



**PATIENT**

Bella Racey

**SPECIES**

Canine

**BREED**

Chihuahua

**SEX**

Female, spayed

**AGE**

12/4/2013

**WEIGHT**

12.9 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**

Kind

**REFERRING VET**

Dr. Mucci

**INVOICE**

13410

**DATE**

12/3/25

**PRESENTING CLINICAL SIGNS**

Pancreatitis October 2025- treated  
began v/d again Nov.

another bout of pancreatitis after this.

owner gave medications again but as soon as they are stopped, patient begins exhibiting symptoms

11/11: Pancreatitis Flare-Up - The elevated pancreatic lipase level (600) is consistent with a flare-up of pancreatitis. This is likely a recurrence of a low-grade, chronic condition, given the history of pancreatitis in early October. The current clinical signs of vomiting, diarrhea, and inappetence are attributed to this flare-up. The mild elevation in ALP is likely secondary to the concurrent gastrointestinal inflammation.

Dehydration - Secondary to fluid losses from vomiting and diarrhea, confirmed by tacky MM on physical examination.

Gastrointestinal Disease - DDx: Inflammatory Bowel Disease, gastric ulceration, gastrointestinal neoplasia. While pancreatitis is the primary diagnosis, these differentials remain considerations, especially given the persistent and recurring nature of the clinical signs. Further investigation with an abdominal ultrasound would be warranted if signs do not resolve or if they recur.

**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 2 cm, are normal.

The left kidney is normal in size (4.51 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 hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (5.01 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 hydronephrosis. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal in size (0.43 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 (0.83 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.

**Spleen**

The spleen is normal in size (0.98 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 enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. 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 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.

**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 segmentally dilated with chyme. 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.

**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.

**Lymph nodes**

1-2 prominent mesenteric lymph nodes are visualized, one of the nodes measuring 0.81 x 0.33 cm.

**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 diffuse hepatic changes are most consistent with vacuolar hepatopathy (i.e., endocrine, idiopathic) with a lower possibility of inflammatory disease, infiltrative neoplasia, or other hepatopathy.

**Secondary Findings:**

- Mild bilateral nonspecific, age-related renal changes.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

\*An obvious cause for the patient's clinical signs is not definitively identified in this study. Considerations include a primary enteropathy (i.e., food allergy/intolerance, inflammatory bowel disease,



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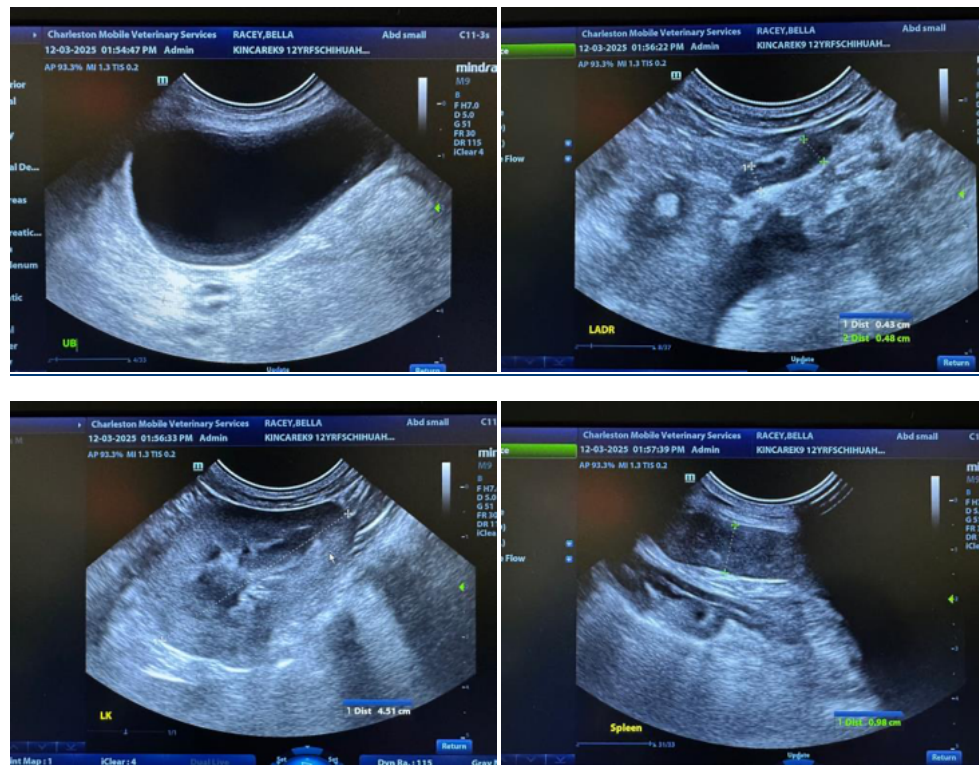
infectious/parasitic disease), underlying metabolic issue (i.e., chronic low-grade pancreatitis, hypoadrenocorticism), other.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The following diagnostics/treatment recommendations can be considered:

- Texas GI panel including serum cobalamin, folate, PLI, TLI and resting cortisol level
- Fecal evaluation for ova/Giardia
- Prophylactic deworming with Fenbendazole.
- 3-4 week hypoallergenic or hydrolyzed protein diet trial
- Initiation of a probiotic with a high colony count +/- fiber supplement (i.e., psyllium).

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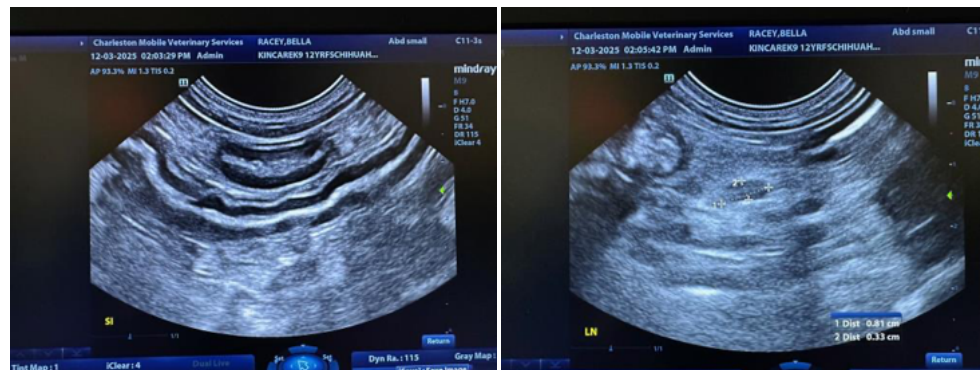
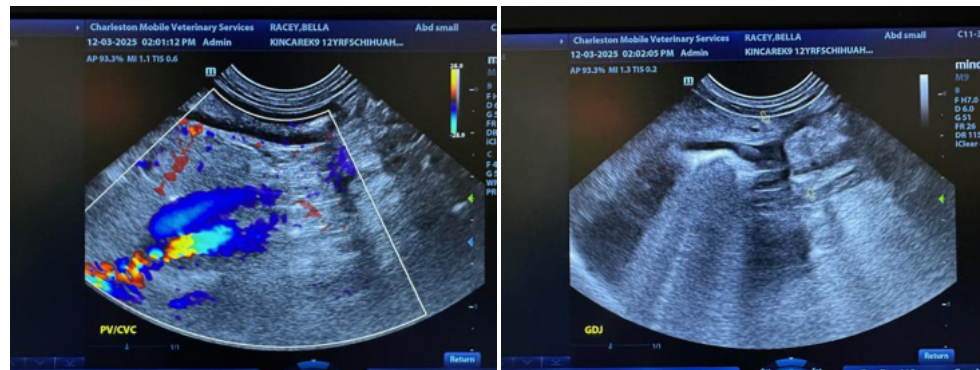
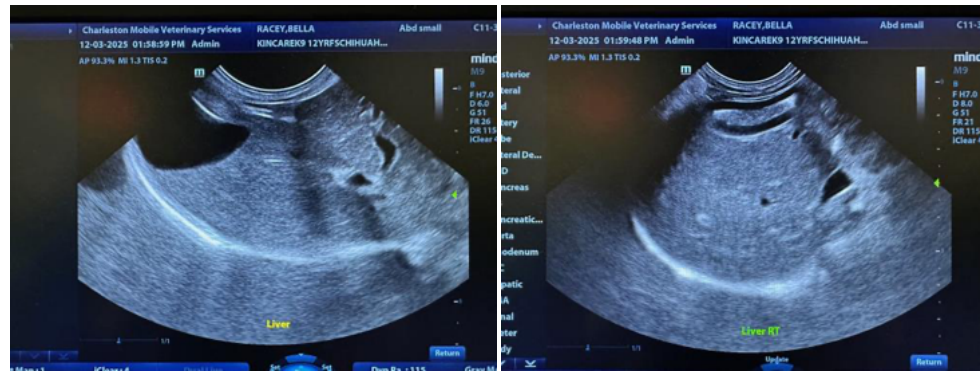
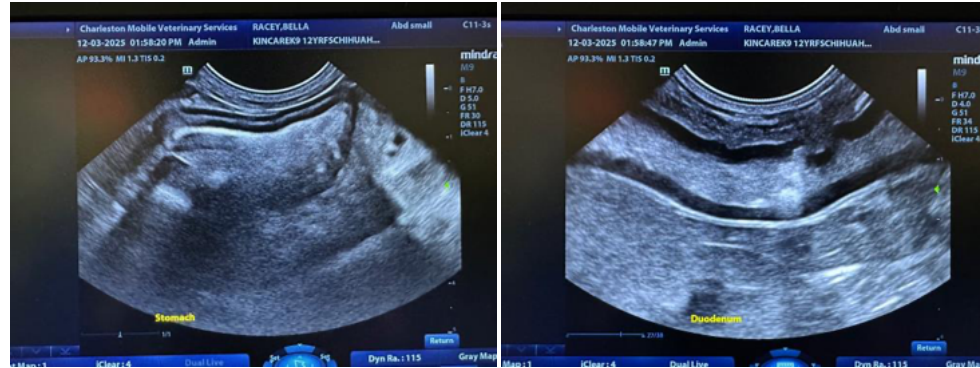
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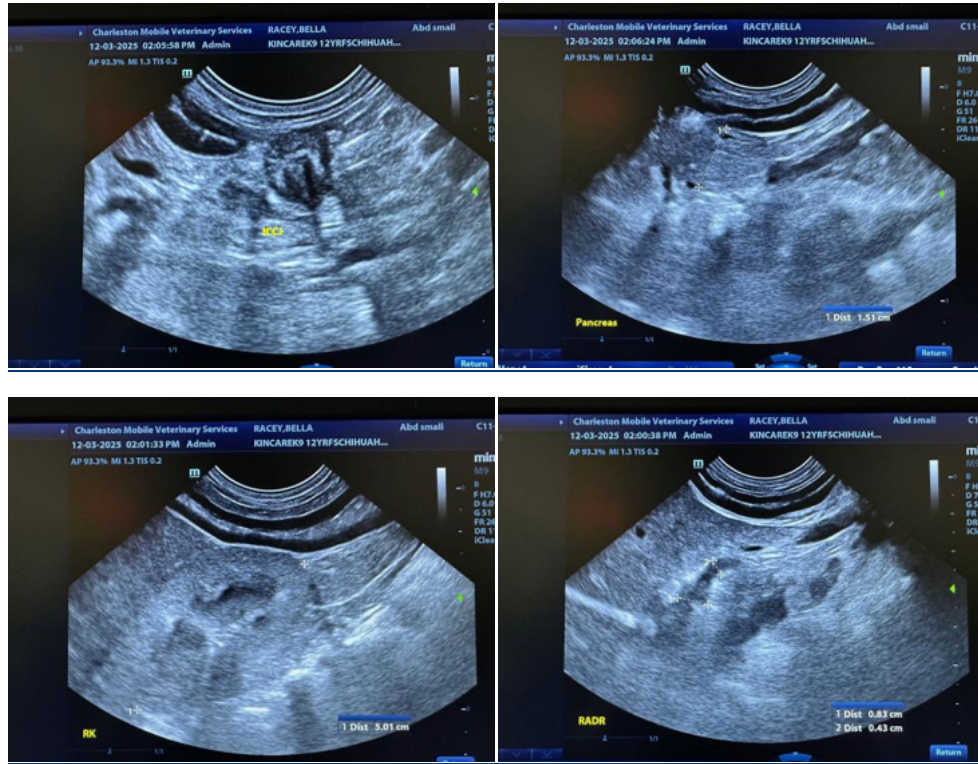
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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](mailto:info@SonoPath.com)