

**PATIENT**

Alvin Coles

**SPECIES**

Canine

**BREED**

Terrier Mix

**SEX**

Neutered Male

**AGE**

4/14/2012

**WEIGHT**

21.7 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**

West Ashley VC

**REFERRING VET**

Dr. Lauren Tierney

**INVOICE**

12002

**DATE**

11.11.22

**PRESENTING CLINICAL SIGNS**

Clinical Exam Findings: Presented November 10, 2022 for a routine dental cleaning. At intake owner notes strange episode that began around 9:00 last night. Owner notes he was totally normal yesterday and then around 9 PM he was unable to stand both rear and forelegs after several minutes he was able to get up owner felt like he was seizure activity however their description does not necessarily fit neurologic event. Remained conscious no rigidity no history of seizure. Currently on Vetryl 10 mg twice daily.

Physical exam was nonremarkable with exception of slightly hunched in lumbar area and large baseball size mass at right inguinal area. Heart and lungs within normal limits. CBC normal profile elevated ALT at 142 and alk phos at 1455. PLI normal. 3 view abdominal radiographs large abnormal shape liver lobes with cranial ground glass appearance. Recommend abdominal ultrasound and consult as I am unable to determine cause of episode and wanted it worked up prior to anesthesia. There is no obvious evidence of metastatic disease in the chest.

Current Medications: Vetoryl 10 mg BID

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder 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 (0.59 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 (4.48 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (4.75 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is mildly enlarged (0.54 cm at cranial pole) (0.63 cm at caudal pole) (1.38 cm in length) with a slightly irregular shape. The parenchyma is mildly hypoechoic with subtle loss of glandular detail. No focal lesions are observed. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is mildly enlarged (0.69 cm at cranial pole) (0.69 cm at caudal pole) (2.52 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 (0.91 cm in width at the level of the hilus) with a normal capsular



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contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

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**Liver**

The liver is subjectively prominent in size. The margins at the caudal process are irregular. The remaining margins are curvilinear. The parenchyma is hype relative to the spleen with minor changes consistent with age-related remodeling. In the region of the caudal process, an approximately 2.53 cm irregular, heterogenous, slightly cavitated mass is visualized. The lesion causes capsular expansion. Hepatic vasculature and intrahepatic 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. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

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**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 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. There is no evidence of an obstructive pattern.

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**Pancreas**

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic 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.

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**Free Abdomen**

A focal area of enflamed mesentery is observed in the left cranial quadrant, adjacent to the left lateral lobe of the liver. A small amount of free fluid is present. The abdominal lymph nodes are normal/not visible.

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**Other**

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

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- Liver mass at the caudate process. Neoplasia (i.e., hemangiosarcoma, adenocarcinoma, adenoma, round cell tumor) is considered likely with a lower possibility of a benign process. The diffuse hepatic parenchymal changes are nonspecific and are likely associated with with benign change (i.e., regenerative nodular hyperplasia, age-related remodeling, and/or vacuolar hepatopathy).
- The focal peritonitis with suspected clot in the left cranial quadrant could be secondary to recent trauma, bleeding from the hepatic mass, coagulopathy, other.

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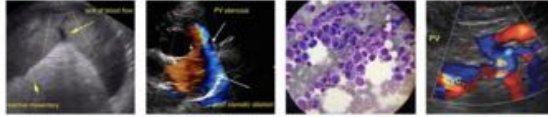
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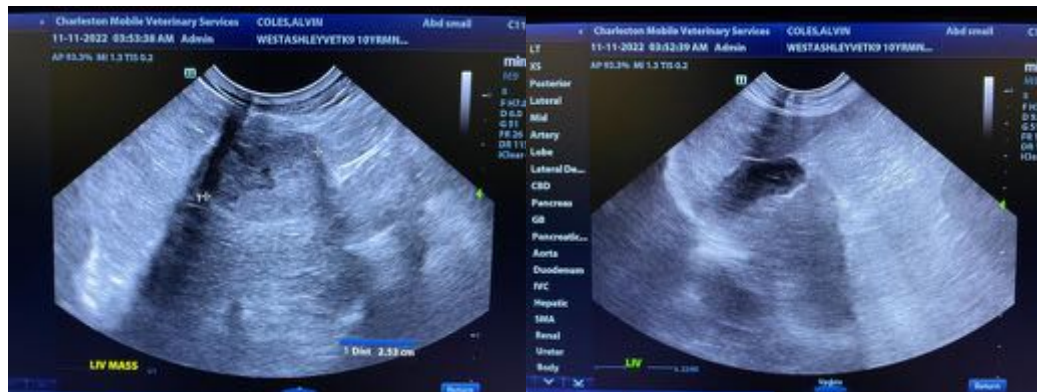
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**Secondary Findings**

- The bilateral adrenal changes are consistent with the previous diagnosis of pituitary-dependent hyperadrenocorticism.
- Minor, bilateral, 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**

- Consider surgical removal of the hepatic mass with submission for histopathology.
- Regarding the patient's seizure-like episode, consider the following:
  1. Baseline blood pressure measurement
  2. Pre-and postprandial serum bile acids to assess for occult hepatic dysfunction
  3. +/- clotting times (i.e., PT/PTT)
- Regarding the focal peritonitis/suspected clot in the left cranial quadrant, consider a recheck ultrasound in 3-4 weeks to assess for progression/resolution.





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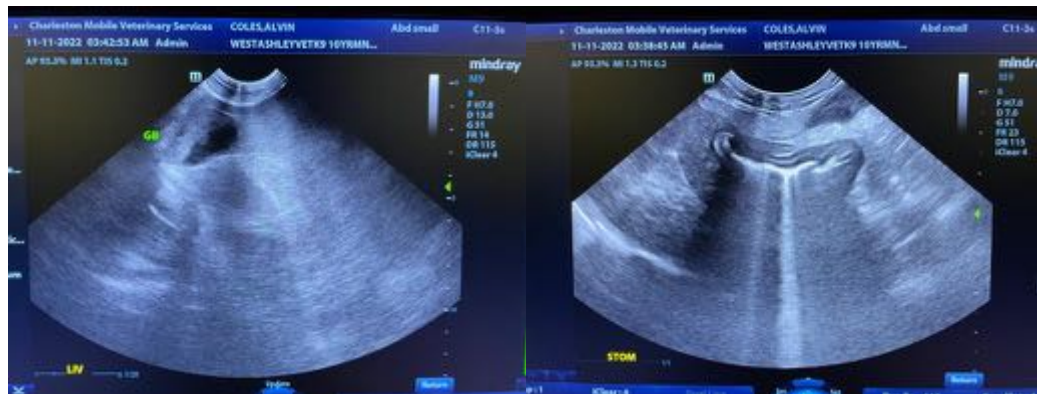
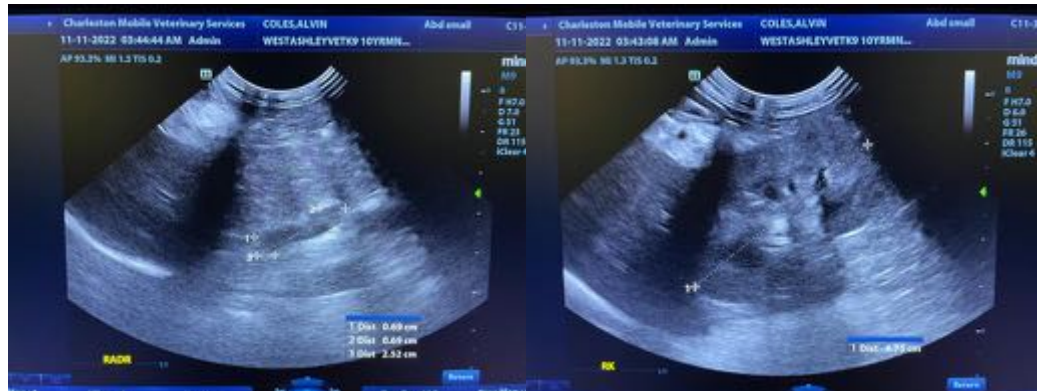
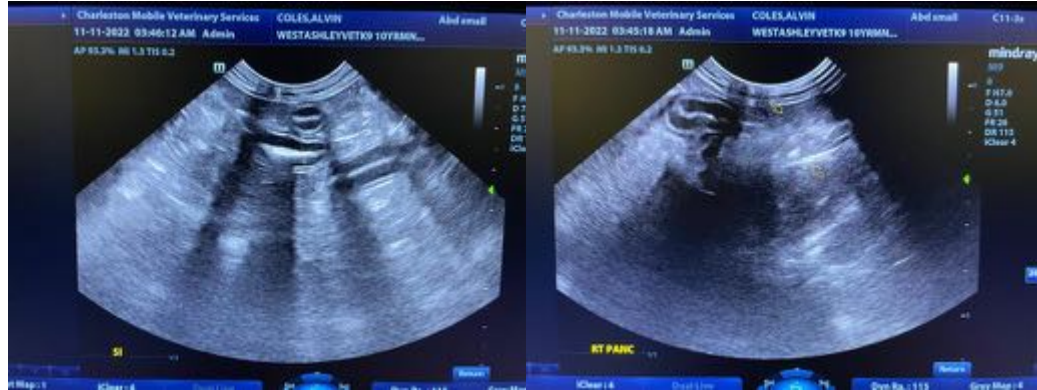
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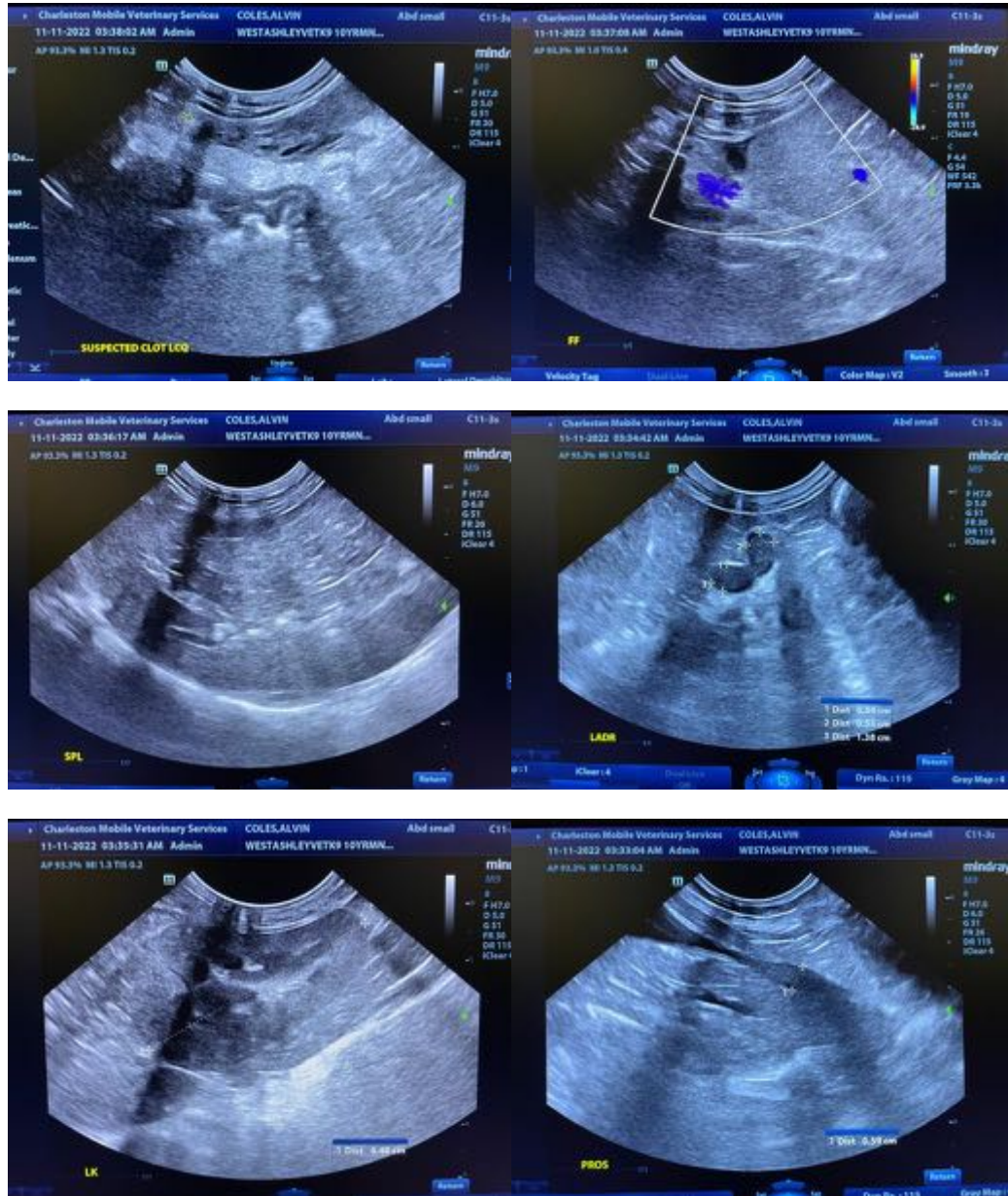
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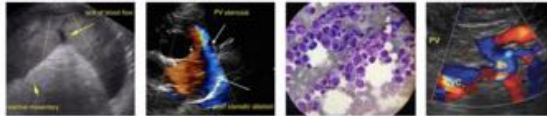
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, DVM, Diplomate DACVIM (Small Animal Internal Medicine)  
info@SonoPath.com



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