



PATIENT

Rhett Bartku

SPECIES

Canine

BREED

Labrador

SEX

Neutered Male

AGE

68.5 lbs

WEIGHT

11 years

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

Southside AH

REFERRING VET

Dr. Forcier

INVOICE

11795

DATE

10.10.22

PRESENTING CLINICAL SIGNS

History of Cushing's Disease. On Trilostane. Recently down in the hind end. Had a Stim which showed a Pre of 2.5. Post 8.3. Has had a recent spike in liver values. ALP 2716. ALT 128. In June, ALP was 1705; ALT 118. CBC unremarkable. T4 normal. 4Dx negative.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The **prostate** is normal in size (0.84 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The **left kidney** is normal size (7.25 cm in length); normal shape and architecture with 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 size (7.18 cm in length); normal shape and architecture with 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 mildly enlarged (0.85 cm at cranial pole) (1.04 cm at caudal pole); normal shape; 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 mildly enlarged (0.84 cm at cranial pole) (0.93 cm at caudal pole) (3.86 cm in length); normal shape; 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 (1.80 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 enlarged with irregular peripheral contours. A >10.00 cm area of coalescing, heterogenous masses is observed at the caudal aspect. In the remainder of the liver, the parenchyma is homogenous. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The **gall bladder** lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The **stomach and intestine** are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering



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pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains shadowing fecal material. There is no evidence of an obstructive pattern.

Pancreas

A portion of the **pancreas** is obscured by the large hepatic mass. In the visualized portion of the right limb, the pancreas appears normal to slightly prominent in size with normal curvilinear peripheral contours. The parenchyma is hyperechoic relative to surrounding omental fat and slightly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

The **peritoneal cavity** is normal. There is no evidence of inflammation or effusion. The abdominal **lymph nodes** are normal/not visible.

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Coalescing masses at the caudal aspect of the liver. Neoplasia (i.e., adenoma, adenocarcinoma, round cell tumor) is considered likely, with a lower possibility of a benign process (i.e., inflammatory).

Secondary Findings

- Mild bilateral adrenomegaly, consistent with the previous diagnostics of pituitary-dependent hyperadrenocorticism.
- Mild bilateral chronic, age-related renal changes
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three-view thoracic radiographs are recommended to assess for pulmonary metastases.

If an aggressive approach is desired, consider referral to a board-certified surgeon to discuss mass removal or debulking. An abdominal CT scan would be useful in presurgical planning. If surgery is not pursued, palliative/symptomatic care is recommended.

A fine-needle aspirate of the hepatic mass can be considered prior to surgery if clotting status is appropriate. However, if results are inconclusive, surgical biopsies may be necessary to get a definitive diagnosis.



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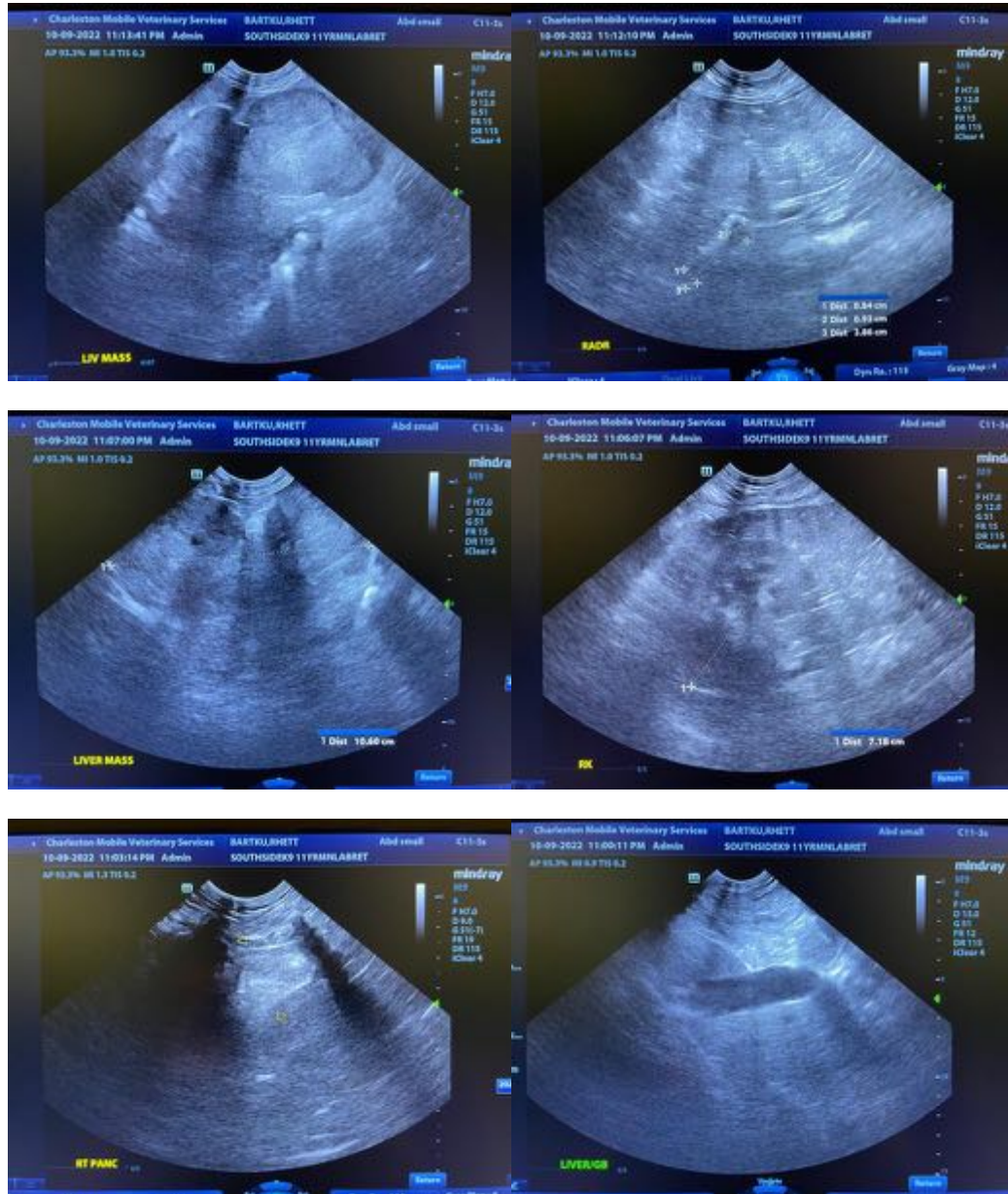
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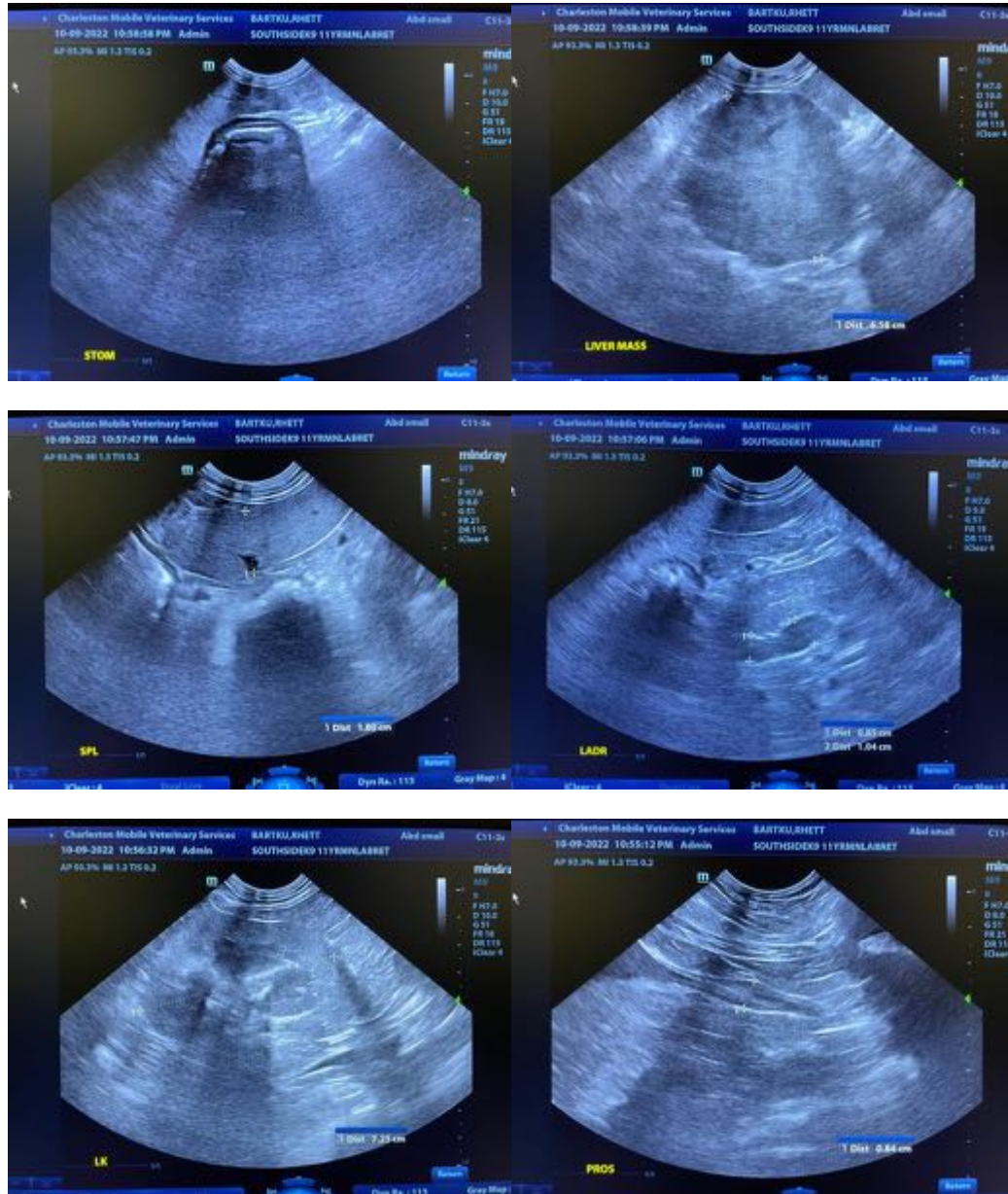
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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