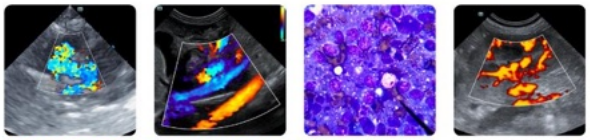

PATIENT

Sonny Titus

SPECIES

Canine

BREED

Cocker Spaniel

SEX

Male, neutered

AGE

10 Yrs.

WEIGHT

37 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Shemanski

HOSPITAL NAME

Western NY VS

REFERRING VET

Dr. Bedell

INVOICE

13719

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5/12/26

PRESENTING CLINICAL SIGNS

History: RDVM REASON FOR REFERRAL: Acute onset of nausea and vomiting. Vomit orange in color. Anemia, thrombocytopenia, and hyperbilirubinemia. Per RDVM, no fever (102 F yesterday per o). Brief Patient History Sonny has chronic arthritis (previously on carprofen daily for >6yrs) and KCS (managed with topical prednisolone, cyclosporine, and tacrolimus). A histiocytoma was excised in August 2025. History from Owner Acute clinical signs began Sunday night with large-volume vomiting; by Monday, the patient developed anorexia, orange excreta, and lethargy. As of today, Sonny is overtly jaundiced with dark urine. Medical history includes a recent positive heartworm test (confirmation pending) despite consistent prevention. Carprofen was discontinued yesterday at the onset of GI signs. Significant household stress is noted due to chronic dog-dog aggression between Sonny and a second dog. Thoracic and abdominal radiographs performed.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately 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 (1.08 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 (6.28 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (6.23 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

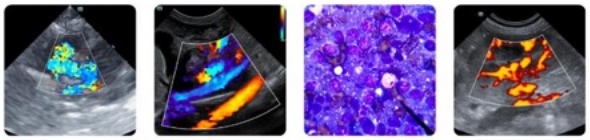
The left adrenal gland is normal in size (0.56 cm at cranial pole) (0.58 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.96 cm at cranial pole) (0.68 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 (1.84 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



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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 gall bladder 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.

Gastrointestinal
The gastric lumen is moderately to severely distended with fluid and ingesta and is hypermotile. The gastric wall in the region of the fundus is normal in thickness with a normal layering pattern. In the region of the pyloric antrum, the wall is variably thickened (up to 0.57 cm) with a prominent muscularis layer. There is questionable intermittent intussusception at the level of the gastroduodenal junction. The remaining small intestinal segments are normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains some shadowing fecal material.

Pancreas
A portion of the pancreas is obscured by the gastric distention. In the visualized portion, no obvious abnormalities are seen.

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:

- Retained gastric fluid and ingesta with mild wall thickening at the pyloric antrum and questionable intermittent intussusception at the gastroduodenal junction. Gastric hypermotility is also evident. True intussusception is a consideration. However, artifact due to severe gastric distention is also possible.
- The gallbladder changes could be consistent with a developing mucocele, cholestasis or less likely, fasting.

Secondary Findings:

- Mild bilateral nonspecific, age-related renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the anemia, consider the following:
  1. Slide agglutination test to assess for autoagglutination

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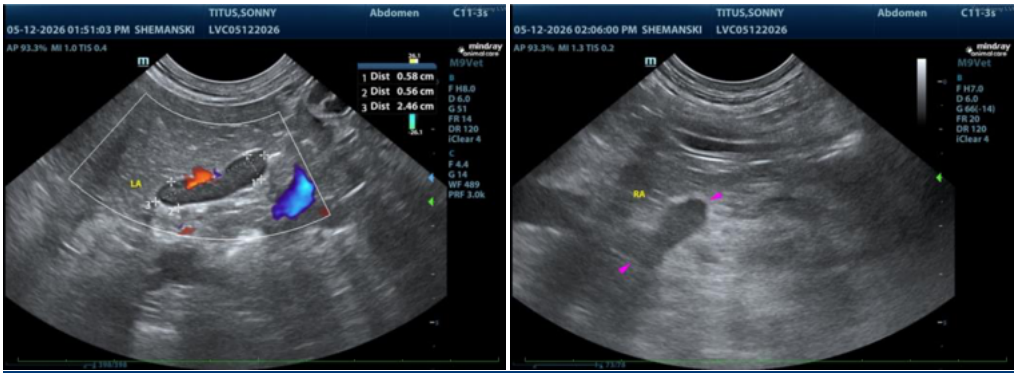
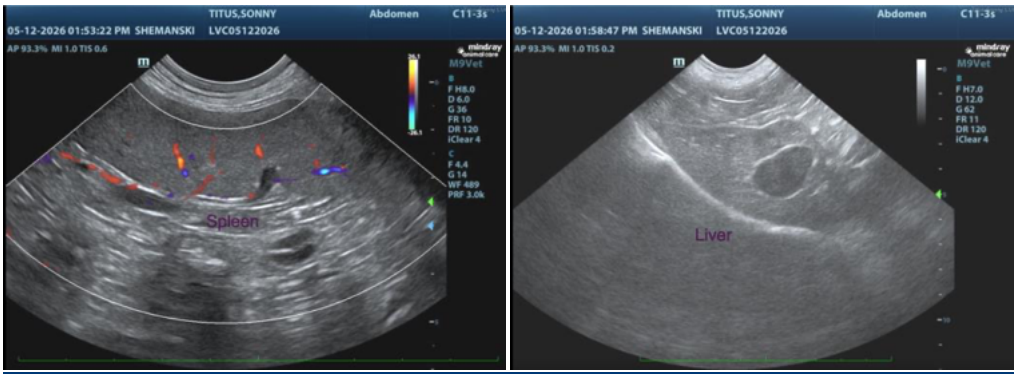
2. A comprehensive tick panel, including PCR and serology (submission to North Carolina State University's Vector Borne Disease Diagnostic Lab) is recommended. https://cvm.ncsu.edu/research/labs/clinical-sciences/vector-borne-disease/.
3. Recheck ultrasound of the gastrointestinal tract following a 12 hour fast to reevaluate the gastroduodenal junction and stomach.

4. +/- upper GI endoscopy to assess for a possible GI bleed
5. Depending on the results of the above diagnostics, treatment for immune mediated hemolytic anemia may be indicated.
   In the meantime, supportive care is recommended with serial monitoring of the patient's hematocrit to assess for worsening anemia.

- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) is recommended. Serial sonographic monitoring (e.g., every 6-8 weeks) of the gall bladder is recommended to assess for progression to a fully formed mucocele. If progression occurs, a cholecystectomy may be warranted.





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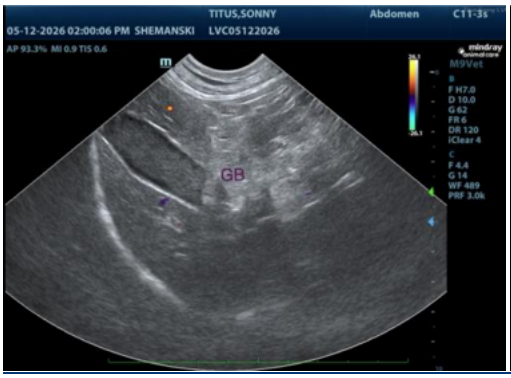

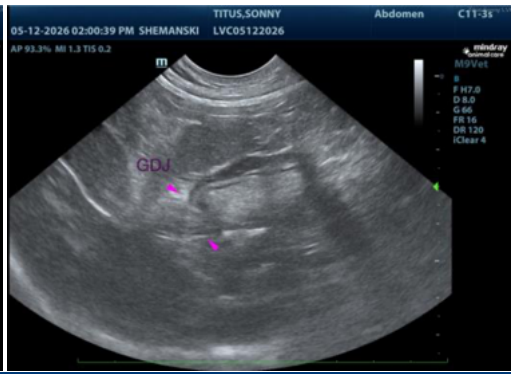

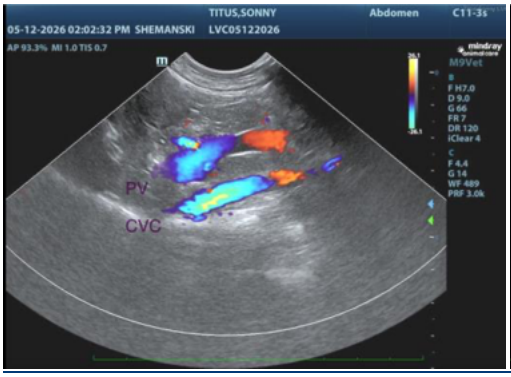

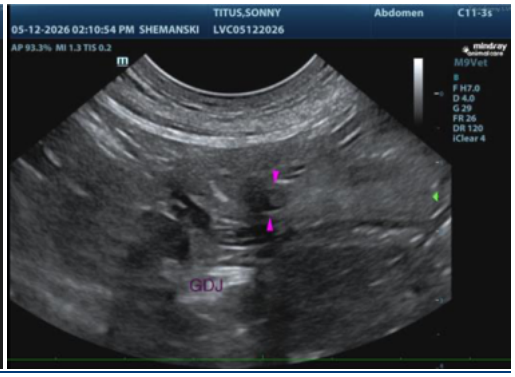

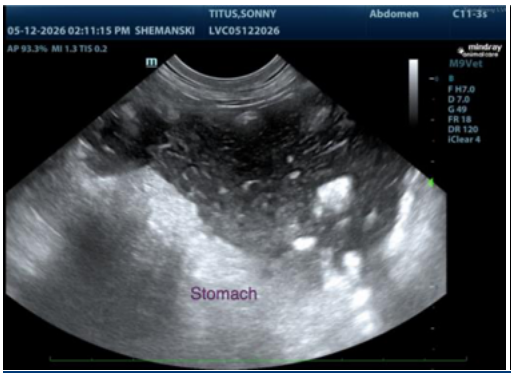

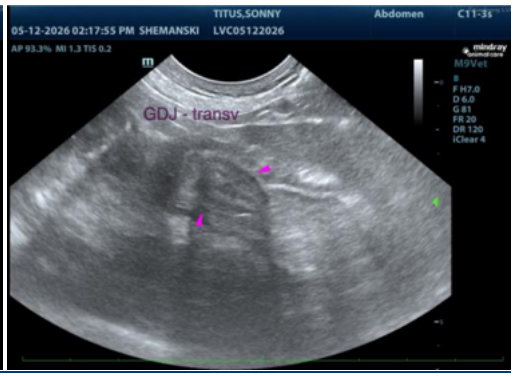

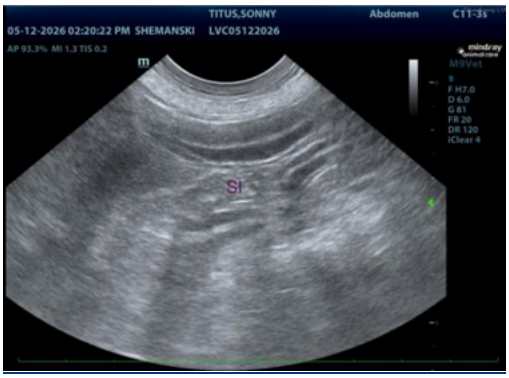

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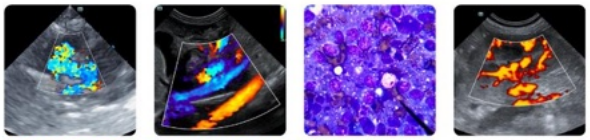

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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