



PATIENT

Hailey Martin

SPECIES

Canine

BREED

Toy Poodle

SEX

Female, spayed

AGE

1/13/20

WEIGHT

15.6 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

Waterway

REFERRING VET

Dr. McCalla

INVOICE

13472

DATE

2/11/26

PRESENTING CLINICAL SIGNS

Health issues: Started Tuesday, vomited all her dinner and then 3-4 more times after that. Yesterday P woke O up and had diarrhea. Eating grass outside. Did not eat on Tuesday. Ate a small amount this morning but vomited it up. Vomited again yesterday morning and this morning 4x.

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 anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 3-4 cm, are normal.

The left kidney is normal in size (3.70 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal 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 (3.94 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal 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 normal in size (0.40 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 (0.48 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 (1.17 cm in width at the level of the hilus). A 1.6 x 1.2 cm hypoechoic to heterogeneous slightly expansile nodule is observed at the medial aspect. In the remainder of the spleen, the margins are curvilinear and the parenchyma is homogeneous. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The liver is subjectively normal in size with normal 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. A small polypoid like lesion is arising from the mucosal surface. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is not distended. 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



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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 right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and heterogeneous in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph nodes

The abdominal lymph nodes are normal/not visible.

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

- An obvious cause for the elevated liver enzymes is not identified in the study. However, a microscopic hepatopathy (i.e., bacterial cholangiohepatitis, Leptospirosis, chronic active hepatitis, copper-associated hepatotoxicity, infiltrative neoplasia (less likely)) is suspected.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The splenic nodule could be consistent with a benign lesion (i.e., focus of lymphoid hyperplasia or similar). Alternatively, an emerging tumor is possible.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Leptospirosis testing (i.e., blood and urine PCR, serology) can be considered particularly if clinical suspicion for disease is high.
- If an aggressive approach is desired, hepatic tissue sampling (i.e., aspirates or biopsies) can be considered assuming normal clotting status. If aspirates are pursued, heavy sedation would be necessary. If biopsies are pursued, aerobic and anaerobic bile cultures and hepatic copper quantitation should also be performed.
- If a conservative approach is desired, consider empirical treatment for bacterial cholangiohepatitis (amoxicillin-clavulanic acid, Denamarin). If no improvement in the liver values is seen within 7-10 days of initiating therapy, antibiotics should be discontinued, and hepatic tissue sampling reconsidered. If liver values improve, continue therapy for at least 4-6 weeks and 1 week beyond normalization of the liver values.
- Regarding the splenic nodule, consider the following:
 1. Fine needle aspiration assuming normal clotting status. A 25-gauge needle should be used. Sedation would be necessary for aspiration.
 2. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.



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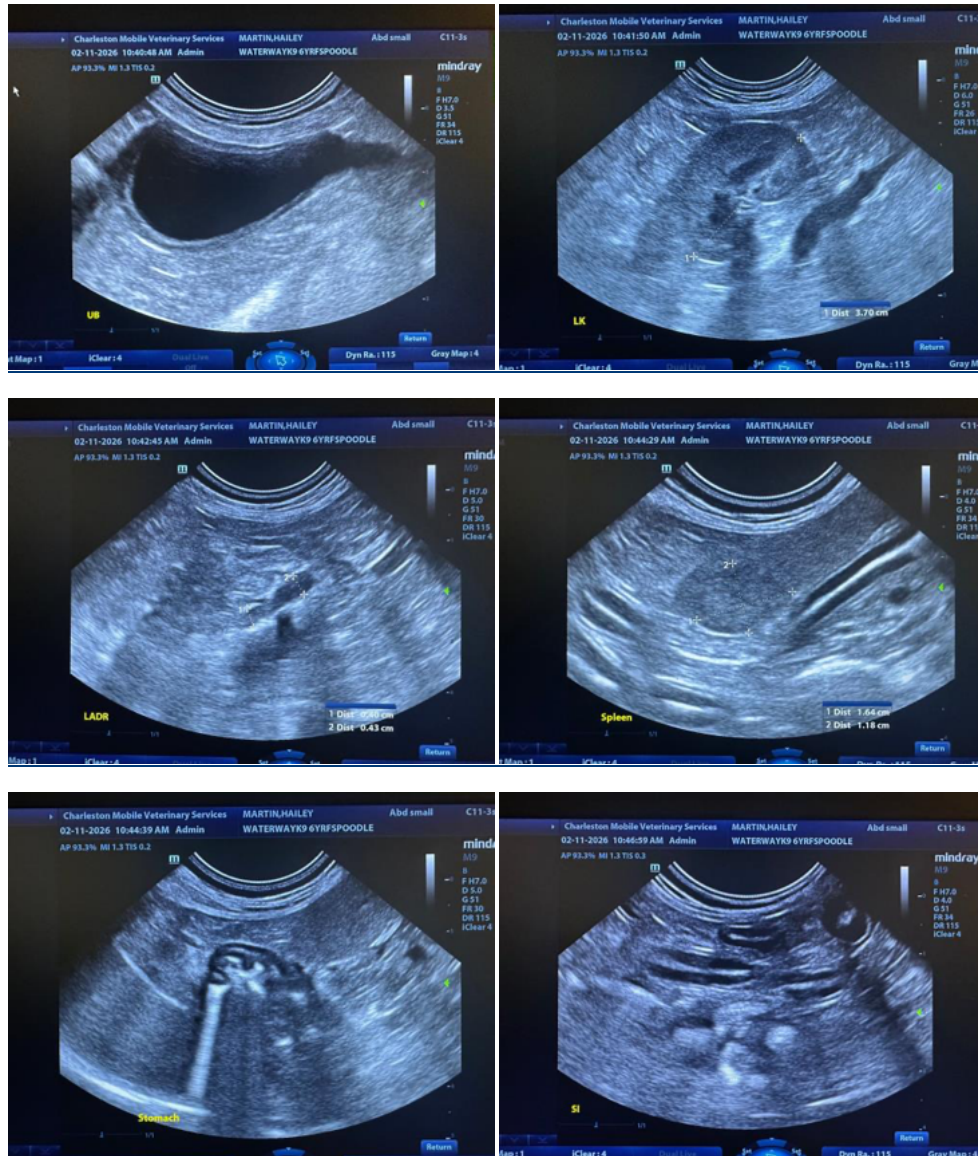
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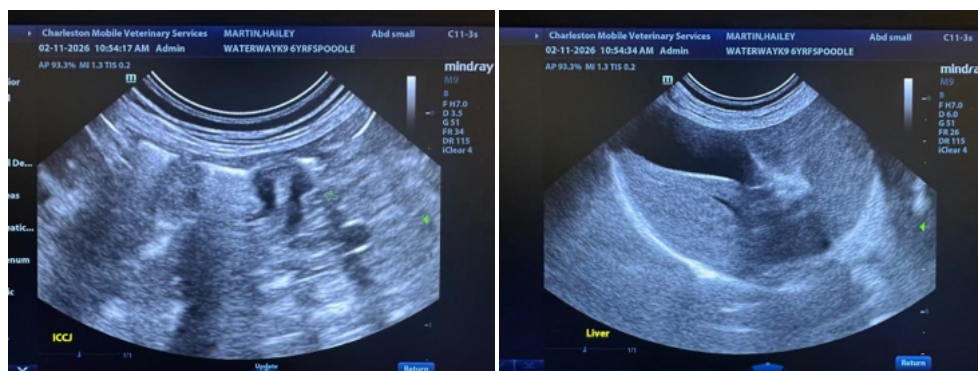
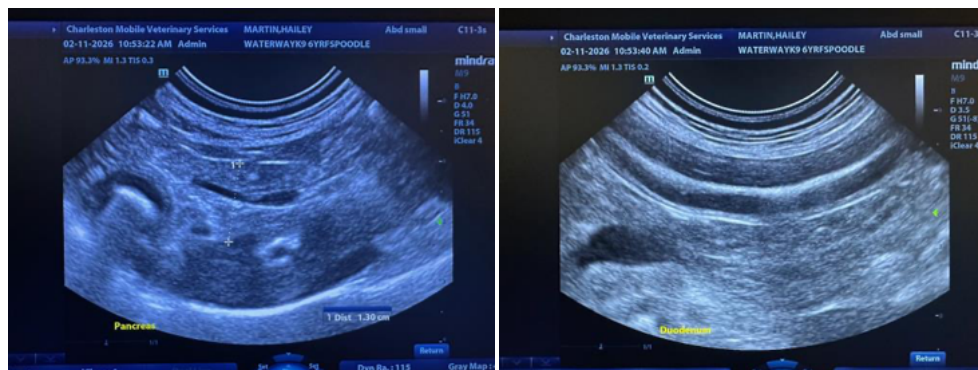
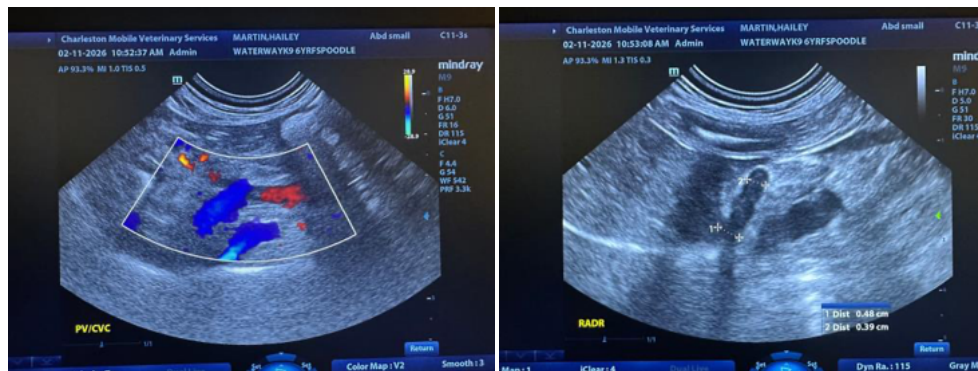
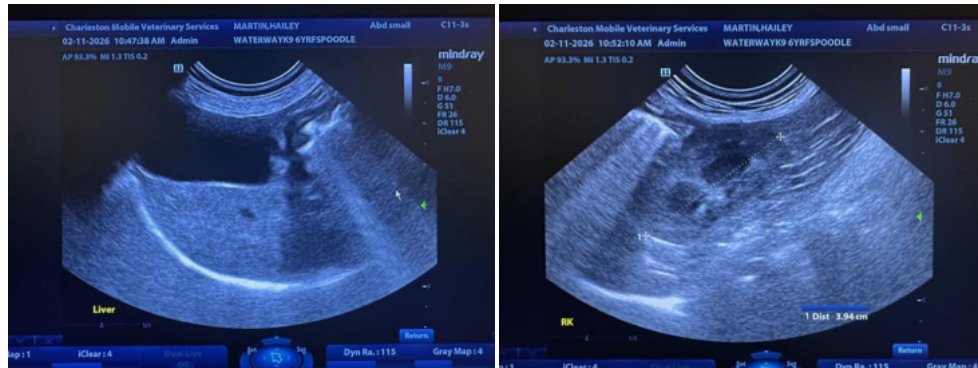
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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