



**PATIENT**

Wally Alberici

**SPECIES**

Canine

**BREED**

Hound mix

**SEX**

Male, neutered

**AGE**

1/12/16

**WEIGHT**

51 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**

13582

**DATE**

3/4/26

**PRESENTING CLINICAL SIGNS**

Pt presented with chronic vomiting, potential black/blood specks per owner

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (1.01 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 (5.96 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 (6.13 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 normal in size (0.59 cm at cranial pole) (0.69 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 (1.01 cm at cranial pole) (0.65 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 (1.85 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. A 1.62 x 0.84 cm hypoechoic to heterogeneous nodule is observed at the medial aspect approximately mid-body. A 0.91 cm hyperechoic nodule is observed at the mid to caudal aspect. 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.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of aggregated, echogenic, gravity-dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

**Gastrointestinal**



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The gastric lumen is mildly distended with slightly echogenic fluid. The gastric wall in the region of the cardia is mildly thickened (up to 1.12 cm) with apparent retention of the normal layering pattern. The remaining gastric wall is normal to borderline thickened (up to 0.55 cm) with retention of the 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**

A few prominent mesenteric lymph nodes are visualized, one of the nodes measuring 2.42 x 0.64 cm.

**Free Abdomen**

There is no obvious evidence of free fluid.

**Other**

In the right cranial quadrant, a 1.6 x 1.0 cm cystic structure is observed.

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

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings:**

- Variable gastric wall thickening with fluid retention. Considerations include gastritis vs emerging neoplasia vs other.
- The hypoechoic splenic nodule could be consistent with a benign lesion (i.e., focus of lymphoid hyperplasia or similar). Alternatively, an emerging tumor cannot be excluded. The hyperechoic splenic nodule likely represents a benign meylolipoma. The diffuse 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).

**Secondary Findings:**

- Mild bilateral nonspecific, age-related renal changes
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The origin of the cystic structure in the right cranial quadrant is unclear. It may be arising from pancreas, liver, mesentery, other. It likely represents a benign incidental finding with a lower possibility of an emerging cystic tumor, other.



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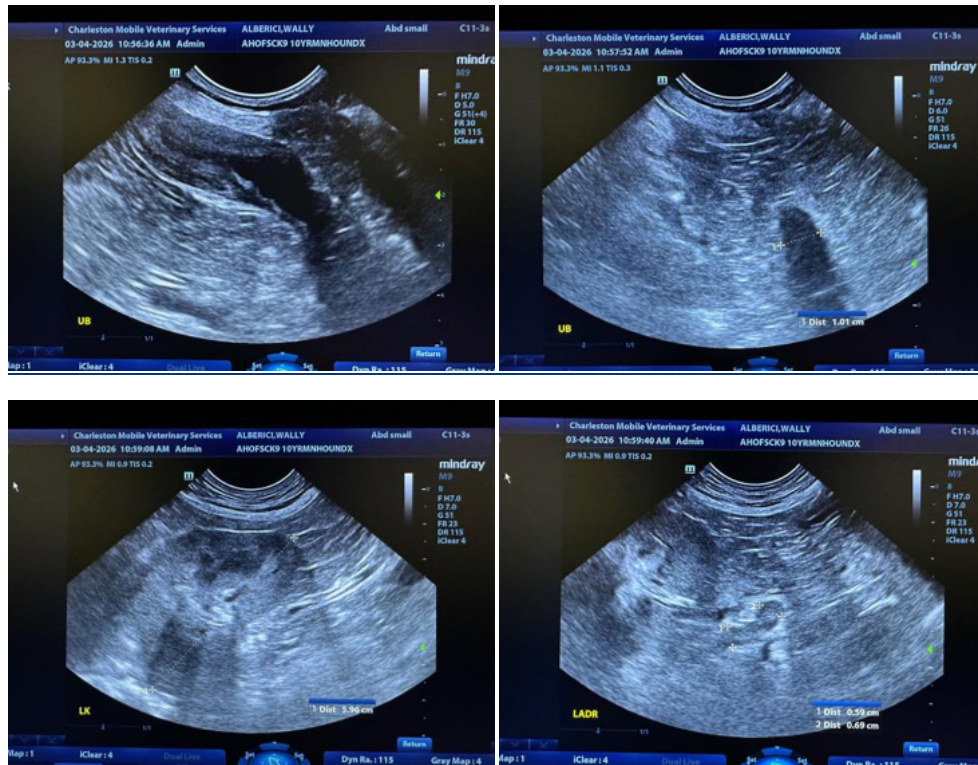
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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
- Given the patient's clinical history of possible hematemesis, an upper GI endoscopy with biopsies may be warranted. Three-view thoracic radiographs are recommended prior to any anesthetic event. If endoscopy is not pursued at this time, consider empirical treatment for gastritis/gastric ulceration. If clinical signs do not improve with medical management, endoscopy should be revisited.
- Regarding the splenic nodule, consider the following:
  1. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
  2. Recheck ultrasound in 1-2 months to assess for growth. The lesion is likely too deep for safe aspiration.





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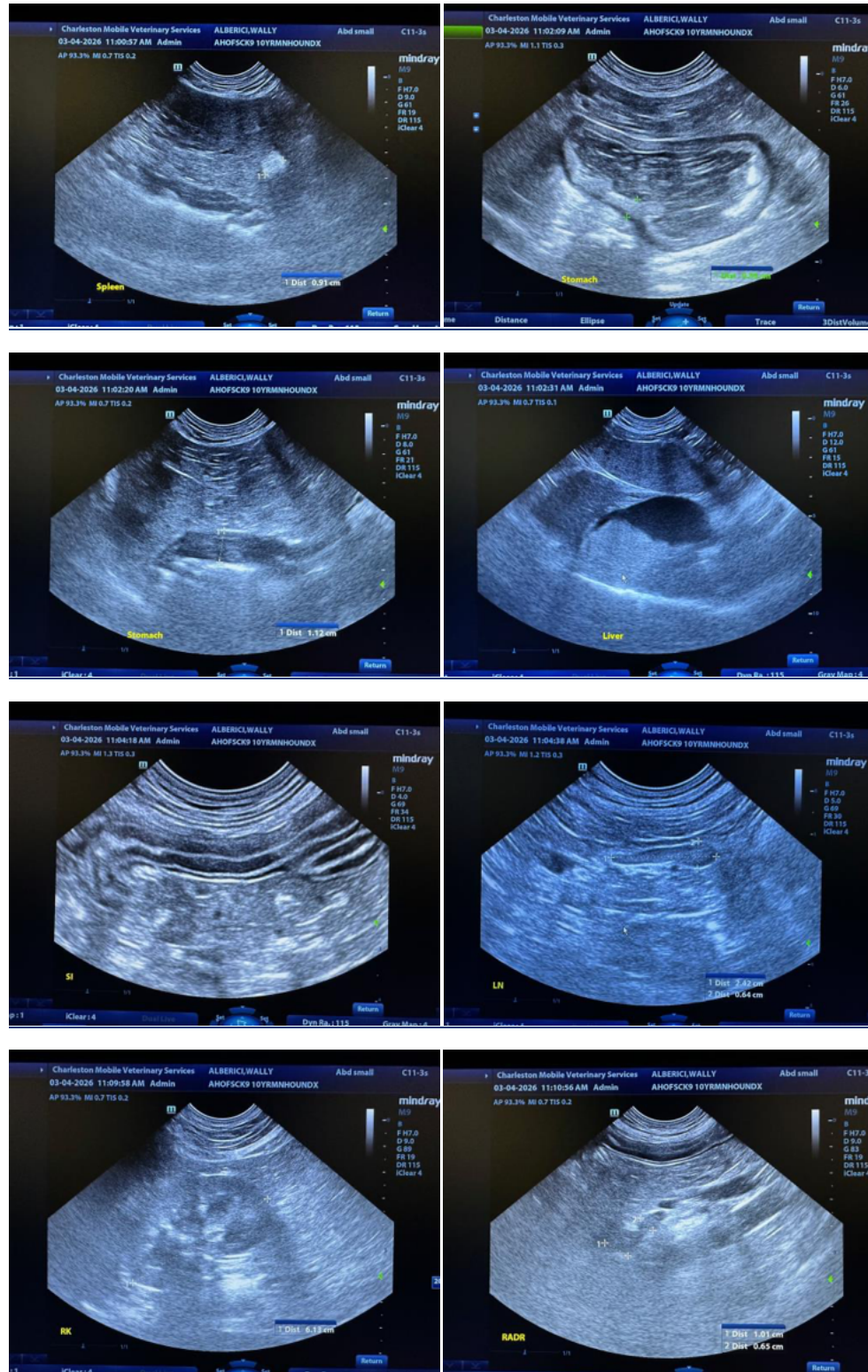
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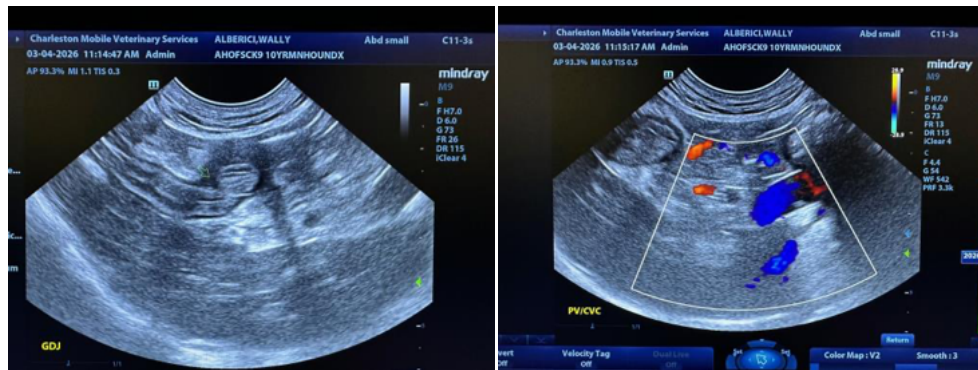
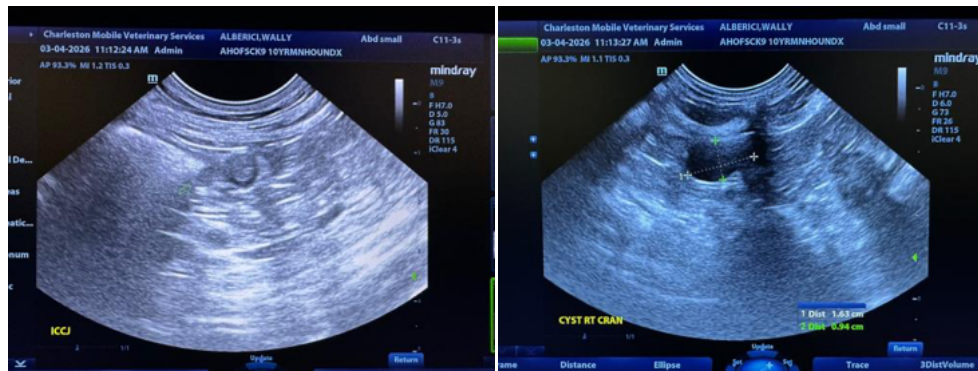
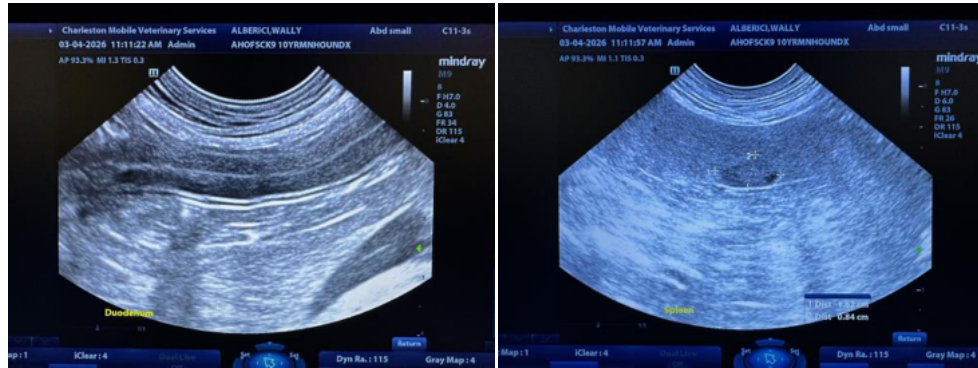
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)