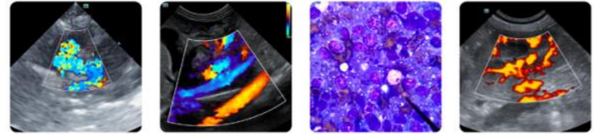


Clinical Sonography & Telecytology
Educational Teleconsultation Services™
SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT
Foster Rauth

SPECIES
Canine

BREED
Austr Shepherd

SEX
Neutered Male

AGE
12

WEIGHT
49 lbs

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

IMAGING PERFORMED BY
Dr. Wasserman

HOSPITAL NAME
Highlands AH

REFERRING VET
Dr. Frankenberger

INVOICE
23027

DATE
5-16-26

PRESENTING CLINICAL SIGNS

History: Sedated with 0.1ml Dexdomitor 0.5mg/ml IV and 0.4ml butorphanol 10mg/ml IV. Adequate for sonogram. History: Soft stools that became progressively worse, now liquid diarrhea. No blood, liquid, gassy, urgency and pacing. Decreased appetite. Vomiting. Was started on Novox 5/13/26 for AD aural hematoma. CBC normal. Panel normal. Spec cpL elevated 427 (0-200), supportive of pancreatitis. Fecal ova/ag negative. Abdomen rads No free fluid in abdomen. Bladder, kidneys normal. Gas in transverse and descending colon. Mild gas in small intestine. Right and left lateral ab stomach appears mild gas and no obvious FB. VD view visible rugal folds, mild gas, more radiopaque in appearance. Kept in hospital for a couple hours for IV fluids and medications. Gave Buprenex, Cerenia, Famotidine, Penicillin, Metronidazole, Ondansetron, and Pro-Pectalin.

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 3.0 cm, are normal.

The prostate is normal in size (0.98 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 (5.98 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 hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.55 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.

Adrenal Glands

The left adrenal gland is normal in size (0.54 cm at cranial pole) (0.62 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 (0.75 cm at cranial pole) (0.62 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.

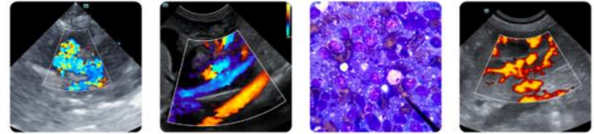
Spleen

The spleen is normal in size (1.60 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 gallbladder lumen is moderately distended. The wall is thin and smooth. A small amount of gravity-



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dependent, echogenic- mineralized debris/sand is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is not distended. The gastric wall in the region of the fundus is normal in thickness with a normal layering pattern. The wall in the region of the pyloric antrum is normal- to moderately-thickened (up to 0.75 cm). There is some thickening of the muscularis layer along the lesser curvature. 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. The ileocecocolic junction and colonic wall are 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.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Mild thickening of the pyloric antral wall. This could be consistent with inflammation, hyperplasia, or less likely, emerging neoplasia.

Secondary Findings

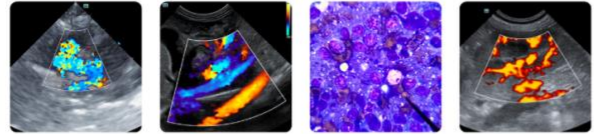
- Mild bilateral nonspecific age-related renal changes

*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

The following diagnostics/treatment recommendations can be considered:

1. Texas GI panel including serum cobalamin, folate, PLI, TLI and resting cortisol level
2. Despite the negative fecal evaluation, consider prophylactic deworming with fenbendazole.
3. A 3-4-week hypoallergenic or hydrolyzed protein diet trial
4. Also consider initiating a probiotic with a high colony count +/- fiber supplement (i.e., psyllium).
5. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.
6. Three-view thoracic radiographs should be performed prior to any anesthetic event.



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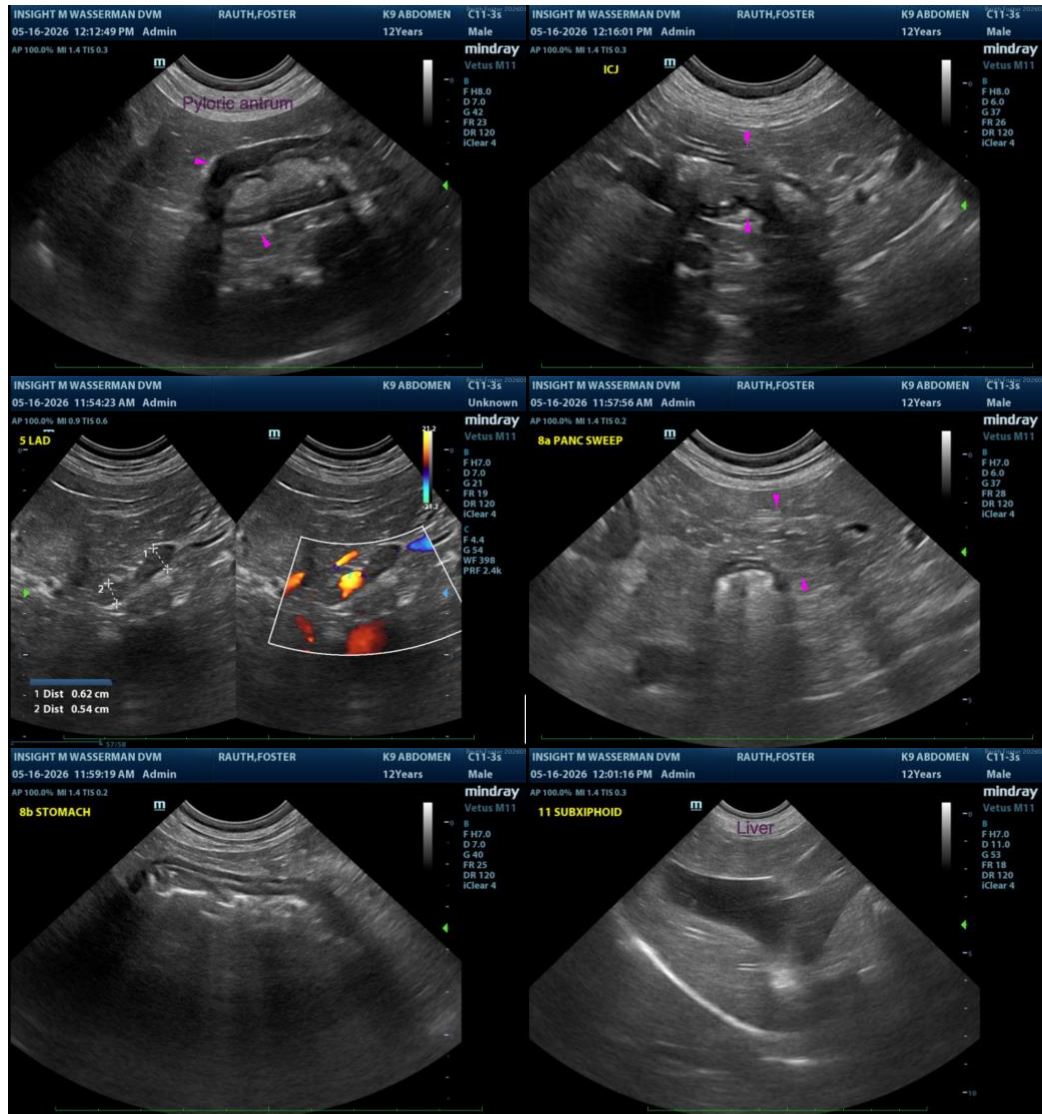

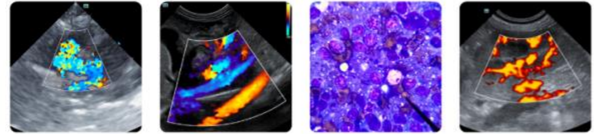

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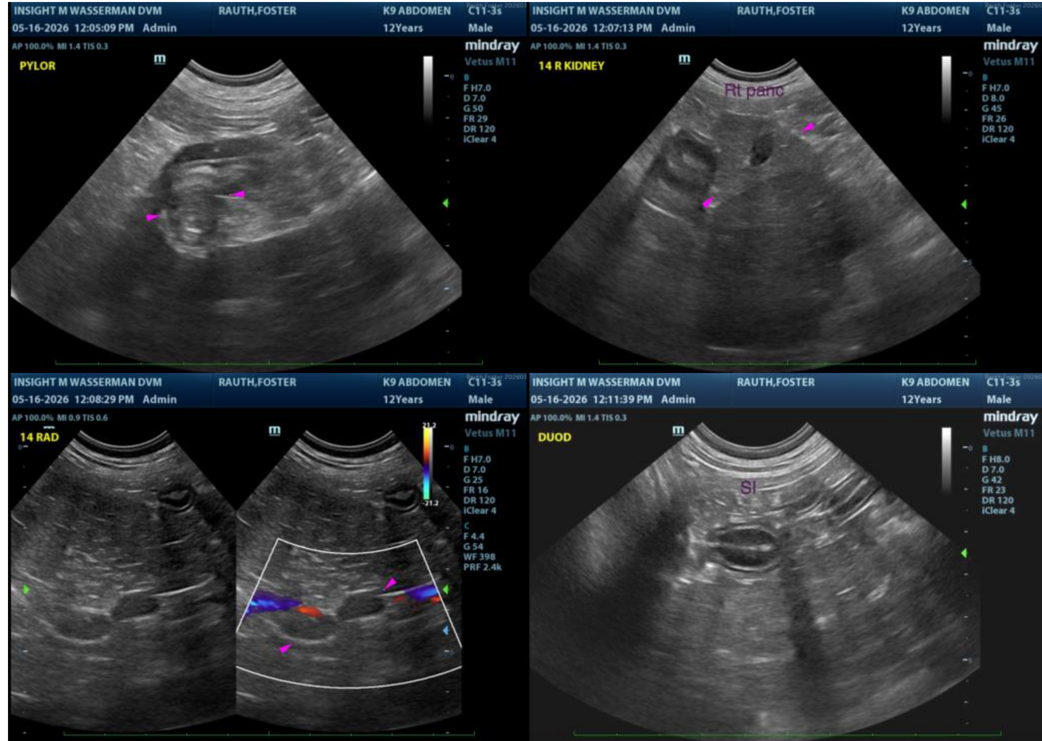

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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