



PATIENT

Chewy Berry

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Male, neutered

AGE

10 Yrs.

WEIGHT

2.55 kg.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Wayland

HOSPITAL NAME

Wilvet South

REFERRING VET

Dr. Wayland

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13602

DATE

6/8/26

PRESENTING CLINICAL SIGNS

PT presented on Sat 6/6 for profuse v+, v+ directly after eating or drinking, listlessness, dullness, lethargy, tremors, and vocalization

Known history of pancreatitis

On low-fat diet for pancreatitis mgmt

Occasional v+ episodes when given table food (scrambled eggs, milk from cereal), typically resolves after a few episodes

Normal until today at 7 AM when last defecated

Vomited over 12 x today

Tremors, vocalization, appears painful

Curled up posture, hiding behavior

No diarrhea (not typical for this patient)

Pancreatitis diagnosed over the last year at Banfield with significant blood work

Recently evaluated at Banfield and reported as doing better

Previous medical history includes carrot stuck in mouth when young

Losing teeth, has patellar luxation (chronic)

Pt returned today 6/8 had not improved, very lethargic, not eating, drinking small amounts, V+ seems painful. Refusing meds.

Pt has appt w/ rDVM 6/9 at 5 PM

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

*60 images obtained on 6/6/26 as follows:

Urinary System

The urinary bladder wall is normal in thickness and 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 2.5 cm, are normal.

The prostate is normal in size (0.46 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 (3.39 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.64 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of the left adrenal gland is evaluated. No obvious pathology is observed in this region.

The right adrenal gland is normal in size (0.46 cm at cranial pole) (0.45 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



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The spleen is normal in size (0.95 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.

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Liver

The liver is subjectively normal in size with smooth peripheral contours. The parenchyma is hypoechoic relative to the spleen. A 1.7 x 1.5 cm hyperechoic nodule is observed on the right side adjacent to the diaphragm. The remaining parenchyma is mildly heterogeneous in appearance. Vascular and biliary tracts are of normal volume with no evidence of congestion.

BREED

Yorkshire Terrier

The gall bladder lumen is moderately distended. The wall is normal to mildly thickened (up to 0.18 cm). Several varying sized choleliths are observed within the lumen, one of the stones measuring 0.65 cm in its longest dimension. Echogenic debris is also suspended within the lumen. In one video clip, the proximal cystic duct appears mildly dilated. The omentum effacing the serosal surface of the gallbladder is hyperechoic. The duodenal papilla is visible and is normal in size (0.30 cm in width).

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Gastrointestinal

The gastric lumen is not distended. The gastric wall is normal to subjectively mildly thickened with retention of the 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 and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

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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.

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Lymph nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

The omentum in the cranial abdomen, adjacent to the liver and gallbladder, is hyperechoic. A small amount of free fluid is observed.

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*9 images obtained on 6/8/26 are as follows:

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The gallbladder is moderately distended. The wall is variably thickened (up to 0.48 cm) with questionable maintenance of integrity. At least one cholelith is observed within the lumen measuring 0.72 cm in its longest dimension. The omentum effacing the serosal surface of the gallbladder is hyperechoic.

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Other

The omentum in the cranial abdomen is hyperechoic. Trace free fluid is observed.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings:

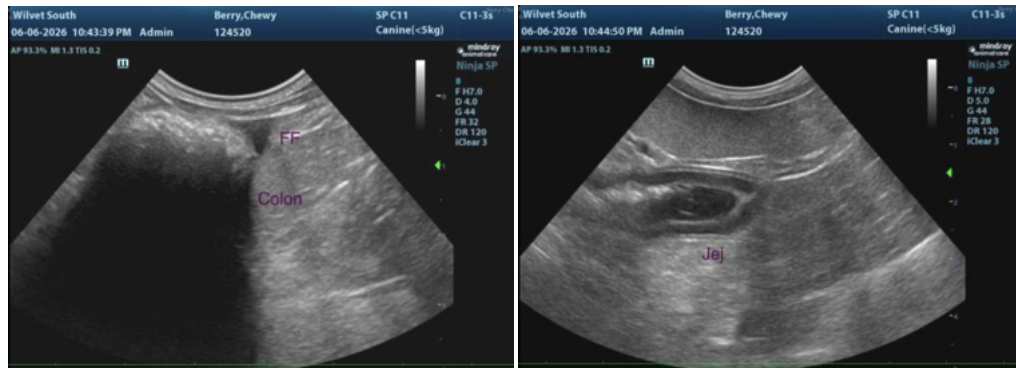
- Choleliths with gallbladder wall changes suggestive of cholecystitis. The images from 6/8 are concerning for gallbladder rupture or impending rupture. Cranial peritonitis is present.
- The hepatic changes are nonspecific and could be secondary to inflammatory disease (i.e., cholangiohepatitis, chronic hepatitis), Leptospirosis, hepatotoxicosis, infiltrative neoplasia (i.e., lymphoma), vacuolar hepatopathy, regenerative nodular hyperplasia, other hepatopathy, or some combination thereof. The hyperechoic hepatic nodule trends toward the benign (i.e., regenerative nodule, meylolipoma) with a lower possibility of more insidious hepatic pathology.

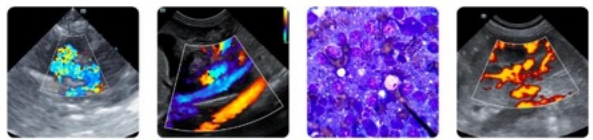
Secondary Findings:

- Bilateral, nonspecific age-related renal changes
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Subjective mild gastric wall thickening suggestive of gastritis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Consultation with a board-certified surgeon is recommended to discuss emergency cholecystectomy due to the concern for gallbladder rupture. Liver biopsies should also be obtained at the time of surgery. Clotting times and thoracic radiographs are recommended prior to anesthesia.





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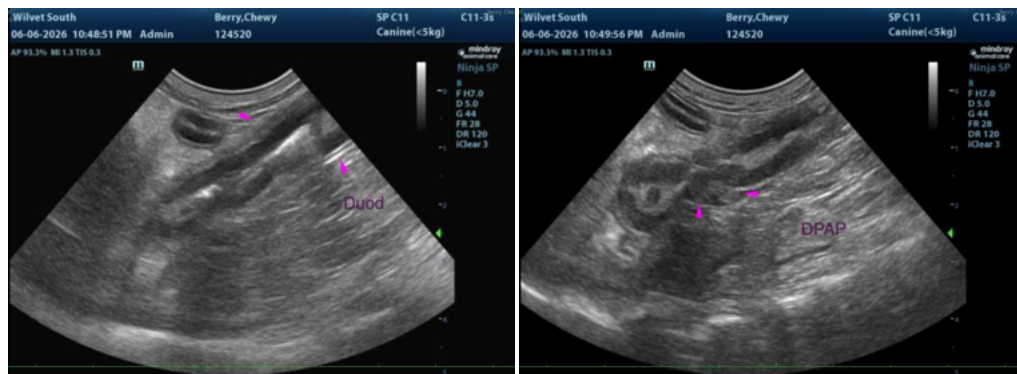
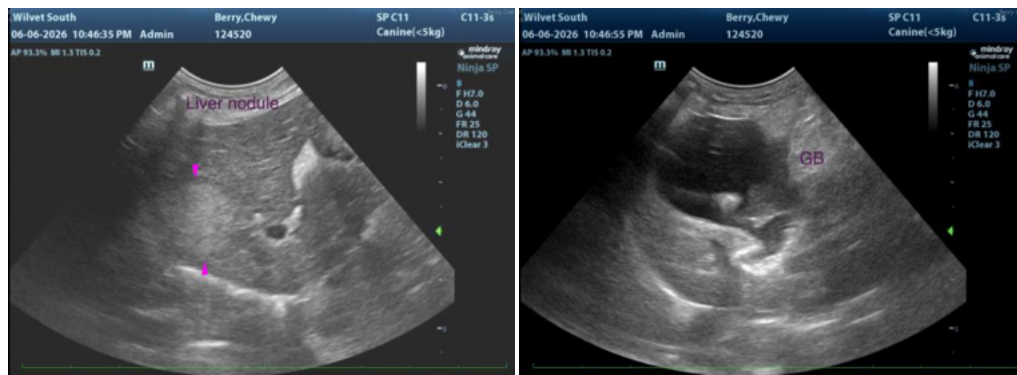
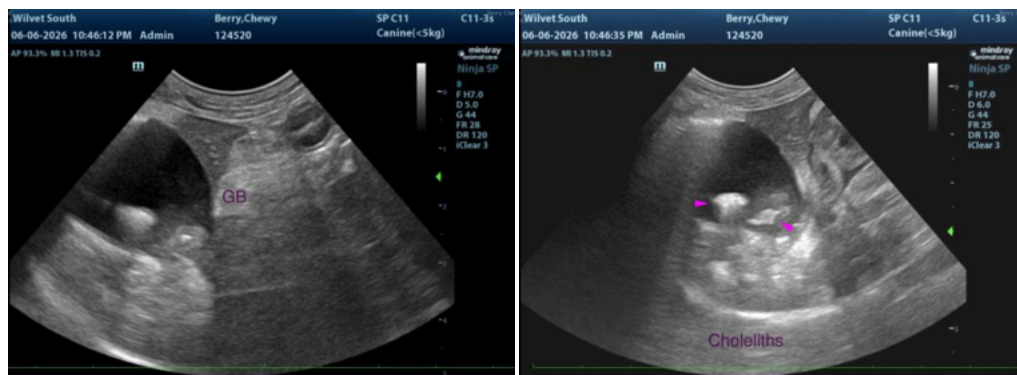
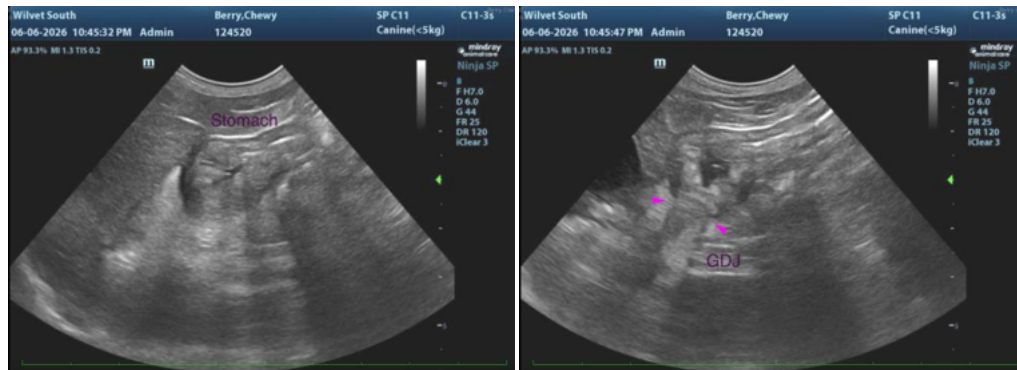
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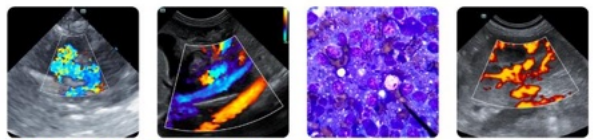
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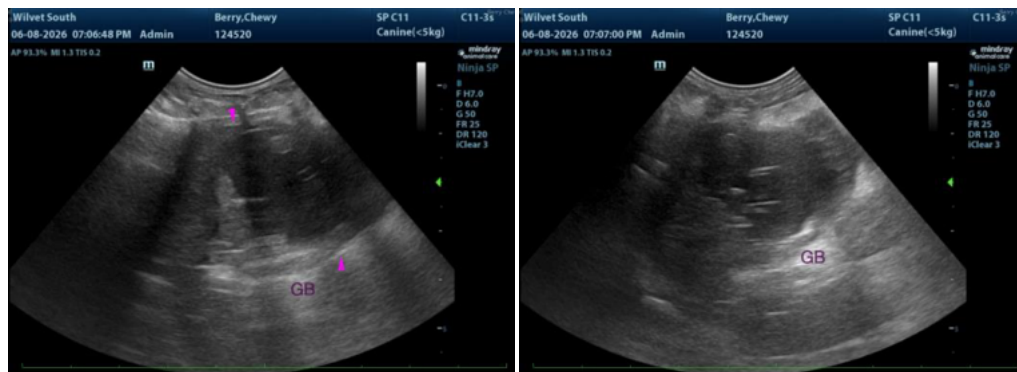
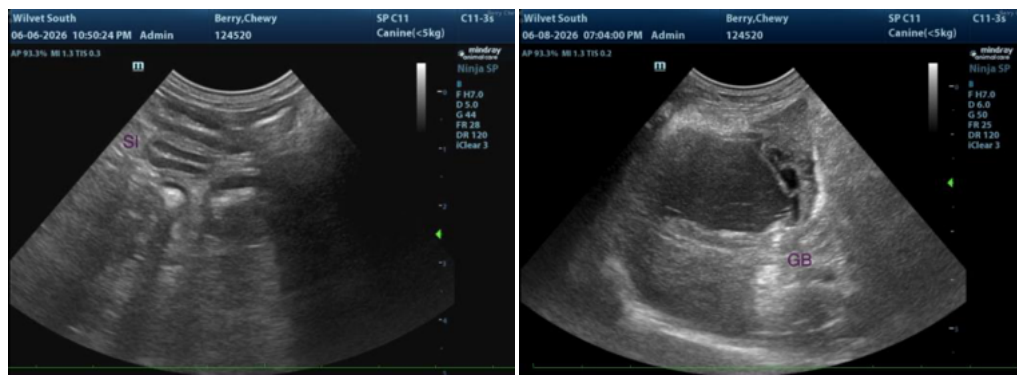
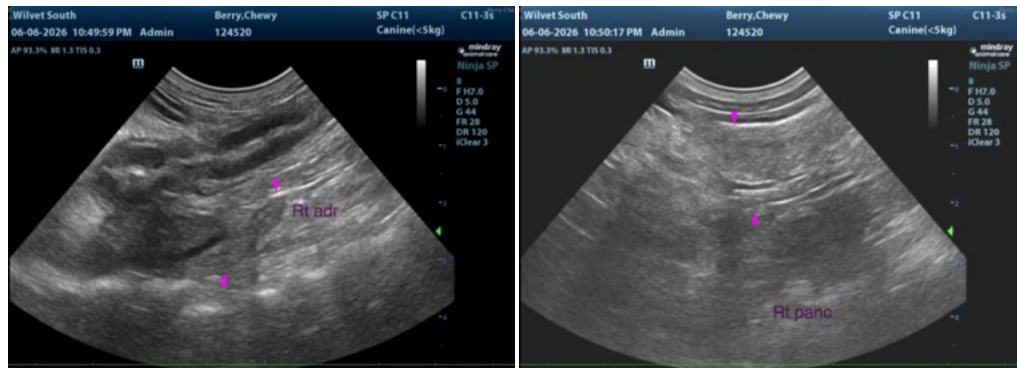
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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