

PATIENT

Ollie Stocks

SPECIES

Canine

BREED

Shih Tzu

SEX

Male, neutered

AGE

8/7/2012

WEIGHT

17.6 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

Ashley Pines AH

REFERRING VET

Dr. Winney

INVOICE

13685

DATE

4/28/26

PRESENTING CLINICAL SIGNS

Chronic skin issues
 hx of elevated alk phos
 intermittent anemia
 hypertension - controlled with Enalapril
 recent 2-3 month history of diarrhea and decreased appetite

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall in the region of the apex is moderately thickened (up to 0.48 cm) with an irregular mucosal surface. The wall tapers to a normal thickness as it extends toward the cystourethral junction. At least 2 cystic calculi are observed, the largest measuring 0.50 cm in diameter. The region of the trigone and the proximal urethra, visible to a depth of 3.5-4 cm, are normal.

The prostate is normal in size (0.65 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 (4.20 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Mild pyelectasia is present (0.23 cm in the transverse plane). There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.48 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.72 cm at cranial pole) (0.59 cm at caudal pole) with a relatively normal shape. The parenchyma at the cranial pole is mildly heterogeneous with some loss of glandular detail. The glandular echogenicity and detail at the caudal pole are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is enlarged (1.39 cm at cranial pole) (0.69 cm at caudal pole) with swollen peripheral contours. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.96 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.97 x 0.62 cm ill-defined hypoechoic nodule is observed at the medial aspect near the hilus. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly heterogeneous in appearance. A 1.5 x 1.2 cm ill-defined hyperechoic to slightly heterogeneous nodule is observed left to mid-liver. 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 gall bladder lumen is moderately distended. The wall is thin and smooth. A scant amount of echogenic debris along with at least 1-2 small non-obstructive choleliths are observed within the lumen. The cystic and common bile ducts are normal/not seen. The duodenal papilla is normal in size (0.23 cm in width).

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 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. The colonic lumen contains shadowing fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas

The base and limbs of the pancreas are 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

A 1.87 x 0.37 cm medial iliac lymph node is visualized.

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 diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease, infiltrative neoplasia and other hepatopathies are considered less likely. The hyperechoic hepatic nodule trends toward the benign (i.e., regenerative nodule, meylolipoma) with a lower possibility of a more insidious hepatic pathology.
- Small non-obstructive choleliths
- Mild bilateral adrenomegaly
- Cystic calculi. The urinary bladder wall changes in the region of the apex are most consistent with cystitis.
- The splenic nodule could be consistent with a benign focus (i.e., lymphoid hyperplasia or similar). Alternatively, an emerging tumor (i.e., sarcoma, round cell tumor) is possible.

Secondary Findings:

- Bilateral nonspecific, age-related renal changes with dystrophic mineralization
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.



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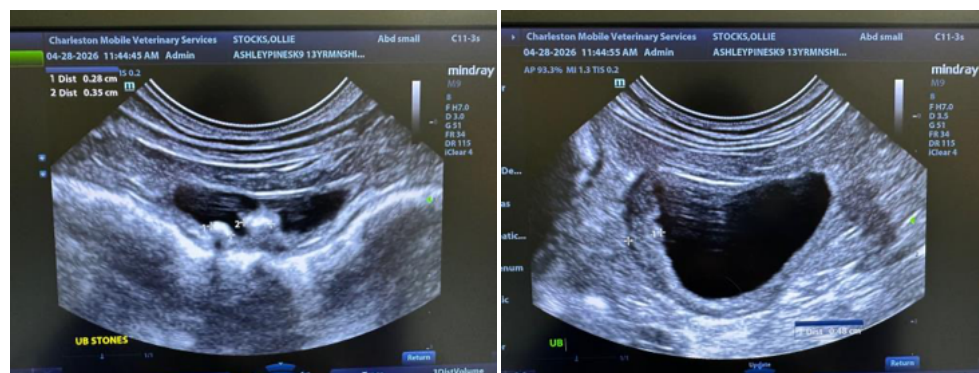
4/28/26

- The prominent medial iliac lymph node is most likely reactive with a low possibility of emerging neoplasia.

*An obvious cause for the patient's diarrhea and inappetence is not identified in this study. Considerations include a microscopic enteropathy (i.e., food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease), underlying metabolic issue, other. r

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the GI Issues, consider the following:
 - 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.
- Regarding the cystic calculi, consider a cystotomy with stone removal, analysis and culture. Alternatively, an attempt at medical dissolution can be considered.
- Regarding the splenic nodule, fine needle aspiration can be considered assuming normal clotting status. A 25-gauge needle should be used. If tissue sampling is not pursued at this time, consider a recheck ultrasound in 2-3 months to assess for growth of the lesion.
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.





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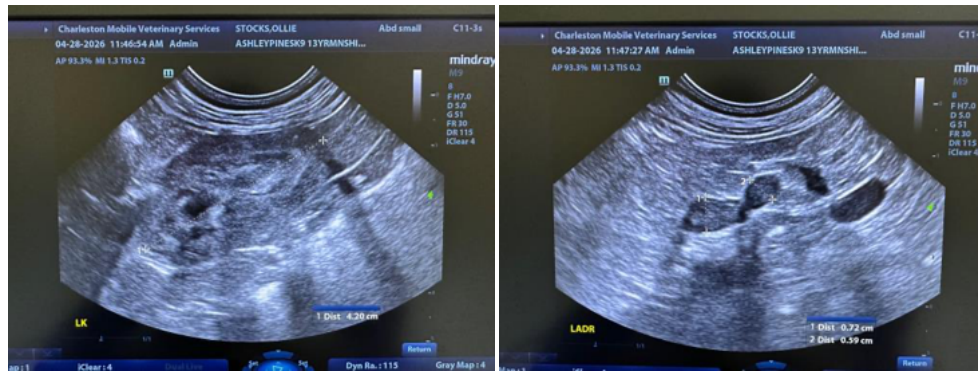
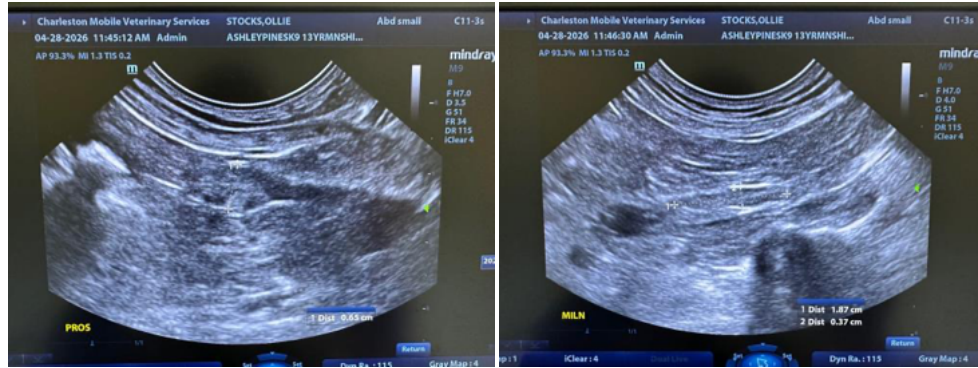
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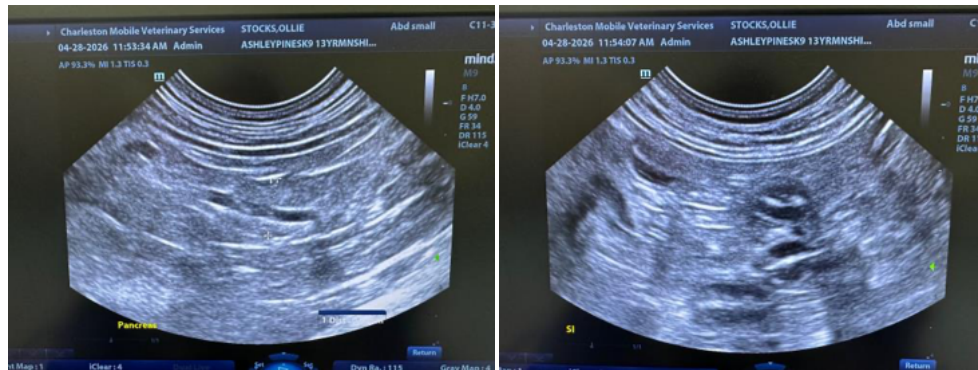
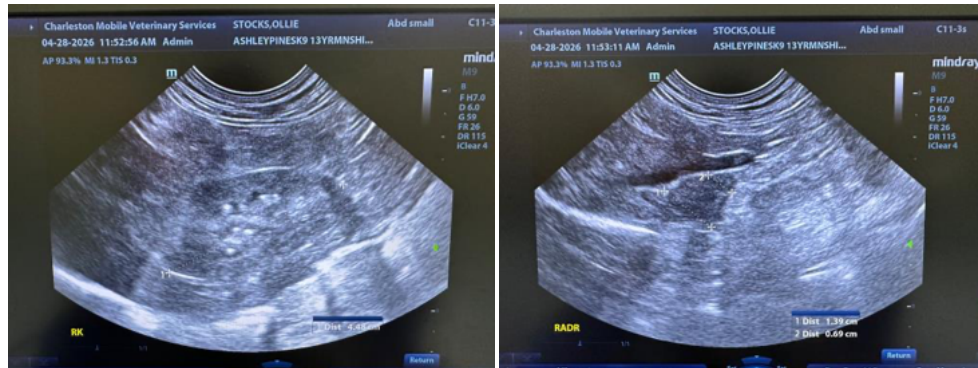
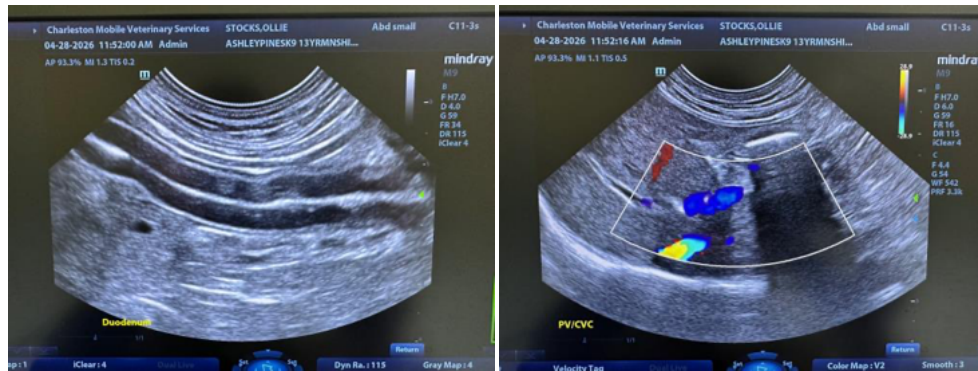
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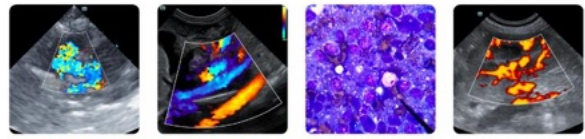
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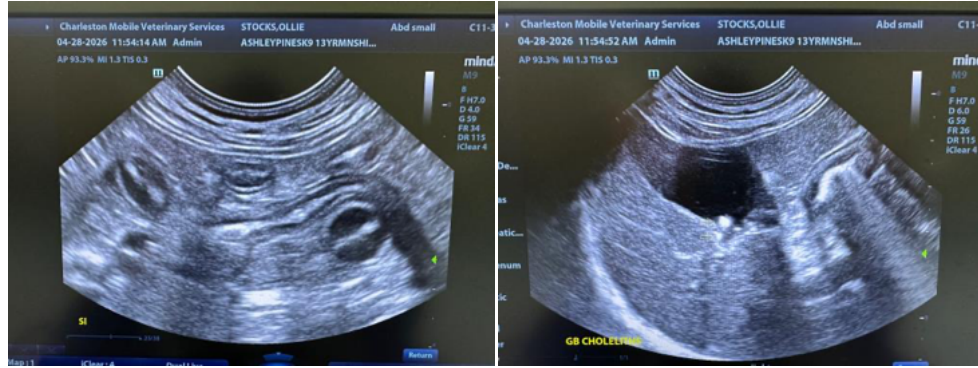
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com