



PATIENT

Stella Ritter

SPECIES

Canine

BREED

Yorkshire terrier

SEX

Female, spayed

AGE

7 Yrs.

WEIGHT

7.8 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Jasmine Palacios

HOSPITAL NAME

Rivers Edge Pet
Medical Center

REFERRING VET

Dr. Wineinger

INVOICE

13736

DATE

5/19/26

PRESENTING CLINICAL SIGNS

History: History of vomiting frank blood was brought up at annual exam on 5/18/26 and mentioned at last years annual. AUS discussed at both exams. P presented for more acute GI signs and behavior changes yesterday - lethargic, vomiting for ~48 hours that seemed to resolve before exam. P had eaten another animals feces just prior to onset of GI signs - fecal testing negative. BM have been formed with a single instance of frank blood on 5/16/26. No reported diarrhea. Physical exam yesterday and today were unremarkable. Current Medications Maropitant 16 mg given 7:30 am. Small amount of vomit on car ride to clinic ~45 minutes after maropitant given. O didn't see the pill in vomitus. Abnormal PE/Chem/CBC/UA Results: Labs performed at rDVM: Mild monocytosis SpecCPI still pending Fecal testing negative

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. Luminal contents are mostly anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (3.26 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal 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 (3.60 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal 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 (0.35 cm at cranial pole) (0.38 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 (0.55 cm at cranial pole) (0.42 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 (0.92 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.



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The gall bladder 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 moderately distended with fluid and gas. Some echogenic debris is suspended within the fluid. The gastric wall is 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 to borderline thickened (up to 0.25 cm). There is slight disruption in the normal 1:3 muscularis: mucosal ratio in some segments. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains liquid appearing fecal material. There is no obvious evidence of an obstructive pattern.

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

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

ULTRASONOGRAPHIC FINDINGS

- Gastric ileus. Functional ileus is suspected as there is no obvious evidence of a mechanical outflow tract obstruction. However, a small or intermittent obstruction cannot be completely excluded.
- The small intestinal wall changes could be consistent with an inflammatory process or less likely, emerging lymphoma.
- Diarrheic stool

**An obvious cause for the patient's chronic intermittent GI 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:

- Texas GI panel including serum cobalamin, folate, PLI, TLI and resting cortisol level
- Fecal evaluation for ova/Giardia
- Prophylactic deworming with Fenbendazole.
- 3-4 week hypoallergenic or hydrolyzed protein diet trial
- Initiation of a probiotic with a high colony count +/- fiber supplement (i.e., psyllium).
- Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted. Three-view thoracic radiographs should be performed prior to any anesthetic event.



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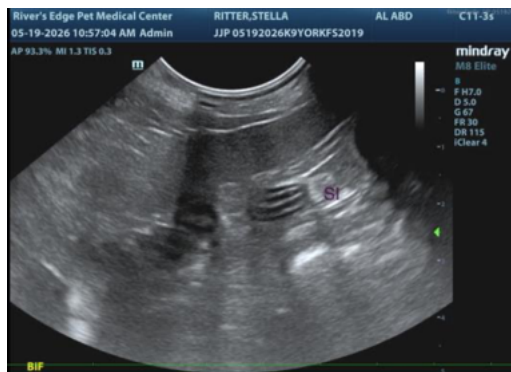
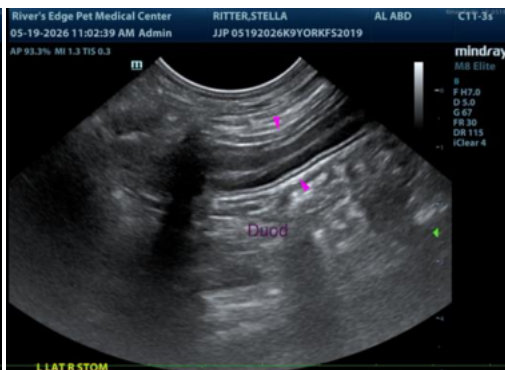
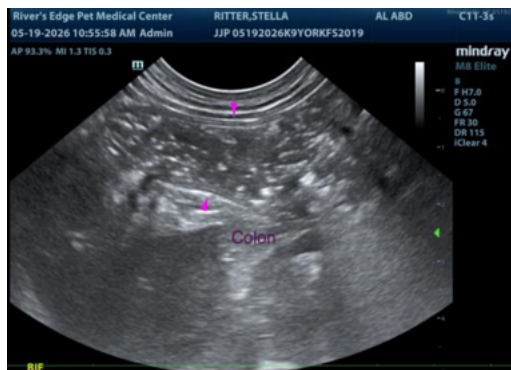
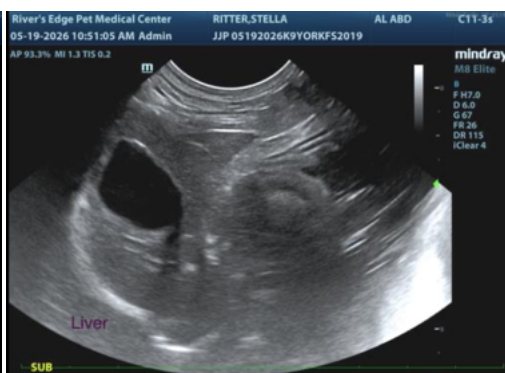
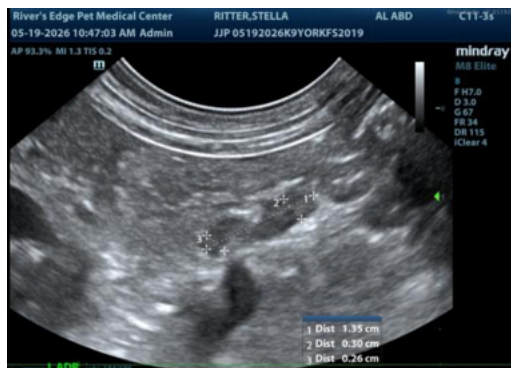
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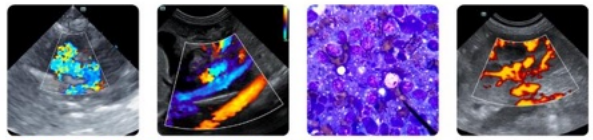
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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