



**PATIENT**

Puck Silvers

**SPECIES**

Canine

**BREED**

English Toy Spaniel

**SEX**

Male, neutered

**AGE**

8.5 Yrs.

**WEIGHT**

20.6 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**

Trinity Island

**REFERRING VET**

Dr. Oldham

**INVOICE**

13512

**DATE**

3/3/26

**PRESENTING CLINICAL SIGNS**

Pt has a couple week history of constipation. Recently had an injury that caused some hind limb weakness. Also had an increase in Lasix dose recently for his heart disease. Has a history of congestive heart failure, skin allergies, umbilical hernia. Has had 3 enemas in the last few days. Is currently on Miralax. Appetite has been poor.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is mildly distended. The wall is diffusely thickened (up to 0.45 cm) with a slightly irregular mucosal surface. Gravity-dependent mineralized sand +/- tiny calculi are observed within the lumen. The region of the trigone and the pre-prostatic urethra are normal.

The prostate is normal in size (1.17 cm in width) with smooth peripheral contours. The parenchyma is homogeneous. Mineralized sand is observed within the lumen. There is no overt dilation of the prostatic urethra.

The left kidney is normal in size (4.92 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Moderate pyelectasia is present (0.54 cm in the longitudinal plane). Non-obstructive mineralized foci are visualized. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (RkAN cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal 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 (0.47 cm at cranial pole) (0.46 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 (0.70 cm at cranial pole) (0.52 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 (1.03 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 portal vein to caudal vena cava ratio is approximately 1:1.



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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**

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 majority of the small intestinal wall is normal in thickness with a normal layering pattern. There is evidence of mucosal speckling in some segments. In one segment of jejunum in the mid-abdominal region, the serosal layer appears slightly irregular. The mesentery effacing the serosal surface in this region is hyperechoic. The ileocecolic junction is normal. The wall of the ascending and transverse colon is normal. The wall of the descending colon is borderline thickened (up to 0.29 cm) with retention of the normal layering pattern. Within the lumen of the descending colon, some fluid and echogenic debris is observed. No distinct fecal balls are appreciated. There is no obvious evidence of an obstructive pattern.

**Pancreas**

The right limb of the pancreas is prominent in size with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is not overtly dilated. Surrounding mesentery is hyperechoic.

**Lymph nodes**

A few prominent lymph nodes are observed in the cranial to mid-abdomen, one of the nodes measuring 1.18 x 0.49 cm.

**Free Abdomen**

The mesentery in the cranial to mid-abdomen is variably hyperechoic. Trace free fluid is observed.

**Other**

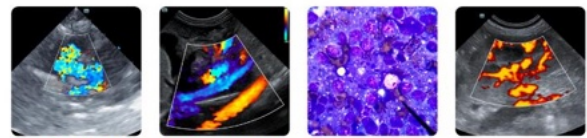
A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings:**

- The pancreatic changes in the right limb are most consistent with mild, acute or chronic active pancreatitis with parenchymal remodeling. It is unclear whether the pancreatitis is a primary issue or if it is secondary to colonic wall inflammation.
- Cranial to mid-abdominal peritonitis, the cause of which is unclear, may be secondary to pancreatic and/or bowel inflammation, other.
- The descending colonic wall changes are suggestive of colitis. There is no obvious evidence of constipation or obstipation at this time.
- The focal segment of jejunum with a disruption in the serosal layer is suggestive of enteritis with a lower possibility of emerging neoplasia. The small intestinal mucosal speckling could be consistent with enteritis or may be a normal variant for this patient.

**Secondary Findings:**



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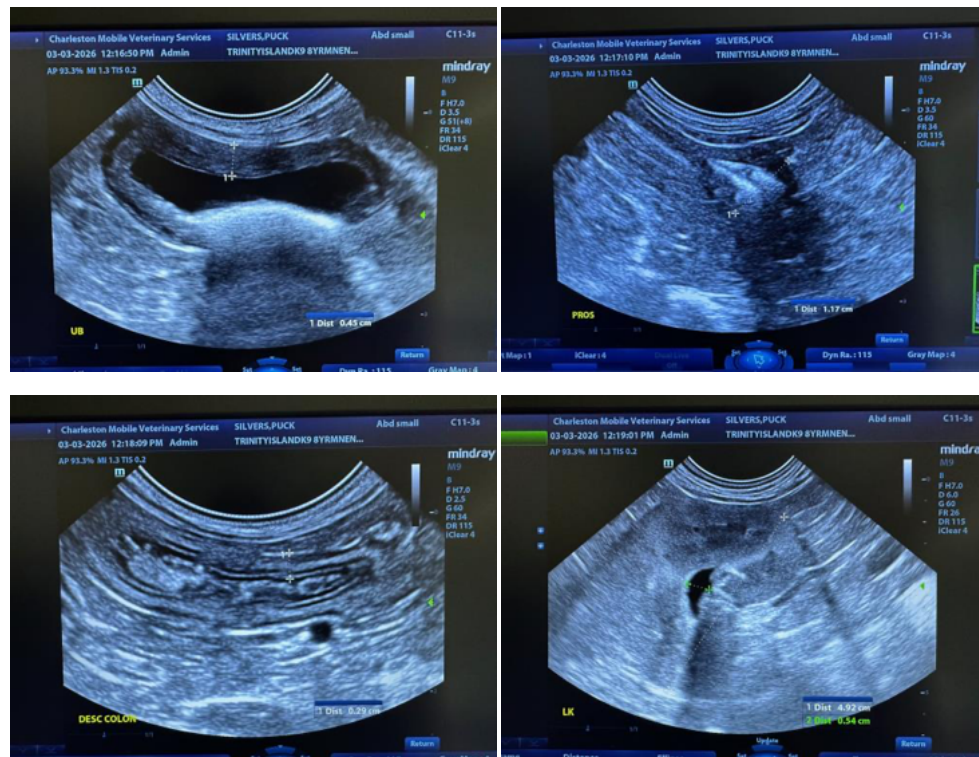
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- Bilateral, nonspecific, age-related renal changes with non-obstructive nephrolithiasis and pyelectasia. The pyelectasia may be secondary to parenchymal remodeling, pyelonephritis, PU/PD (if applicable) or some combination thereof.
- Urinary bladder and prostatic urethral sand +/- tiny calculi. The bladder wall changes could be consistent with cystitis or may be artifactual due to lack of full repletion.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

\* The cause of the patient's constipation is unclear. It may be multi-factorial in nature. A hind-end injury could have caused the patient to be reluctant to posture for bowel movements resulting in some degree of constipation. This, in combination with an increase in the furosemide dose, may have resulted in dehydration, further exacerbating reduced colonic motility. However, other causes (i.e., primary bowel disease) should also be considered.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Supportive care for pancreatitis and peritonitis is recommended along with stool softeners as needed. If clinical signs persist despite medical management, further workup may be indicated.





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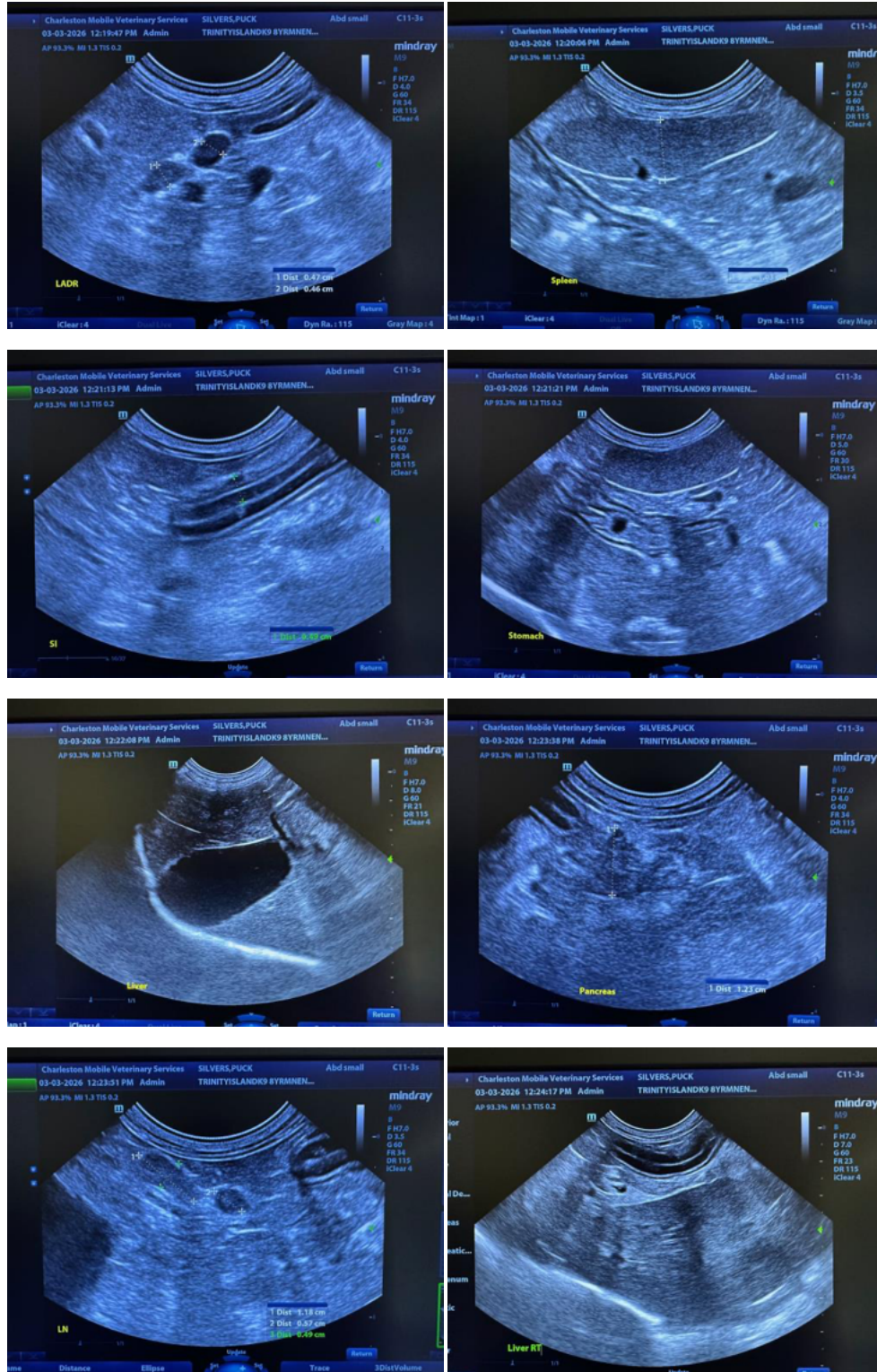
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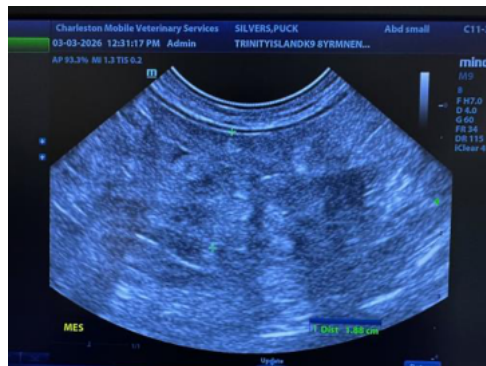
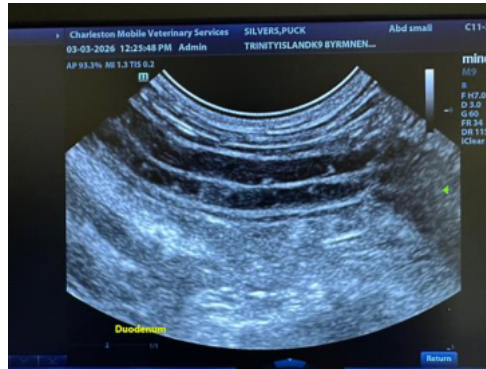
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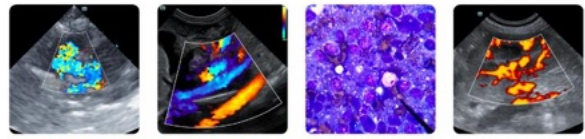
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)  
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