



PATIENT

Jack Cawley

SPECIES

Canine

BREED

Pomeranian

SEX

Male, neutered

AGE

11/14/2012

WEIGHT

11 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

AH of South Carolina

REFERRING VET

Dr. Stone

INVOICE

13364

DATE

11/19/25

PRESENTING CLINICAL SIGNS

Chronic pancreatitis and weight loss. Most recent cPL 208. In October 1288. CBC WNL.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is mildly distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (0.93 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 (3.74 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. Several small cortical cysts are seen. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.66 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. Several small cortical cysts are seen. Hyperechoic shadowing diverticular foci 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 (0.42 cm at cranial pole) (0.43 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 (0.50 cm at cranial pole) (0.39 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 overall normal in size (0.93 cm in width at the level of the hilus) with undulating/irregular peripheral contour. The parenchyma is subtly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal with no evidence of thrombosis.

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 portal vein to caudal vena cava ratio is approximately 1:1.

The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.

Gastrointestinal



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The stomach and intestine are free of stasis and exhibit normal peristaltic activity. 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 to mildly thickened (up to 0.37 cm). There is disruption in the normal 1:3 muscularis:mucosal ratio in most segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is slightly hyperechoic 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

A few prominent mesenteric lymph nodes are visualized, one of the nodes measuring 1.28 x 0.55 cm. Surrounding mesentery is slightly hyperechoic.

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The small intestinal wall changes are suggestive of an inflammatory process (i.e., inflammatory bowel disease). However, other etiologies (i.e., infectious/parasitic disease, food allergy/intolerance) cannot be excluded.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

Secondary Findings:

- Bilateral nonspecific age-related renal changes with dystrophic mineralization and cortical cysts.
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The following diagnostics/treatment recommendations can be considered:

1. An updated chemistry panel is recommended to assess metabolic function.
2. Texas GI panel including serum cobalamin, folate, PLI, TLI and resting cortisol level
3. Fecal evaluation for ova/Giardia
4. Prophylactic deworming with Fenbendazole.
5. 3-4 week hypoallergenic or hydrolyzed protein diet trial
6. Initiation of a probiotic with a high colony count +/- fiber supplement (i.e., psyllium).



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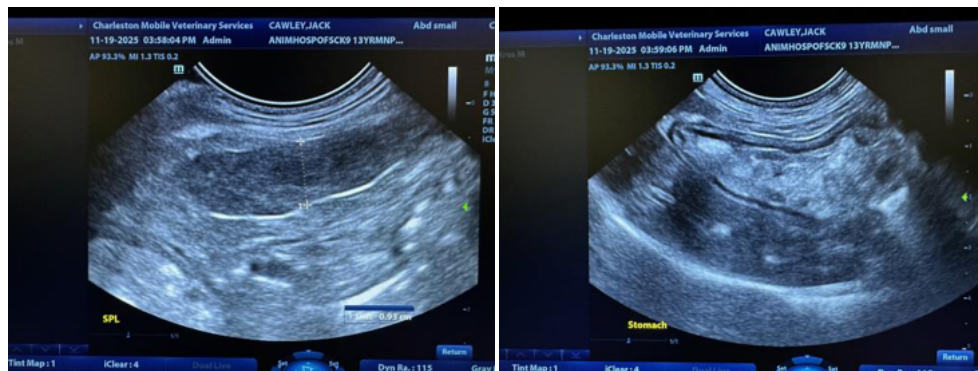
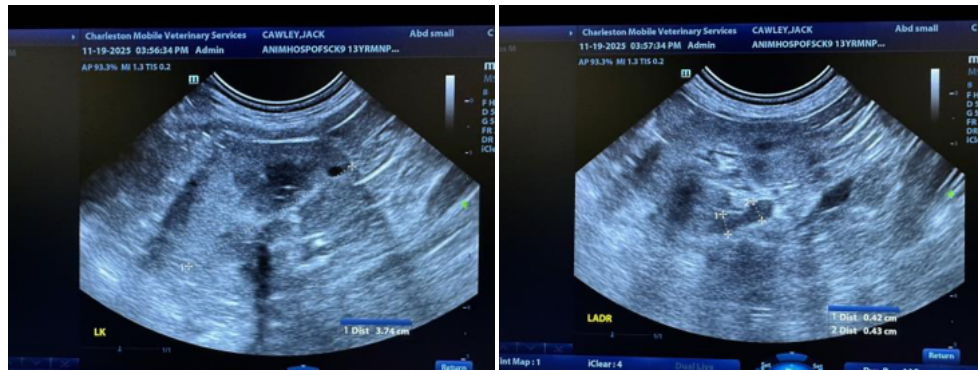
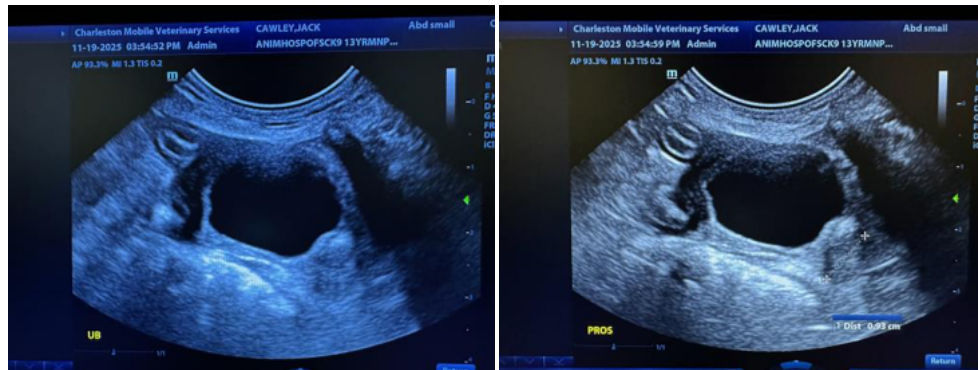
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- Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted. Three-view thoracic radiographs should be performed prior to any anesthetic event.





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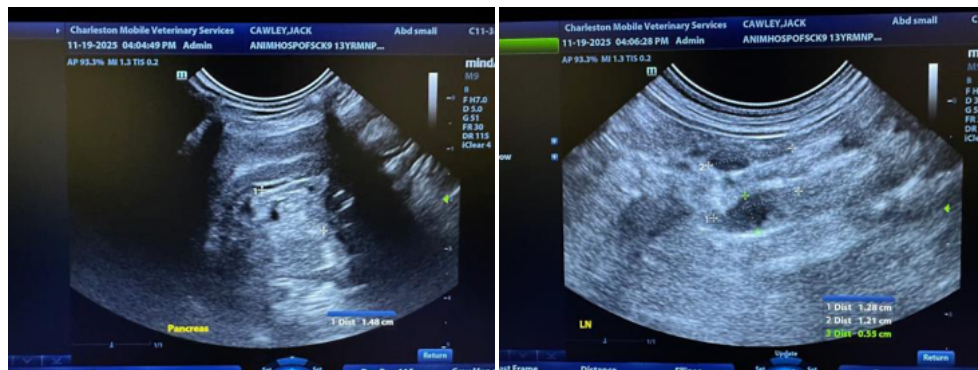
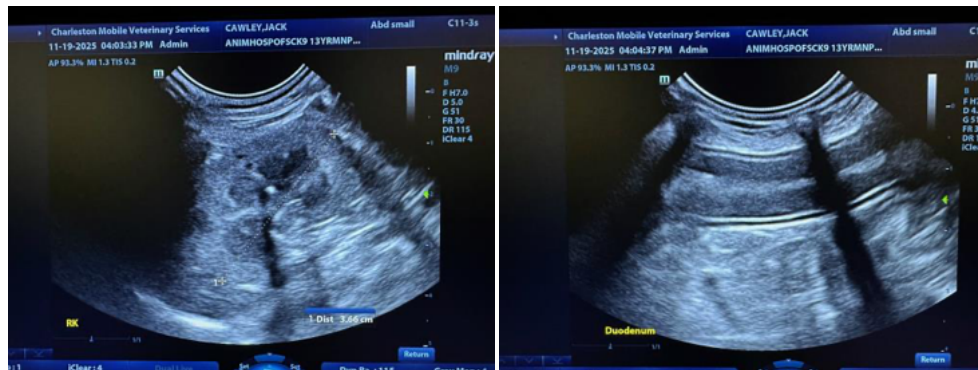
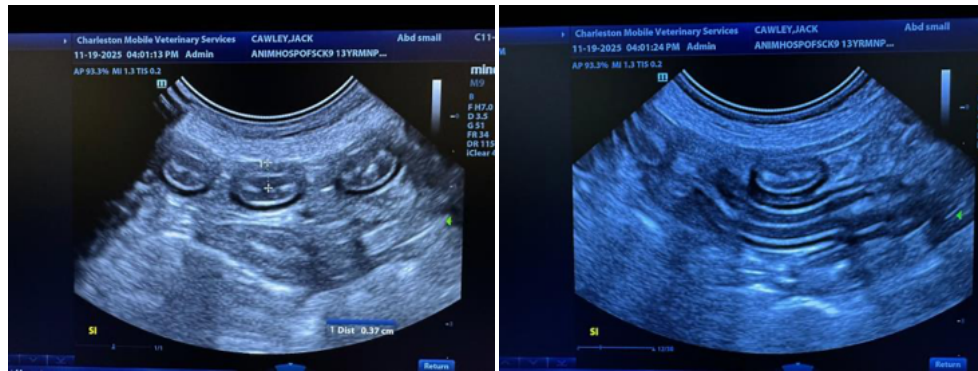
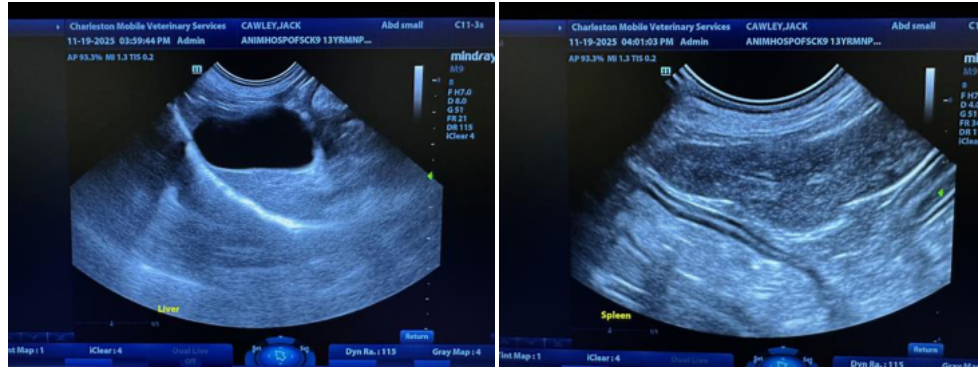
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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