



PATIENT

Basil El Shafey

SPECIES

Canine

BREED

Pomeranian

SEX

Female Spayed

AGE

9

WEIGHT

Not Provided

INTERPRETED BY

Kathleen Sennello DVM
MS, Diplomate ACVIM
(Sm Animal Internal Med)

**IMAGING
PERFORMED BY**

Kathleen Sennello DVM
MS, Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Central VH
Summerville

REFERRING VET

Dr Chad Reynolds

INVOICE

23073

DATE

5-28-26

PRESENTING CLINICAL SIGNS

Patient has a history of suspected chronic intermittent pancreatitis. Presented May 21st for anorexia and history of diarrhea. Appetite has improved in the last 24 hours. GI panel in February of 2026 revealed an elevated TLI and PLI. Borderline low B12. Normal cortisol level. ALP of 263.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately-distended. The wall is normal in thickness with a smooth mucosal surface. Several, small, cystic calculi are observed within the lumen. The remaining luminal contents are mostly anechoic. The region of the trigone is normal. A small urethrolith is observed approximately 1.0 cm from the cystourethral junction. The urethra is not overtly dilated.

The left kidney is normal in size (4.36 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild- to moderate loss of corticomedullary distinction. A few cortical cysts are seen (one of the larger measuring 0.50 cm in its longest dimension). Several, small, nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.33 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild- to moderate loss of corticomedullary distinction. A few cortical cysts are seen (one of the larger measuring 0.55 cm in its longest dimension). A few nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.47 cm at cranial pole) (0.48 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) (0.38 cm at caudal pole) with a slightly irregular shape. A 0.63 x 0.42 cm hyperechoic- to heterogenous nodule is observed at the mid-aspect. The remaining glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.16 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 prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic- to slightly hypoechoic 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 small amount of aggregated, mostly gravity-dependent, echogenic to mineralized debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal



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The gastric lumen is mildly distended with ingesta. 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 not dilated. The small intestinal wall is normal in thickness with a normal layering pattern. There is evidence of mucosal speckling in some segments. Discreet masses are not identified. The ileocecolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is slightly heterogenous 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

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

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The small intestinal wall changes, in conjunction with the previous borderline hypcobalaminemia is suggestive of a primary enteropathy (i.e., food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease, other).
- Small cystic and urethral calculi

Secondary Findings

- Bilateral nonspecific age-related renal changes with nonobstructive nephrolithiasis
- Gallbladder debris/sand/sludge, non-mucocele
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease, infiltrative neoplasia and other hepatopathies are considered less likely. However, correlation with the patient's liver values is recommended.

- The right adrenal nodule could be consistent with focal nodular hyperplasia, adenoma, emerging adenocarcinoma, pheochromocytoma, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider repeating baseline lab work (including a CBC, chemistry panel, urinalysis, and T4) to assess overall metabolic function.



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- Also consider cobalamin supplementation along with a limited antigen or hydrolyzed protein diet that is also low in fat.

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- A probiotic fiber supplement may also prove beneficial.
- Ultimately, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis.

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- Regarding the adrenal nodule, consider a recheck ultrasound in 2-3 months to assess for growth.
- Regarding the cystic calculi, consider a cystotomy with stone removal, analysis and culture. Alternatively, consider an attempt at medical dissolution.

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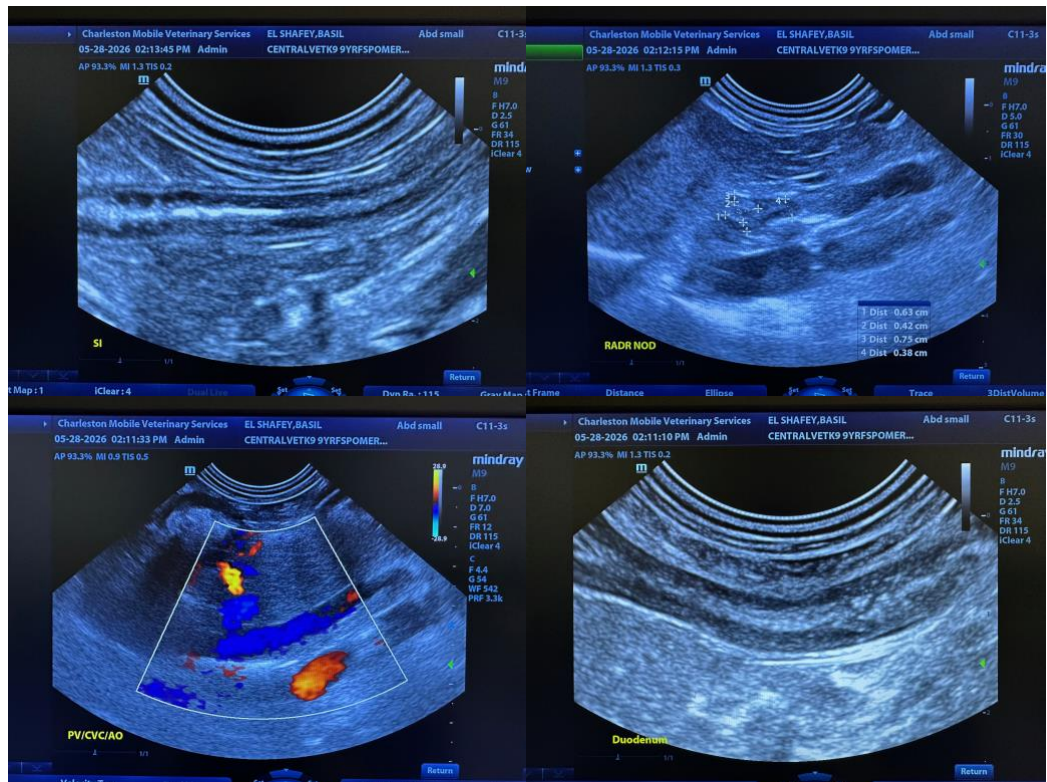
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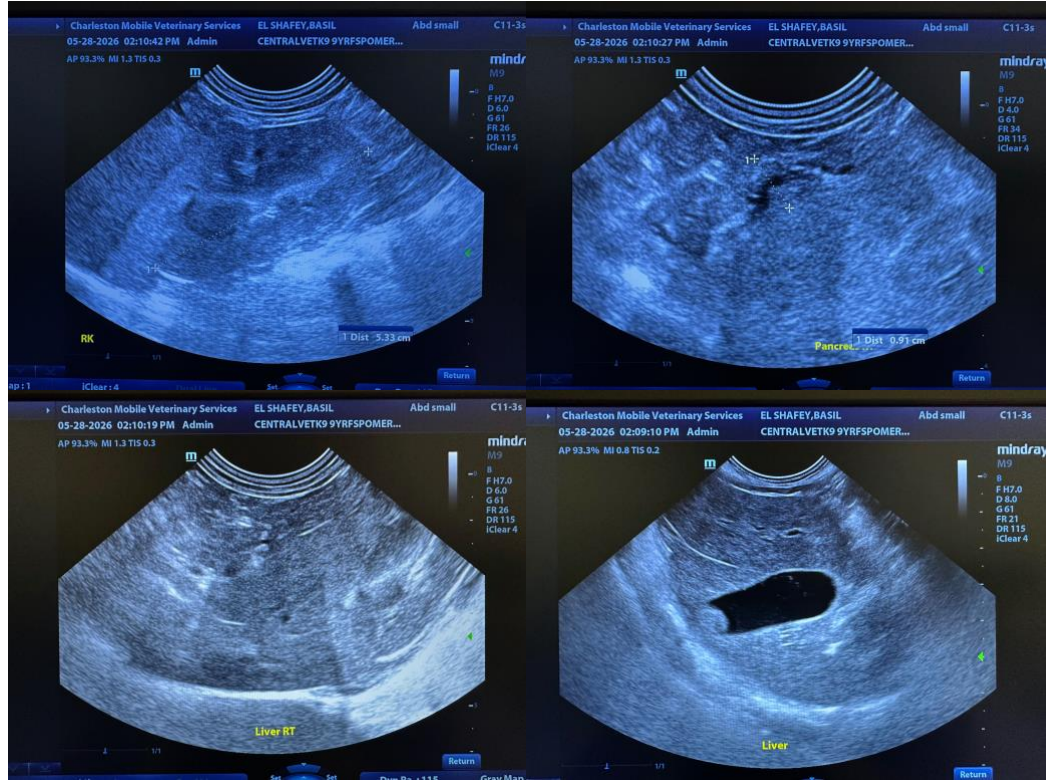
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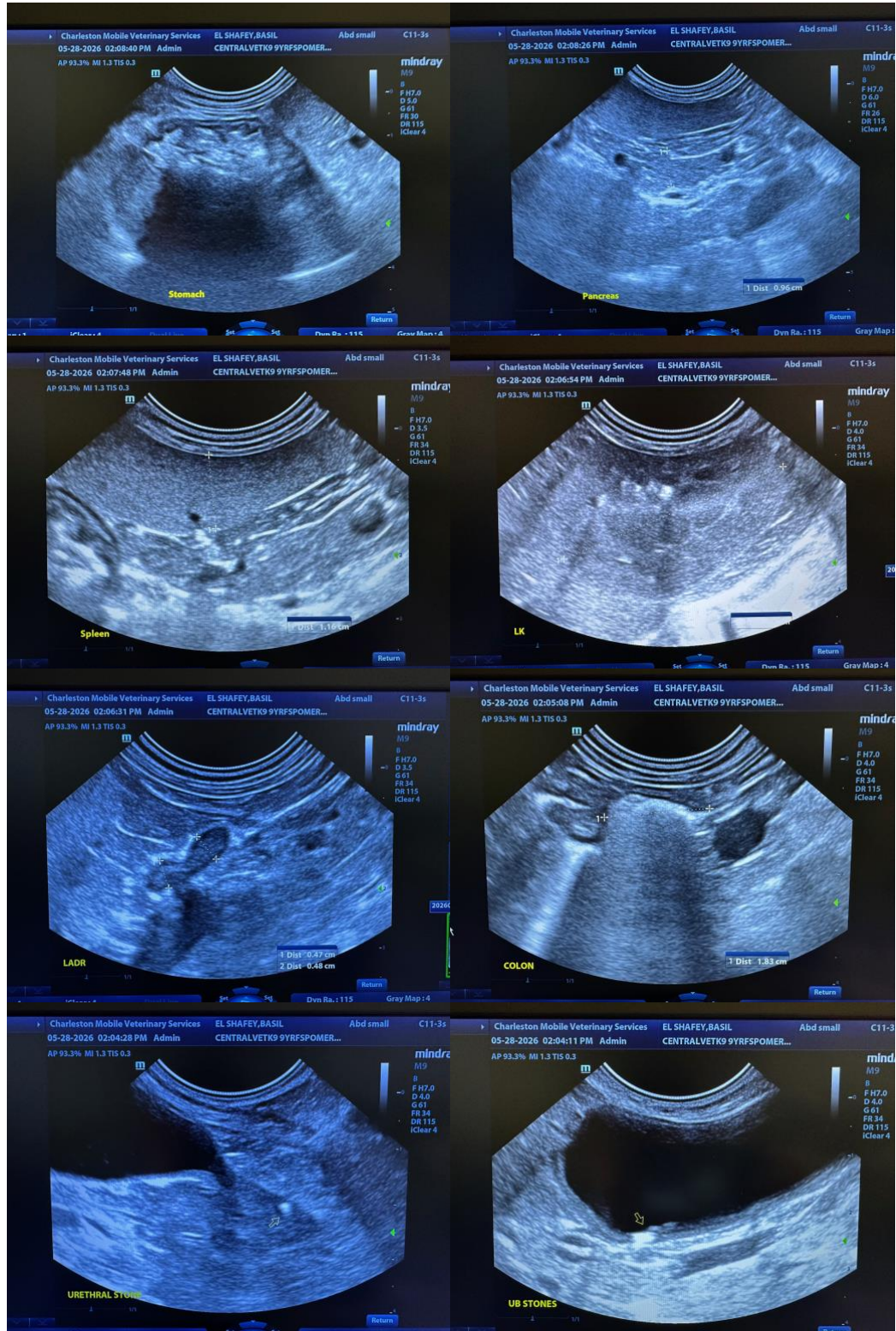
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com

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