



**PATIENT**

Pickles Beasley

**SPECIES**

Canine

**BREED**

Shepherd X

**SEX**

Female Spayed

**AGE**

1/9/13

**WEIGHT**

Not Provided

**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**

Dunes VC

**REFERRING VET**

Dr Devin  
Soileau

**INVOICE**

22954

**DATE**

5-1-26

**PRESENTING CLINICAL SIGNS**

Patient went to the ER April 25 for reduced appetite and loose stool. Was presumptively diagnosed with pancreatitis. Had elevated liver enzymes at that time. Abdominal radiograph showed an enlarged liver. Patient has been on Carprofen. On April 29, still not doing right. Decreased appetite, but stools improved. Received subcutaneous fluids, Entice and famotidine. Bloodwork from April 25 shows a hematocrit of 30%. White blood cell normal. Platelets 41,000. ALP 560. ALT 120.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 3.5-4.0 cm, are normal.

The prostate is normal in size (0.70cm 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 (8.48 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (8.58 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal in size (0.61 cm at cranial pole) (0.78 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 (1.14 cm at cranial pole) (0.60 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 prominent in size (3.09 cm in width at the level of the hilus) with smooth peripheral contours. The parenchyma is subtly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

**Liver**

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature 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. A moderate amount of gravity-dependent, echogenic debris 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 segmentally dilated with gas and chyme. 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 is prominent in size with slightly irregular peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and heterogenous in appearance. The pancreatic duct is visible but not overtly dilated. The mesentery effacing the serosal surface is slightly hyperechoic.

**Lymph Nodes**

The abdominal lymph nodes are normal/not visible.

**Free Abdomen**

There is no obvious evidence of free fluid.

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- The pancreatic changes in the right limb are suggestive of chronic +/- active pancreatitis with parenchymal remodeling, +/- fibrosis.
- The hepatic changes are nonspecific and could be secondary to inflammatory disease (i.e., cholangiohepatitis, chronic hepatitis), Leptospirosis, hepatotoxicosis, infiltrative neoplasia (i.e., lymphoma), vacuolar hepatopathy, regenerative nodular hyperplasia, other hepatopathy, or some combination thereof.
- Gallbladder debris, non-mucocele

**Secondary Findings**

- Bilateral nonspecific age-related renal changes
- 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).

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

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- Consider repeating baseline lab work to reevaluate the patient's liver values.
- The following diagnostics/treatment recommendations can be considered:
  1. Texas GI panel including serum cobalamin, folate, PLI, TLI and resting cortisol level
  2. A fecal evaluation for ova/Giardia



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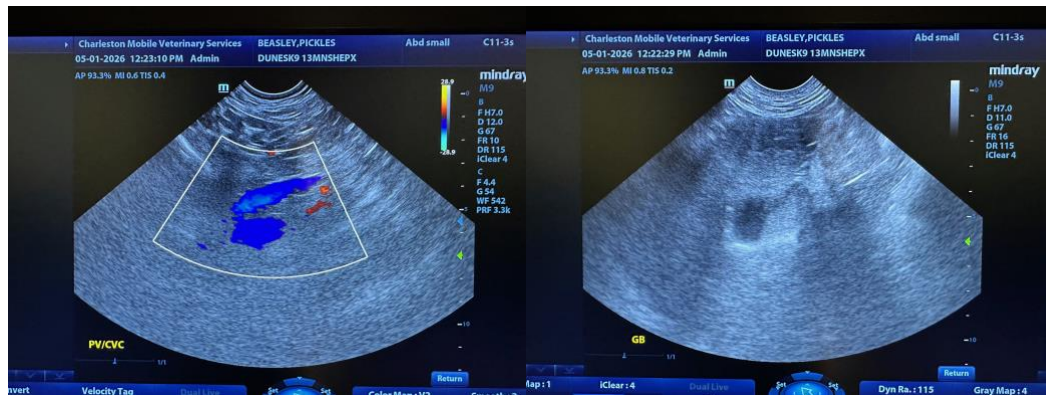
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3. Prophylactic deworming with fenbendazole.
  4. A 3-4-week hypoallergenic or hydrolyzed protein diet trial
  5. Also consider initiating a probiotic with a high colony count +/- fiber supplement (i.e., psyllium).
  6. Depending on the results of 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.
- Regarding the elevated liver values, hepatic tissue sampling (i.e., aspirates or biopsies) can be considered assuming normal clotting status. If biopsies are pursued, aerobic and anaerobic bile cultures and hepatic copper quantitation should also be performed. If further testing is not pursued, serial monitoring (i.e., every 2-3 months) of the patient's liver values is recommended. If values continue to increase, further work-up may be indicated. Initiation of a hepatic antioxidants can also be considered.





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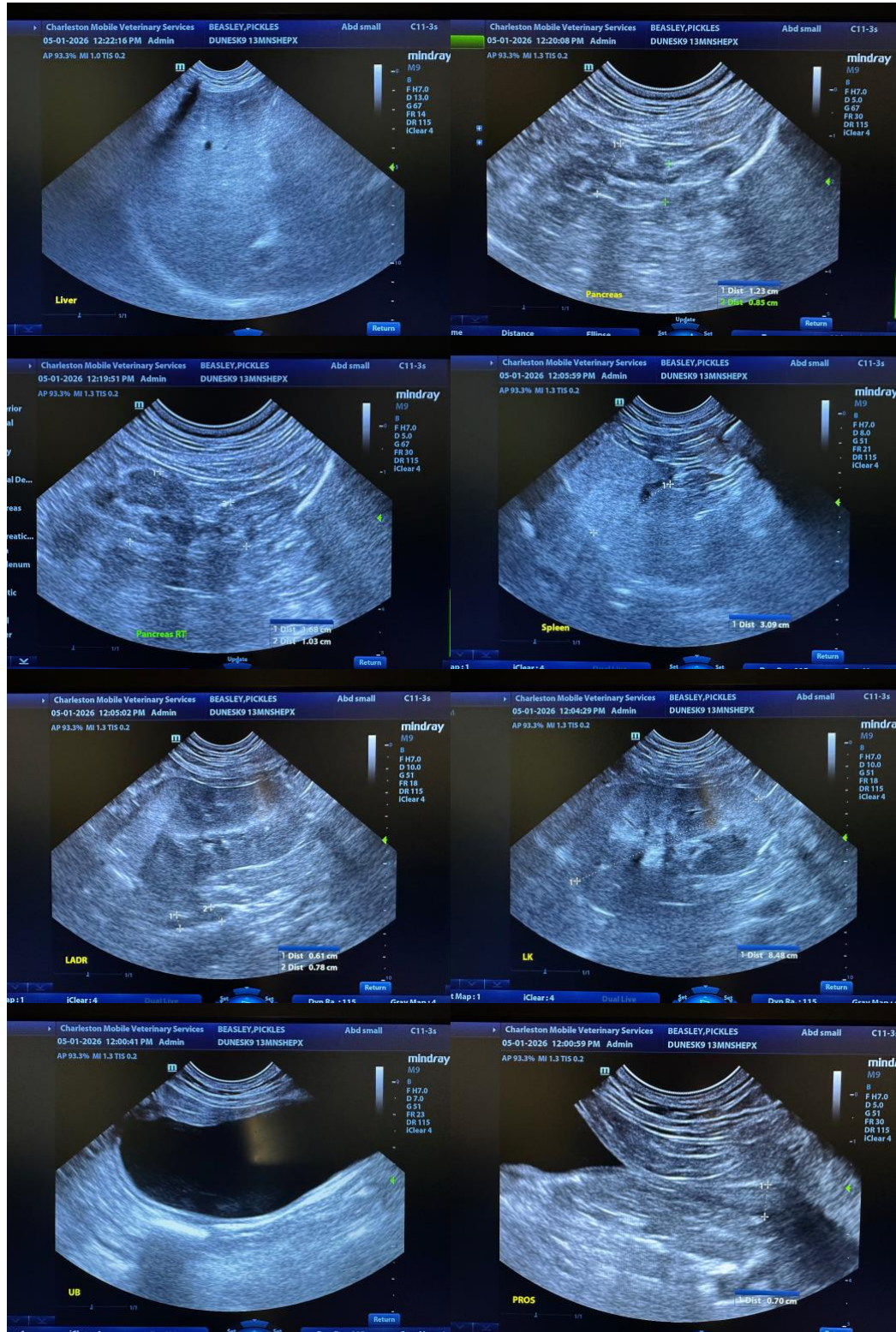
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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