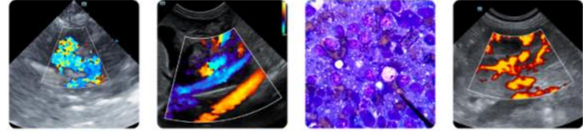
Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND



Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath FOSTERING THE ART OF VETERINARY MEDICINE™
www.charlestonmobile.net
info@charlestonmobile.net 800.403.5408

PATIENT

Zeppy Propes

SPECIES

Canine

BREED

Labradoodle

SEX

Male Neutered

AGE

1.5

WEIGHT

9.9 kg

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Blue Pearl MP ER

REFERRING VET

Dr Graham - ER
Dr Starr attending AUS

INVOICE

22846

DATE

4-8-26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Zeppy, a 1.5yo Labradoodle, presents as a direct transfer for vomiting and diarrhea and inappetence starting this weekend that has not responded to outpatient supportive care.

On 04/06/2026, Zeppy presented for vomiting and loose stool that began over the weekend. The pet sitter reported the last vomiting episode was around 11:30 that day and noted straining to produce liquid stool with a bit of blood. The patient was described as lethargic the previous day but slightly more peppy on the day of presentation. Potential triggers included new mulch in the yard, access to Yak bones, and a history of chewing underwear. The owner had also recently discontinued Fluconazole, which was prescribed on 03/25/2026. The physical exam revealed a temperature of 102.7°F, mild to moderate calculus, and greenish hair discoloration around the perineum.

4/6/26- Bloodwork (CBC and chemistry panel) was largely unremarkable, with only a high MCH (25.9 pg) and MCHC (37.1 g/dl). Radiographs showed generalized gas in the intestines, interpreted as likely secondary to mild inflammation, with no signs of obstruction confirmed by a radiologist review. The diagnosis was gastroenteritis. Treatment included subcutaneous fluids (100 ml), injections of maropitant (Cerenia) and famotidine, and the patient was sent home with a Proviable kit and a low-fat canned diet with instructions for small, frequent meals. An email from Dr. Rainwater to the owner summarized these findings, stating the best guess was dietary indiscretion.

04/06/26:
- SQ fluids
- Famotidine- Administered as a 1 mg/kg subcutaneous injection.
- Proviable Medium to Large Dog Kit (R)- Sent home with instructions to use as directed.
- Maropitant (Emeprev) 1 mg/kg SQ

On 04/07/2026, Zeppy was brought back to the hospital for not feeling well, continued inappetence, and recurrent vomiting that started around 10:00 AM. The owner reported he had eaten dinner the previous night and had solid stools that morning before the vomiting resumed. The physical exam revealed a temperature of 102.2°F, mildly tacky mucous membranes, and a heart rate that was slower than the previous day but with a normal rhythm. An assessment of vomiting again was made, with rule-outs including a probiotic reaction, worsening enteritis, or an occult foreign body. The plan included hospitalization for observation, intravenous catheterization, and IV fluids at 2.5 times maintenance. He received an injection of Cerenia (0.95 units) and Ondansetron (2.40 units). The owner requested repeating radiographs, which showed no significant changes from the previous day. After discussing conservative management versus hospitalization, the owner elected to transfer Zeppy to an emergency facility for overnight care. Ondansetron tablets were dispensed to be given every 12 hours for three days for nausea.

4/7/26:
- Ondansetron 8mg, 6 tablets- 1 tab by mouth every 12 hours for three days for nausea.
- Maropitant (Emeprev) 1 mg/kg SQ
- Ondansetron 2mg/ml- 2.40 units administered via injection.
- Initial intravenous fluids administered. Planned for 2.5x maintenance for 1 hour then transfer to ER.

Prior medical history includes a diagnosis of pruritus on 03/25/2025. A year later, on 03/25/2026, Zeppy was diagnosed with pododermatitis and pruritus during a wellness exam. He also had a past episode of diarrhea noted on 04/12/2025. Routine care includes vaccinations for Rabies, DAP, and Bordetella, and a Flex4 test, all of which are up to date as of the last visit.

4/7/26 6 PM ER PE
QAR, mild dehydration, pink/mildly tacky mm, no murmur, clear lungs, mild-moderate abdominal pain and nausea on abdominal palpation, soft non-formed to slightly light brown, brown-orange diarrhea

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Abnormal lab-work values:
4/6/26- CBC, Chem 17- WNL
4/7/26- NSAID Panel w/ Lytes: WNL ; PCV/TS 45%/ 5.4 g/dL, BG 104 mg/dL , Lact 0.6 mmol/L
Current Medications: 4/7/26 hospitalized at bp er with phylyte IVF, Cerenia 1 mg/kg q24h, Protonix 1 mg/kg IV q12h, ondansetron 0.5 mg/kg IV q8h, methadone 0.2 mg/kg Iv once, metoclopramide 0.5 mg/kg IV once

Radiographic Findings: Emailed both sets of abdominal rads from rDVM

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System
The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is distended. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.72 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 (4.07 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.52 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands
The left adrenal gland is normal in size (0.43 cm at cranial pole) (0.46 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 (0.82 cm at cranial pole) (0.50 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 (1.59 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 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. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal

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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 ileocecocolic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

Pancreas
The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Lymph Nodes
Two- to three prominent mesenteric lymph nodes are visualized (one measuring 1.24 x 0.71 cm). In addition, a 1.58 x 0.46 cm lymph node is observed in the cranial abdomen.

Free Abdomen
The mesentery adjacent to the stomach is hyperechoic. 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

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

- Mild peritonitis adjacent to the stomach, likely secondary to mild gastritis

*An obvious cause for the patient's clinical signs is not definitively identified in this study. Considerations include dietary indiscretion, toxicity, infectious/parasitic disease, food allergy/intolerance, inflammatory bowel disease, underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A fecal evaluation for ova and Giardia is recommended (if not already performed).
- Supportive care for acute gastroenteritis should be continued.
- If clinical signs persist despite medical management, further work-up (i.e., resting cortisol level, GI panel, +/- endoscopic or surgical GI biopsies) may be indicated.

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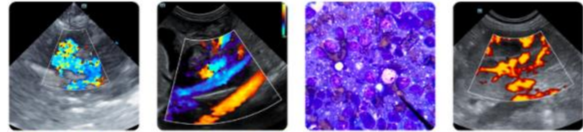

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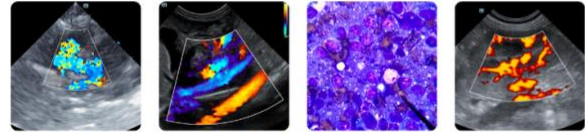

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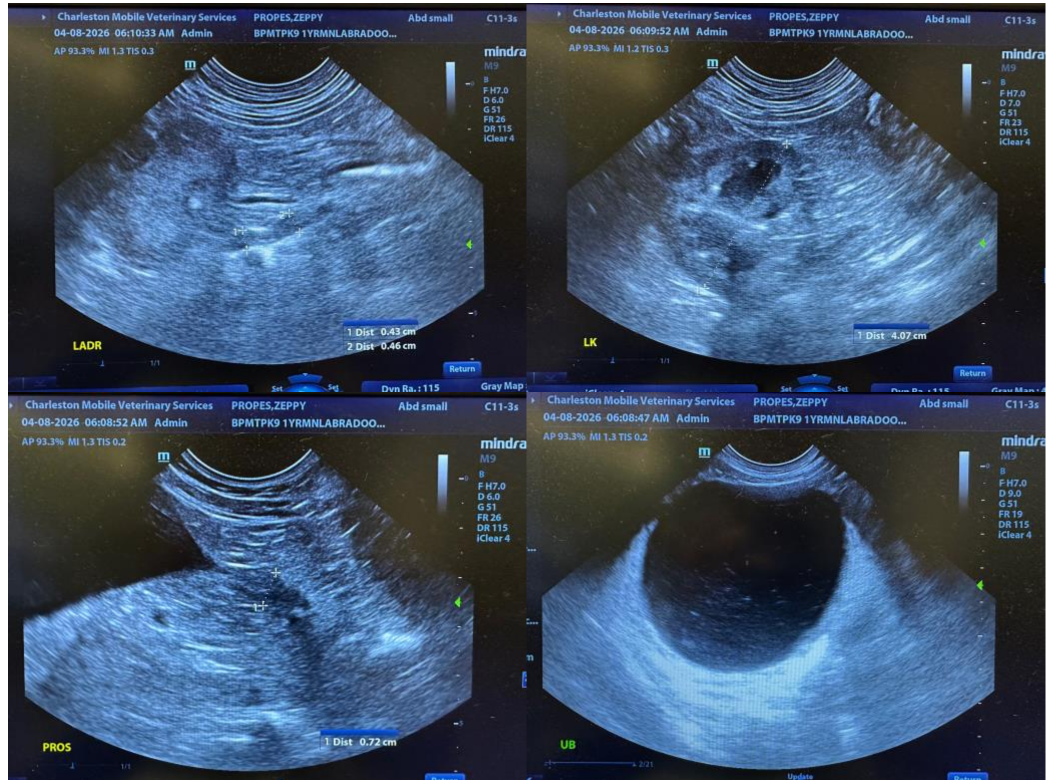

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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