



PATIENT

Bandit Cole

SPECIES

Canine

BREED

Bulldog mix

SEX

Male, neutered

AGE

11/10/2017

WEIGHT

112.5 lbs.

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

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

HOSPITAL NAME

Meadowlawn Conway

REFERRING VET

Dr. Heim

INVOICE

13390

DATE

1/14/26

PRESENTING CLINICAL SIGNS

The patient has a history of IMHA diagnosed November 2025. Was started on Prednisone and was tapered down to 60 mg once a day, however PCV started trending downward so Prednisone increased to 40 mg BID. Was having excessive side effects to the Prednisone at 60 mg BID. Also on Azathioprine 100 mg once a day. Had been doing great but presented to the ER on 1/12 for a painful abdomen, sent home on Metronidazole and Sucralfate, re-presented on 1/13. Abdominal rads WNL, elevated ALT, ALP and GGT, started hepato-support and Ursodiol. Buprenorphine seemed to help. ADR this morning. Lab work from 1/13- hematocrit 33%, reticulocytes not elevated, borderline leukocytosis with a mild neutrophilia, normal platelets, mild monocytosis. ALT 603, ALP 1939, GGT 125. Pt has had a previous splenectomy at a different hospital. Histopathology results unknown.

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 3 cm, are normal.

The prostate is normal in size (1.05 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 (8.14 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 (8.21 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.

Adrenal Glands

The left adrenal gland is subjectively normal in length (0.48 cm at cranial pole) (0.36 cm at caudal pole) with a flattened contour. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is subjectively normal in length (0.68 cm at cranial pole) (0.42 cm at caudal pole) with a flattened contour. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

Previously splenectomized. In the region of the splenic fossa, a 1.65 x 0.95 cm focus of slightly hypochoic, ill-defined tissue is observed.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypochoic relative to the spleen and slightly mottled in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic 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 normal in thickness. A 2.40 cm non-obstructive cholelith is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

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 and appropriate mural detail. Discreet masses are not identified. The ileocecolic junction and colonic wall are normal. There is no 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

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Minor mottling of the hepatic parenchyma. This is a non-specific finding. Given the elevated liver values, considerations include an inflammatory hepatopathy (i.e., bacterial cholangiohepatitis, chronic hepatitis), hepatotoxicosis (i.e., secondary to Azathioprine), regenerative nodular hyperplasia, vacuolar hepatopathy, fibrosis, Leptospirosis and/or other hepatopathy.
- Non-obstructive cholelith, likely an incidental finding.

Secondary Findings:

- Bilateral nonspecific, age-related renal changes
- The flattened adrenal glands are likely secondary to chronic corticosteroid use.
- The ill-defined tissue in the region of the splenic fossa may represent scar tissue or less likely, inflammation or emerging neoplasia.
- If the patient was fasted for this study, the presence of ingesta within the gastric lumen could suggest delayed gastric emptying.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Discontinuation of Azathioprine is recommended due to the potential for hepatotoxicosis with this immunosuppressive agent.
2. Consider Leptospirosis testing, particularly if clinical suspicion for disease is high.
3. Also consider initiation of a broad-spectrum antibiotic therapy (i.e., amoxicillin clavulanic acid, a fluoroquinolone) as empirical treatment for bacterial cholangiohepatitis. If hematocrit continues to



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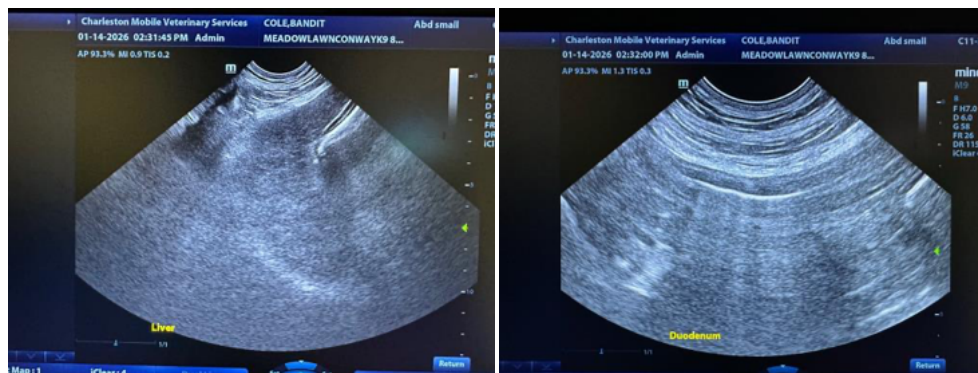
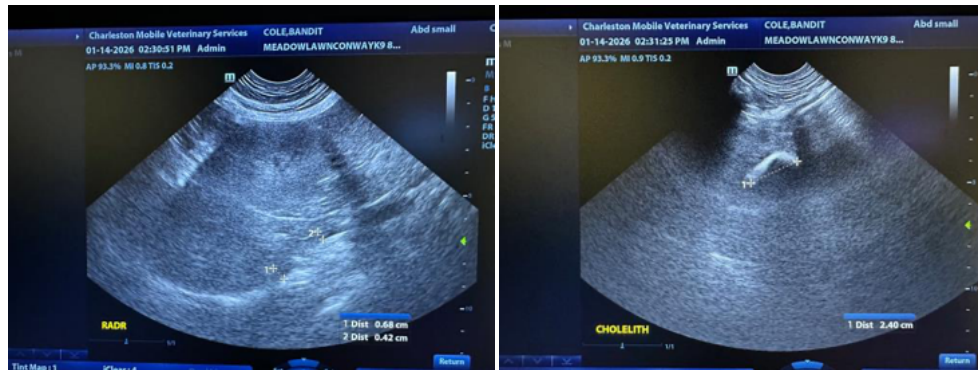
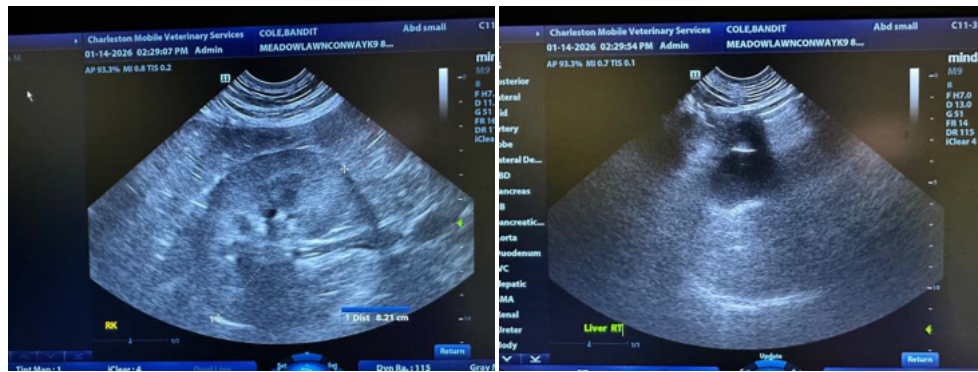
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decrease and another immunosuppressive agent (i.e., Cyclosporine, Mycophenolate, Leflunomide) may be warranted.

4. Consider referral to a board-certified internist for continued management due to the complicated nature of the case.





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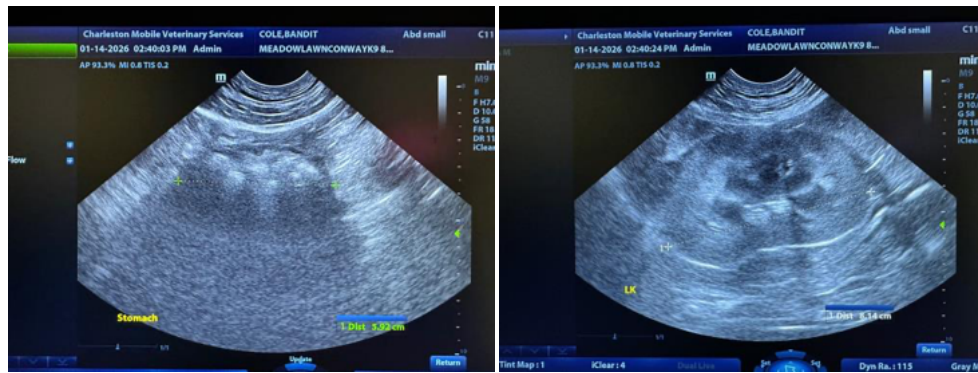
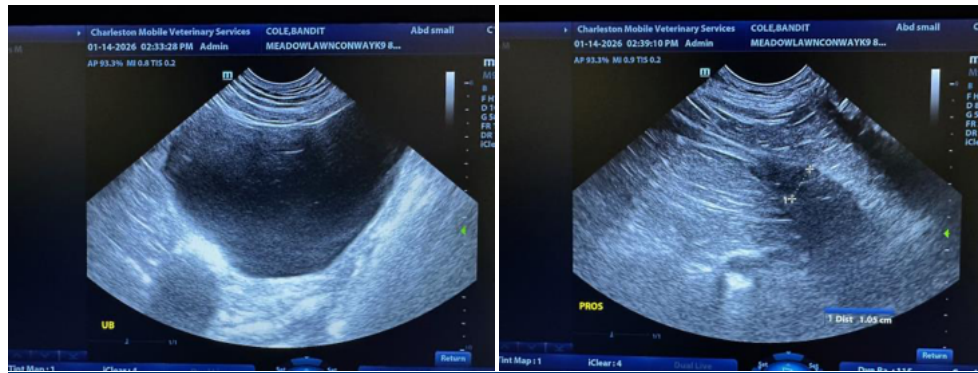
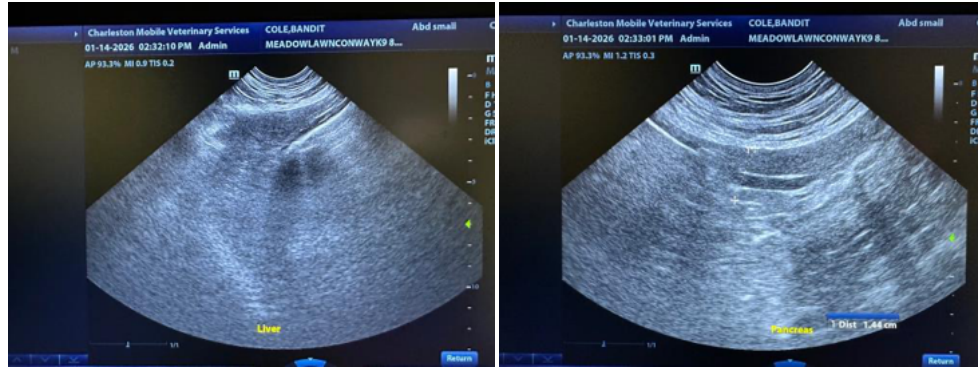
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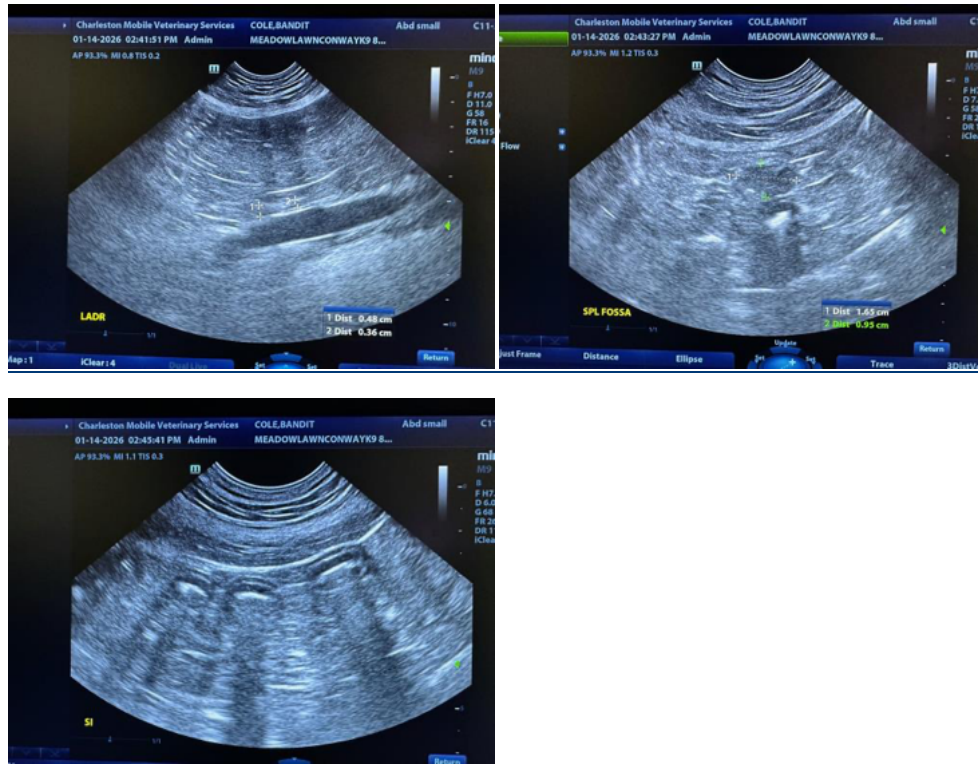
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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