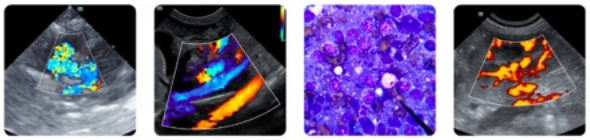


PATIENT

Otis McCall

SPECIES

Canine

BREED

Shepherd Cross

SEX

Neutered male

AGE

12 years

WEIGHT

51.4 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Kristi Whitten

HOSPITAL NAME

North Fork VC

REFERRING VET

Dr. Marrs

INVOICE

72132

DATE

3/2/26

PRESENTING CLINICAL SIGNS

- History: Pt has hx of elevated ALP and minimally elevated ALT since 1/2025. Pt currently taking Denamarin. Pt came in for exam on 2/23 for acting anxious at night. Brief u/s showed hepatic mass and small hyperechoic splenic nodule; rec AUS for further evaluation of extent of hepatic mass, see if can be surgically resectable, etc.
- Jan 25: ALT 177, ALP 851; 4/25: ALT 138, ALP 1,161; 5/25: ALT wnl at 107, ALP 1,408; 6/25: ALT 133, ALP 1,387; 2/26: ALT 74, ALP 592. Pt is diabetic; well controlled on current dose of insulin.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The wall is thin and smooth. The urine is anechoic. The bladder neck and proximal urethra have a normal ultrasonographic appearance. No uroliths or sonographic evidence of inflammatory or neoplastic changes are identified.

Left kidney: 5.38×3.46 cm. Cortical thickness 0.58 cm (sagittal plane). The cortex is isoechoic relative to the liver. Corticomedullary ratio and corticomedullary definition are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern. Renal length and cortical thickness are within expected limits for a dog of this size.

Right kidney: 3.36×3.00 cm. Cortical thickness 0.48 cm (sagittal plane). The cortex is hyperechoic relative to the liver parenchyma. Corticomedullary ratio and definition are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern. The recorded renal length is subjectively shorter than the contralateral kidney; correlation with image plane and measurement orientation is recommended, as this may reflect technical foreshortening.

Adrenal Glands

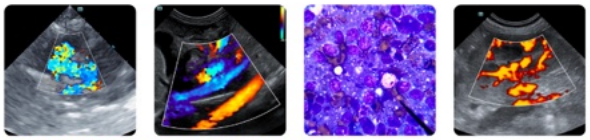
Left adrenal gland measures 0.94 cm (cranial pole) and 0.95 cm (caudal pole) in dorsoventral dimension. These measurements exceed the commonly accepted upper reference limit (~0.74 cm caudal pole) for a dog of this body weight and are therefore enlarged.

The right adrenal gland was not visualized.

Spleen

Splenic thickness measures 2.97 cm, within expected limits for a dog of this size. The parenchyma is homogeneous with fine echotexture and contains a few small focal hyperechoic nodules. The splenic capsule is smooth and regular. Splenic vasculature appears normal.

Liver



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The majority of the liver is subjectively normal in size, with sharp margins and regular contour. The hepatic parenchyma is homogeneous and isoechoic relative to the falciform fat. Within what appears to be the left medial liver lobe, there is a cavitary mass with irregular margins that distorts the hepatic capsule. No additional nodules or masses are identified in the other recorded hepatic lobes.

The gallbladder is moderately distended. The wall is thickened with apparent mucosal glandular hyperplasia. The lumen contains a significant amount of biliary sludge. The appearance is consistent with an early or developing gallbladder mucocele. No common bile duct dilation is identified.

Gastrointestinal

The stomach is semi-empty with minimal ingesta. Gastric wall thickness measures 2.61 mm with preserved layering.

Duodenum: 3.36 mm.
Jejunum: 3.99 mm with preserved wall layering.

Measurements are within accepted canine reference ranges. No evidence of obstruction, ileus, mural loss of layering, or focal intestinal masses is identified.

Colon: 1.93 mm in the descending segment with formed feces; within normal limits.

Pancreas

The evaluated portions of the pancreas show no sonographic evidence of inflammation or focal mass lesion.

Peritoneal Cavity

No abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation appears normal.

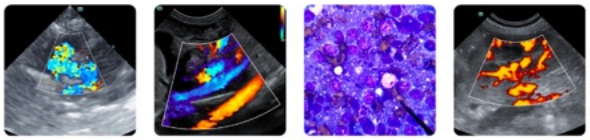
ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Solitary cavitary mass in the presumed left medial liver lobe with irregular margins and capsular distortion
- Left adrenal gland enlargement.
- Gallbladder mural thickening with mucosal glandular hyperplasia and significant sludge, consistent with developing mucocele

SECONDARY FINDINGS

- Incidental small splenic hyperechoic nodules (consistent with myelolipomas or Bates bodies).



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The solitary cavitary hepatic mass appears confined to a single hepatic lobe, presumed to be the left medial lobe, without sonographic evidence of extension into adjacent lobes. It measures at least 6 cm and causes capsular distortion. There is no clear evidence of additional hepatic nodules, lymphadenopathy, or abdominal metastasis. Overall, the findings are most consistent with a primary hepatic neoplasm. The most likely differentials include massive hepatocellular carcinoma and intrahepatic cholangiocarcinoma. Based on the lesion's solitary nature, apparent left lobar location, expansile ultrasonographic appearance, and absence of detectable metastatic disease, massive hepatocellular carcinoma is considered more likely. If confirmed, the massive form of hepatocellular carcinoma is often amenable to surgical resection, and complete excision may be associated with a favorable prognosis in appropriately selected cases. However, detailed vascular assessment (including Doppler evaluation of portal and hepatic venous involvement) was not performed, and definitive assessment of surgical resectability cannot be determined based on the current study alone.

The left adrenal gland is symmetrically enlarged exceeding accepted reference limits for this body weight. In a diabetic patient with persistently elevated ALP, adrenal-dependent hyperadrenocorticism is a significant differential. However, the non-visualization of the right adrenal gland limits complete assessment. Endocrine testing is required for functional characterization.

The gallbladder demonstrates mural thickening with mucosal glandular hyperplasia and significant sludge accumulation, consistent with a developing mucocele. There is no evidence of biliary obstruction at this time. In a diabetic patient, altered lipid metabolism and gallbladder dysmotility likely contribute.

There is no ultrasonographic evidence of metastatic disease within the imaged abdomen, no abdominal effusion, and no significant lymphadenopathy. The small splenic hyperechoic nodules are most consistent with incidental myelolipomas.

Recommendations

- Consider full staging for the hepatic mass, including thoracic imaging and surgical consultation to assess resectability. Dedicated vascular evaluation with Doppler ultrasound is recommended, although a contrast-enhanced CT would be preferable for comprehensive pre-surgical planning.
- Recommend endocrine testing to evaluate hyperadrenocorticism given adrenal enlargement and biochemical history.
- Monitor or medically manage the developing gallbladder mucocele as clinically indicated.
- Given the cavitary nature of the lesion and the potential for non-diagnostic sampling or hemorrhagic complications, pre-surgical biopsy may not alter management if the mass is considered resectable. Coagulation testing is recommended prior to any invasive procedure. Final decisions should be made in conjunction with the surgical team.
- Final diagnostic and therapeutic decisions remain at the discretion of the attending clinician based on overall clinical assessment.

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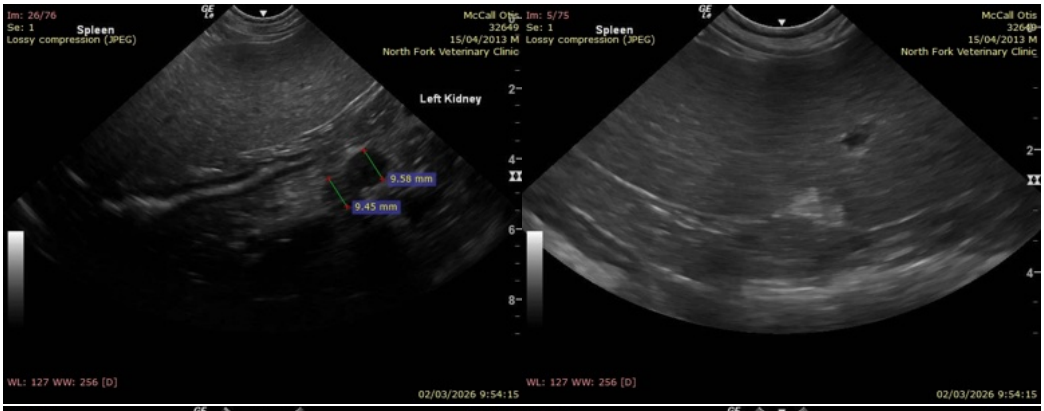

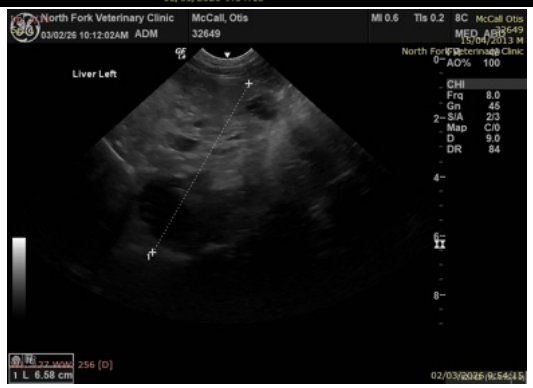

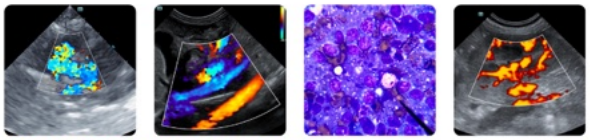

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

info@SonoPath.com