



## PATIENT

Titan Rose

## SPECIES

Canine

## BREED

Rottweiler

## SEX

Male, neutered

## AGE

9 Yrs.

## WEIGHT

35 kg.

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Dr. Milligan

## HOSPITAL NAME

Dockside Veterinary  
Imaging

## REFERRING VET

Dr. Alexander

## INVOICE

13600

## DATE

6/8/26

## PRESENTING CLINICAL SIGNS

History: \*ER patient\* Pt presented yesterday for for a 24 hours history of excessive bloody diarrhea and severe vomiting that progressed to having blood in it this morning. He is normally a picky eater, but had no interest in food this morning. He can barely go more than a few minutes without having bloody diarrhea. He is not known to get into things he shouldn't. Today P has been vomiting (regurgitating) with no cause identified. CBC chem WNL. cPL borderline elevated. USG 1.038, 3+ proteinuria.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder is moderately distended. The wall in the region of the apex is mildly irregular. A 1.01 x 0.82 cm nodule is arising from the mucosa at the region of the apex. The remaining urinary bladder wall is normal in thickness with a smooth mucosal surface. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is enlarged (at least 4.1 cm in width) with smooth peripheral contours. A >3.6 cm irregular cystic area is observed within the parenchyma. The remaining parenchyma is mildly heterogeneous in appearance. The prostatic urethra is not overtly dilated.

The left kidney is slightly small in size (5.26 cm in length) with smooth peripheral contours. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Moderate pyelectasia is present (0.45 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (6.31 cm in length) with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Moderate pyelectasia is present (0.67 cm in the longitudinal plane). There is no evidence of nephroliths or hydroureter. Renal vasculature is normal.

### Adrenal Glands

The left adrenal gland is normal in size at the cranial pole (0.66 cm at cranial pole) and mildly enlarged at the caudal pole (0.88 cm at caudal pole). The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.93 cm at cranial pole) (0.60 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 (1.80 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 gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.



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### ***Gastrointestinal***

The gastric lumen is mildly distended with ingesta and small hypoechoic non-shadowing bodies. A small amount of shadowing material is also observed within the lumen. The gastric wall is thickened (up to 0.070 cm) with a prominent muscularis layer. The small intestinal lumen is not dilated. The small intestinal wall is normal to mildly thickened (up to 0.48 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio. Discreet masses are not identified. The ileoceocolic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

### ***Pancreas***

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional 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 gastric wall changes are most consistent with gastritis with a lower possibility of emerging neoplasia. Minor retained gastric ingesta. The shadowing material within the gastric lumen may represent normal ingesta and/or foreign material. It appears non-obstructive at the time of this study.
- The small intestinal wall changes are most consistent with an inflammatory process with some potential for emerging neoplasia.
- Bilateral nonspecific, age-related renal changes. The bilateral pyelectasia may be secondary to pyelonephritis, parenchymal remodeling, PU/PD (if applicable), fluid therapy (if applicable) or some combination thereof.

### Secondary Findings:

- The urinary bladder wall changes are suggestive of polypoid cystitis, however emerging neoplasia cannot be excluded.
- The prostate changes could be consistent with cystic hyperplasia, particularly if the patient was neutered later in life. Other considerations include prostatitis or emerging prostatic neoplasia with cystic change.
- Mild left adrenomegaly

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A fecal evaluation for ova and Giardia along with a fecal PCR infectious disease panel are recommended. Also consider prophylactic deworming with fenbendazole.
- A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.



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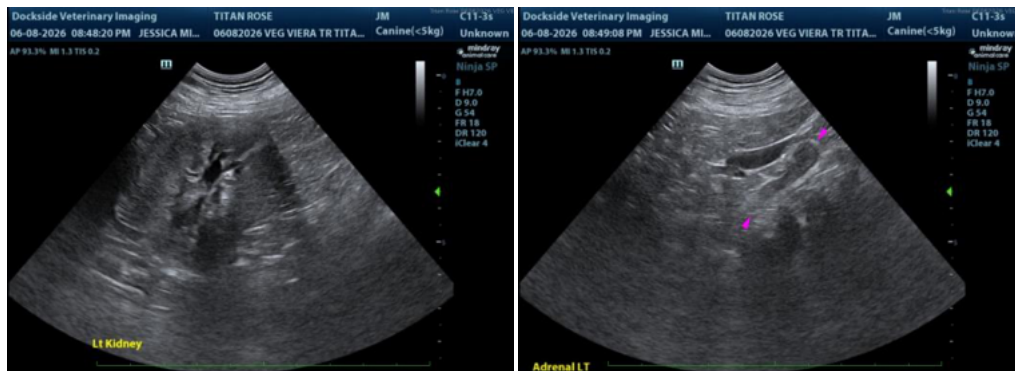
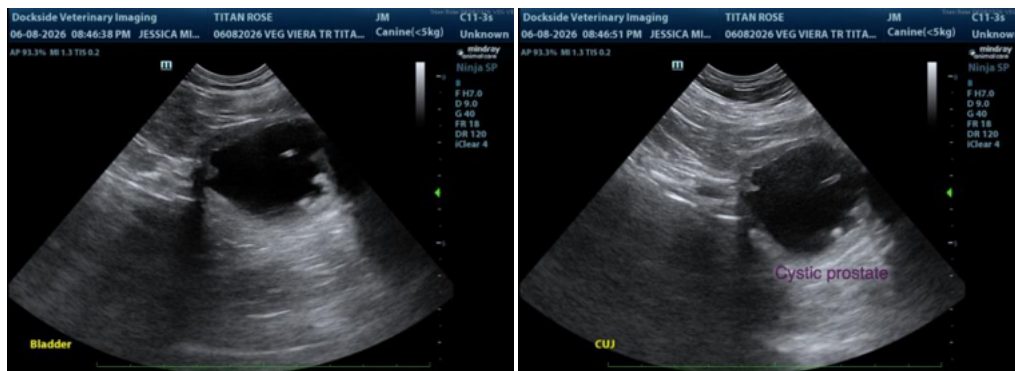
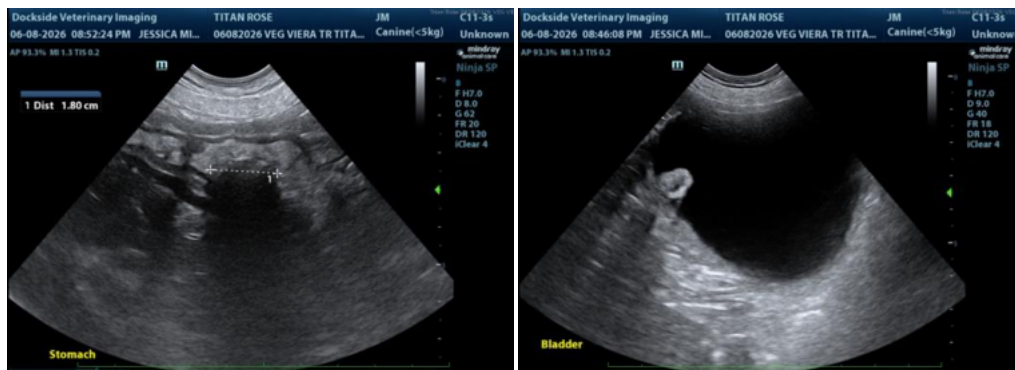
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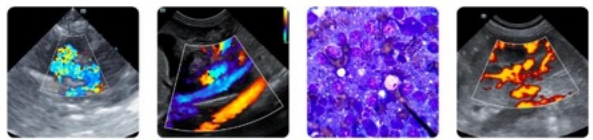
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- Continued aggressive supportive care for acute hemorrhagic gastroenteritis is recommended. If clinical signs persist despite medical management, further GI workup may be indicated.
- Regarding the renal changes and proteinuria, consider the following:
  - Urinalysis with culture and sensitivity
  - UPC (if proteinuria is present in the absence of infection)
- Regarding the urinary bladder and prostatic changes, consider a urine BRAF test to further evaluate for lower urinary tract neoplasia, particularly if clinical suspicion for disease is high.
- Given the patient's age, three-view thoracic radiographs are also recommended to assess cardiopulmonary status, particularly in light of the history of vomiting and regurgitation.





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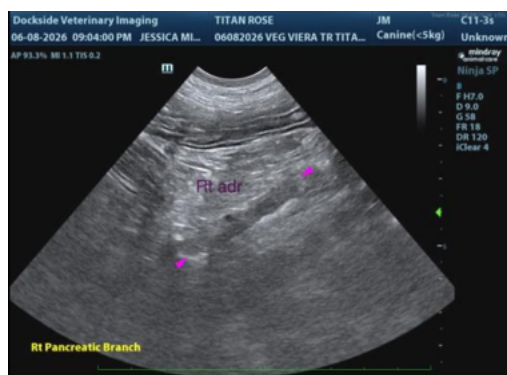
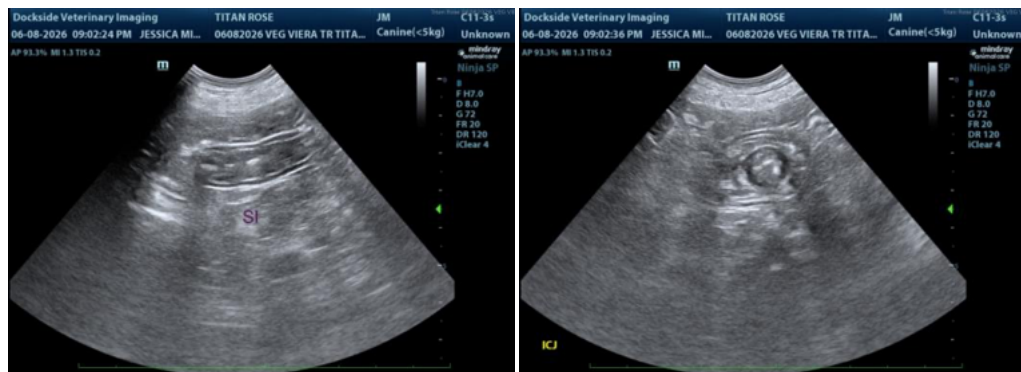
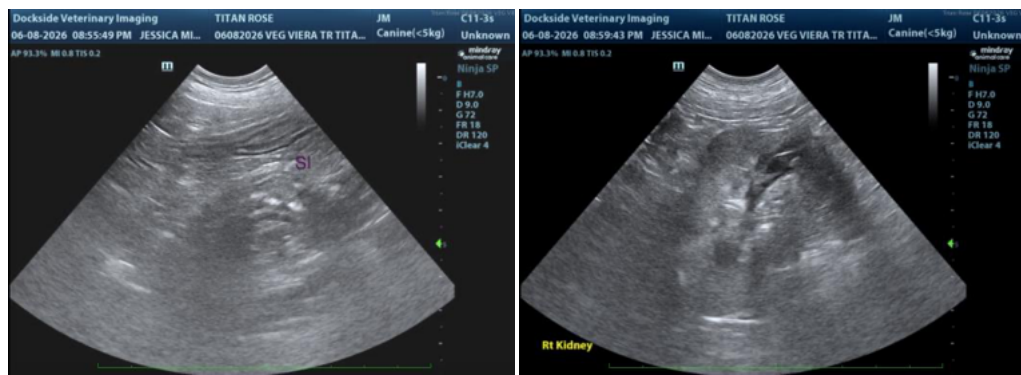
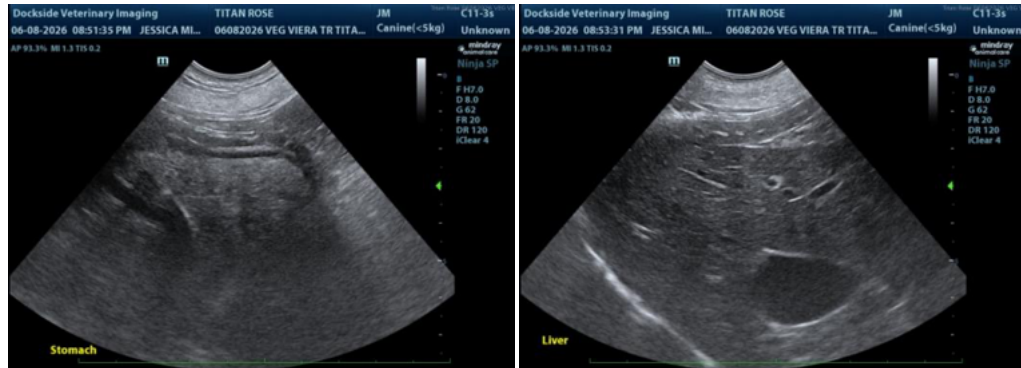
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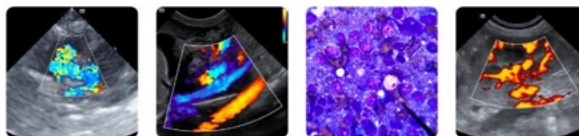
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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[info@SonoPath.com](mailto:info@SonoPath.com)

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