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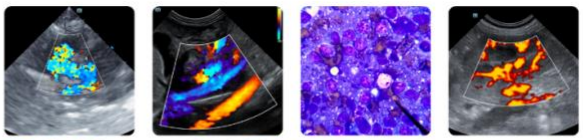


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

**PATIENT**

Bailey Brewer

**SPECIES**

Canine

**BREED**

Mixed

**SEX**

Female Spayed

**AGE**

02/15/2013

**WEIGHT**

24.5Kgs

**INTERPRETED BY**

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

**IMAGING PERFORMED BY**

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

**HOSPITAL NAME**

BluePearl MP ER

**REFERRING VET**

Dr Fraser

**INVOICE**

22234

**DATE**

11-9-25

## PRESENTING CLINICAL SIGNS

Previous splenectomy for sarcoma. Had liver metastases on recent ultrasound
Abnormal lab-work values/Diagnostics:
- CBC: HCT 30 (L), WBC 16.84 (H), Neut 13 (H), Mono 1.85 (H)
- Chem: K 3.2 (L), ALT 162 (H), ALP 233 (H)
Current Medications: Rimadyl inj 1.06mL
Radiographic Findings/ Diagnostics:
- 2v left humeral and 3v TXR (Submitted for radiologist review): Findings:
Six radiographs are available for interpretation.
Thorax:
Multifocal ill-defined soft tissue and mineral-structured pulmonary nodules, approximately 2-12 mm in maximum diameter, are visible. The largest nodule can be detected at the 5th-6th intercostal space and superimposed on the aorta on the lateral images. The cardiac silhouette is within normal limits of size. Intracardiac and cardiothoracic ratios are normal, failing to demonstrate evidence of individual chamber enlargement or pericardial disease. There is no evidence of enlargement of the esophagus, pleural effusion, or intrathoracic lymph node enlargement. The diaphragm is intact, and the extra-thoracic skeletal structures are normal.
Forelimbs:
There is a mild degree of soft tissue swelling around the mid-portion of the left humerus. The medullary cavity shows decreased opacity. A long oblique sharp fracture line within the humeral diaphysis has moderate proximal and lateral dislocation. The margins of the fracture are irregular and sharp.
Abdomen:
The liver is moderately enlarged with round margins and mass effect on the gastric axis—mild loss of the serosal details within the abdomen. The bladder and kidneys are unremarkable. The GIT tract is filled with fluid and gas.
- Hepatomegaly is nonspecific and of uncertain clinical significance. It should be correlated with clinical signs and bloodwork. Differentials include vacuolar hepatopathy (such as that secondary to an endocrinopathy), nodular hyperplasia, cholestasis, congestion, hepatitis, and neoplasia. Ultrasound of the abdomen and FNA can be discussed for further evaluation.
Assessment:
- Acute, most likely pathological, closed, complete, and displaced fracture of the left humerus with secondary soft tissue swelling (no history of trauma). There are small multifocal structured interstitial nodules, most likely consistent with pulmonary metastasis.
- Significant hepatomegaly with mass effect on the stomach warrants hepatic neoplasia/metastasis. Loss of the cranial peritoneal serosal detail indicates mild peritoneal effusion, possibly caused by paraneoplastic factors or mesenteric fat reaction.

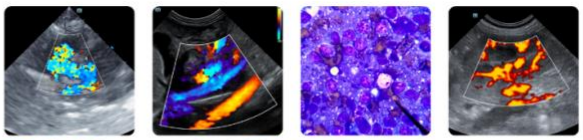
## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

***Urinary System***

A Foley catheter is in place within the urinary bladder lumen. During the study, saline was adminstered through the catheter to mildly dilate the bladder. The wall is of appropriate thickness for the level of repletion. The mucosal surface is most smooth. A scant amount of echogenic debris is observed within the lumen. No cystic calculi are observed.

The left kidney is normal in size (7.40 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. A 3.03 x 2.14 cm heterogenous, slightly cavitated mass is observed at the craniolateral aspect.

The right kidney is normal in size (6.79 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





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distinction. A 1.53 x 1.48 cm ill-defined, hypoechoic nodule is observed at the caudal pole.

***Adrenal Glands***

The left adrenal gland is normal in size (0.7 cm at cranial pole) (0.77 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 (0.81 cm at cranial pole) (0.61 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***

Previous splenectomy. In the region of the splenic fossa, a 3.9 x 2.94 cm ill-defined, hypoechoic mass effect, with hyperechoic mesentery is observed.

***Liver***

The liver is prominent to enlarged with smooth peripheral contours. The parenchyma is isoechoic relative to the right renal cortex. Numerous, varying-sized hypoechoic nodules/masses are observed throughout the organ (one measuring 6.32 x 4.65 cm in its longest dimension). 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.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A small amount of echogenic to hyperechoic gravity-dependent debris/sand is observed within the lumen. The cystic and common bile ducts are normal/not seen.

***Gastrointestinal***

The gastric lumen is mildly to moderately distended with ingesta. 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 ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

***Pancreas***

The left limb is prominent-in-size with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and subtly mottled in appearance. The pancreatic duct is not overtly dilated. Surrounding mesentery is mildly hyperechoic.

***Lymph Nodes***

See “Free Abdomen”.

***Free Abdomen***

Various portions of mesentery throughout the abdomen are hyperechoic. Several irregular, hypoechoic nodules are observed throughout the mesentery (one measuring 1.08 cm in its longest dimension). A small amount of free fluid is observed.

***Other***

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

**ULTRASONOGRAPHIC FINDINGS**

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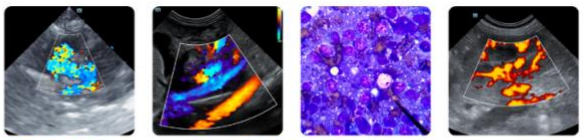

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## Primary Findings

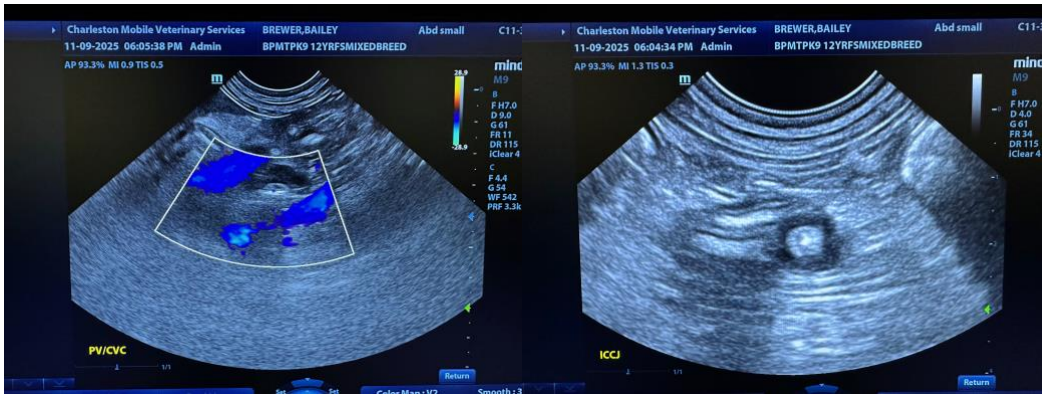
- Numerous hepatic nodules/masses. Metastatic neoplasia (from the previous splenic mass) is strongly suspected with a lower possibility of a multifocal inflammatory process or regenerative nodules.
- Left renal mass and right renal nodule. These lesions are also concerning for metastatic disease, with a lower possibility of inflammatory nodules/granulomas.
- The mass effect in the region of the splenic fossa is concerning for recurrence of neoplasia, with a lower possibility of a benign process (i.e., inflammatory).
- The hypoechoic nodules seen throughout the mesentery may represent metastatic lesions within the mesentery, prominent lymph nodes, other.
- Mild ascites

## Secondary Findings

- Gallbladder changes/sand, non-mucocele
- The pancreatic changes are suggestive of mild acute or chronic active pancreatitis, with minor parenchymal remodeling.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Due to the concern for metastatic disease throughout the abdomen, palliative care is recommended in lieu of aggressive diagnostics/treatments. However, consultation with the patient's oncologist is recommended.



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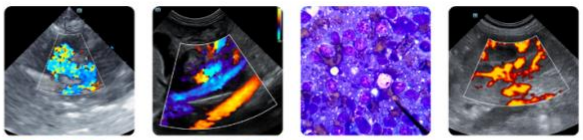

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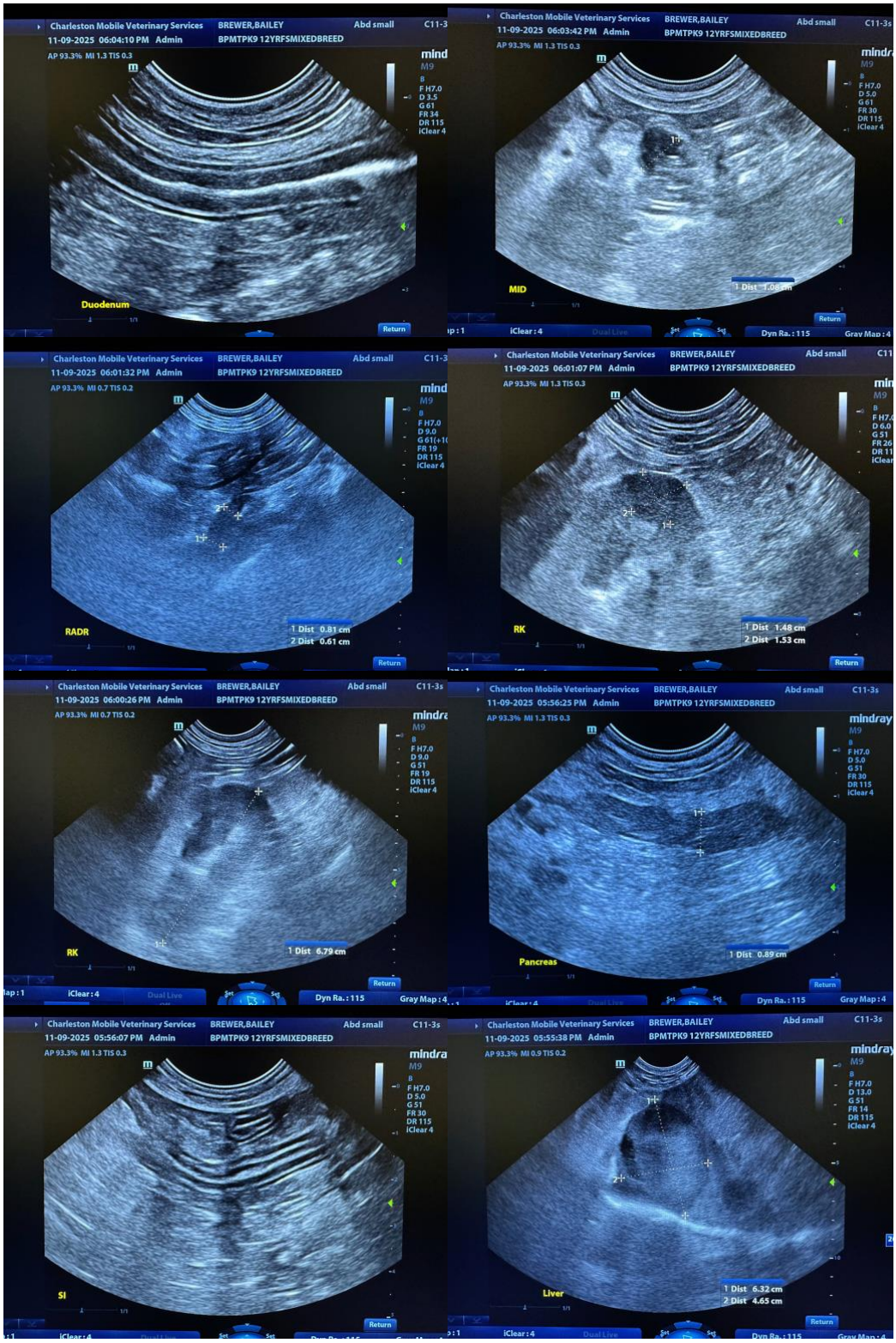

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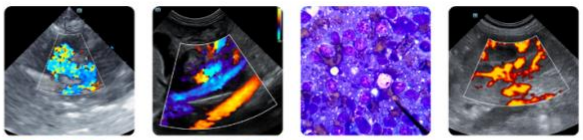

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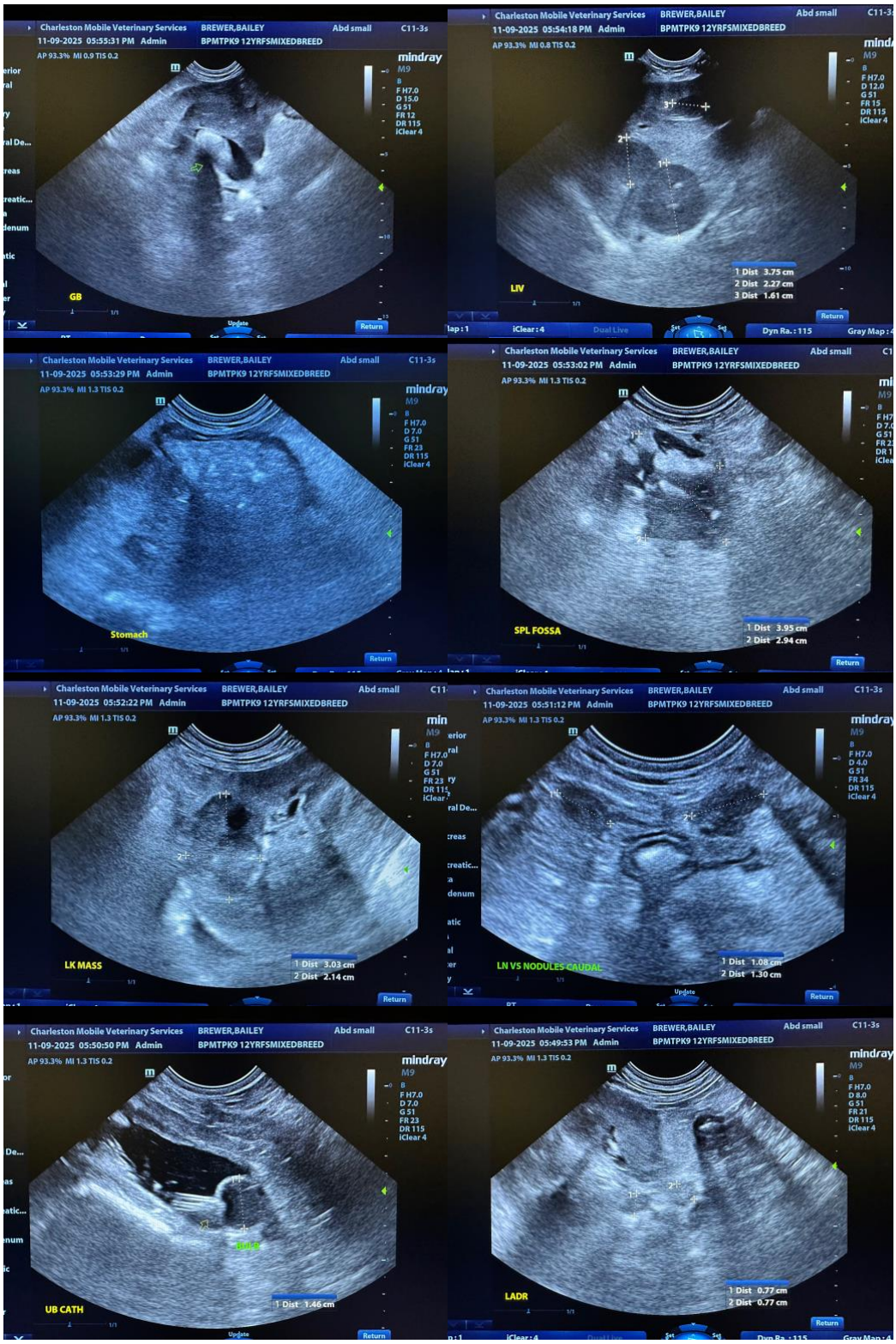

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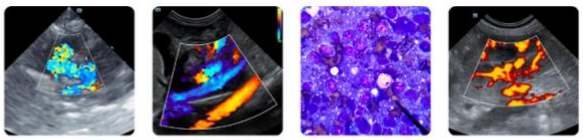

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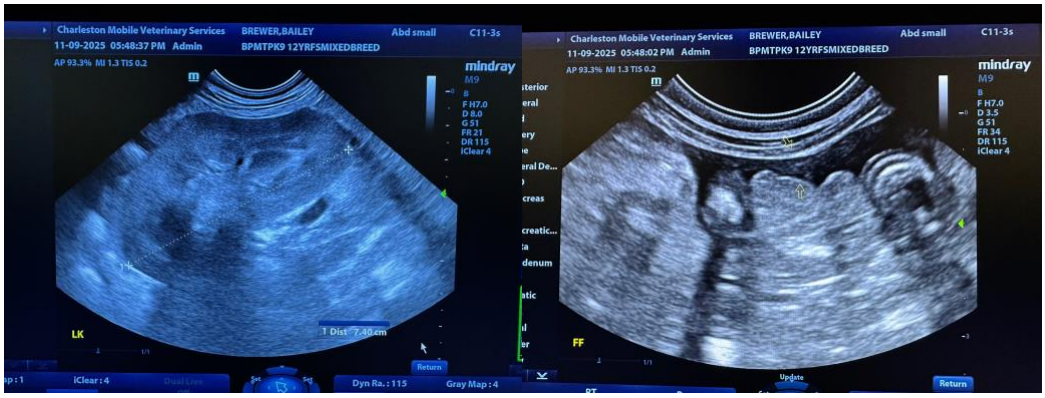


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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