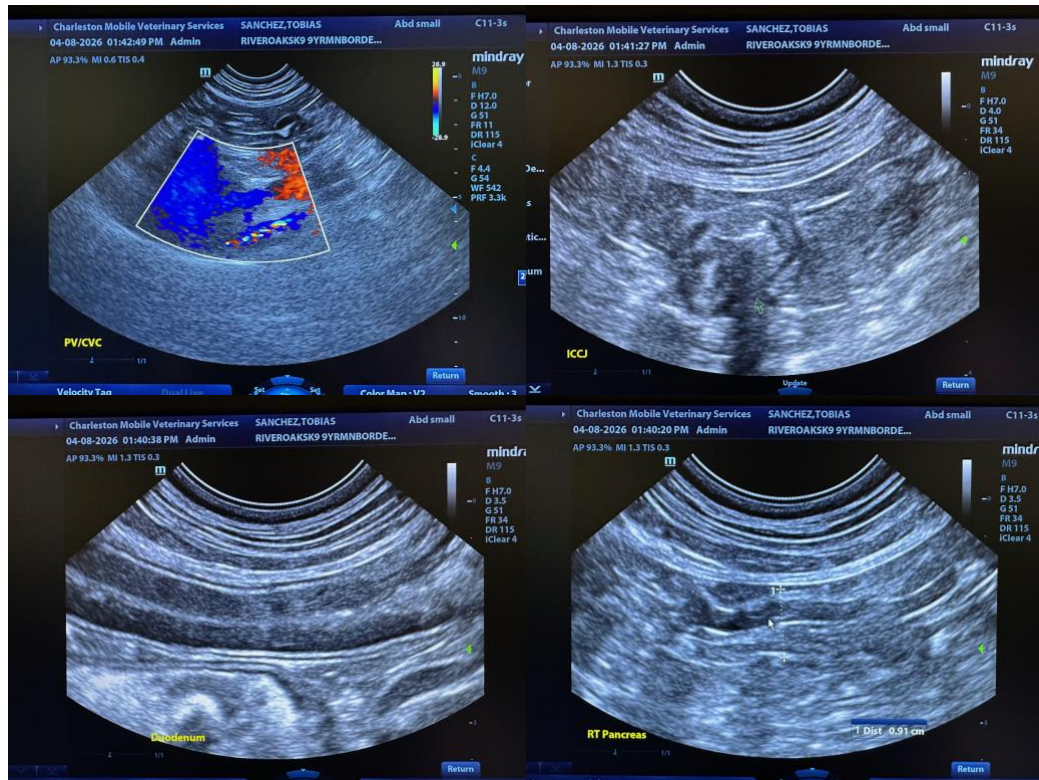
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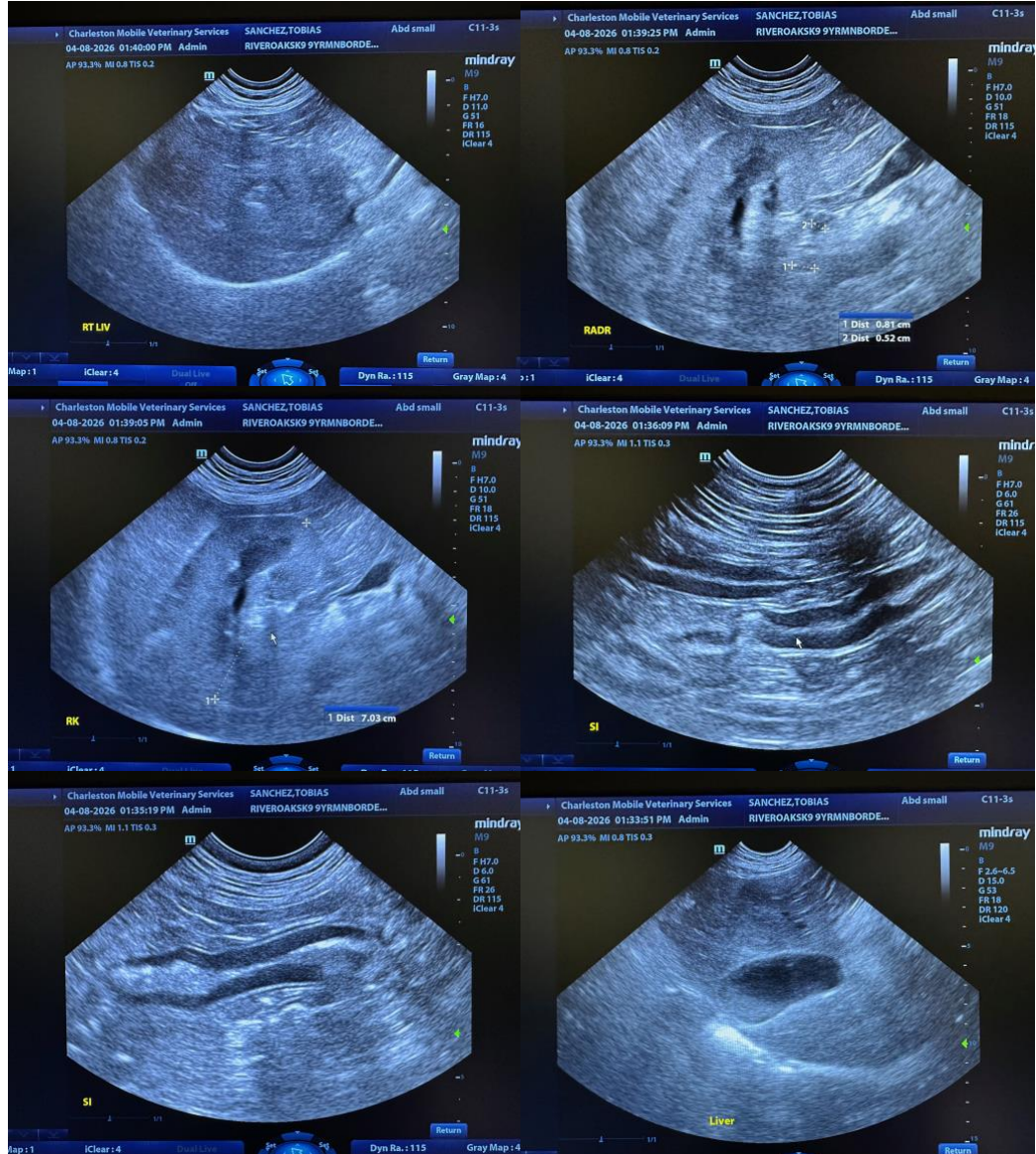
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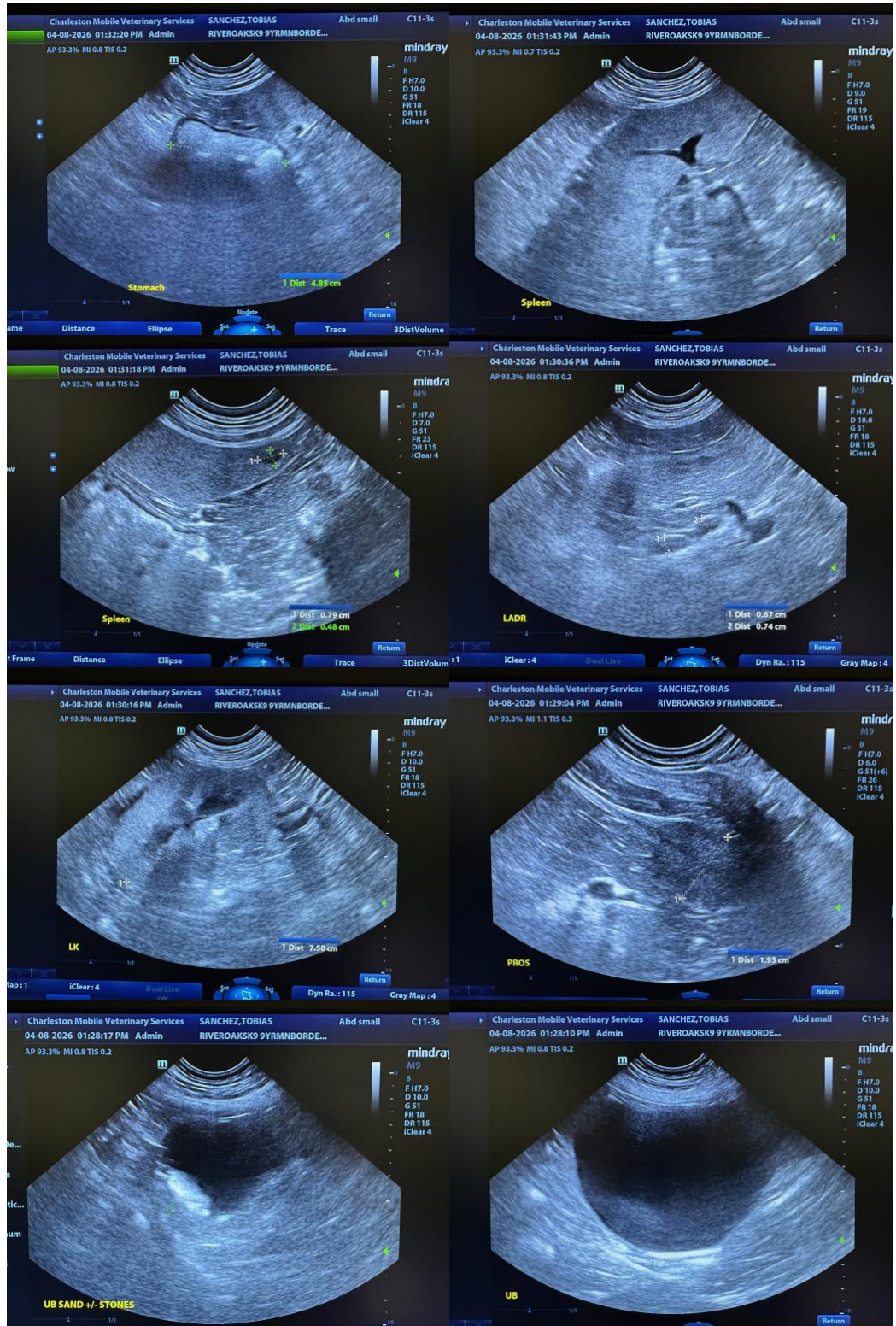
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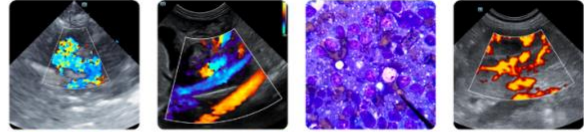
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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

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