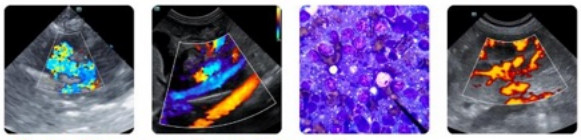


DATE

12/15/25

PATIENT

Max Gettier

SPECIES

Canine

BREED

Boston Terrier

SEX

Male, neutered

AGE

11/16/2014

WEIGHT

42.6 lbs.

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

HOSPITAL NAME

Fork VH

REFERRING VET

Dr. Soherty

INVOICE

13438

PRESENTING CLINICAL SIGNS

Patient History: Dog appears stable and showing no clinical signs but has had an unusually high ALKP over the past few months and now the ALT is gradually increasing. The owner has concerns about the possibility of a liver issue.

Current Medications: None listed.
Labwork Results: Labwork attached, reported as: 11/30/25: ALKP 3820 (5-160), ALT 138 (18-121) 10/29/25 ALKP >2000 (23-212)
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.78 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 (5.97 cm in length) with a normal shape, architecture and 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 hydroureter. Renal vasculature is normal.

The right kidney is normal in size (6.05 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. A few small cortical cysts are seen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is enlarged (1.66 cm at cranial pole) (0.84 cm at caudal pole)(3.47 cm in length) with an irregular shape. A 2.0 x 1.4 cm hyperechoic to heterogeneous macronodule/mass is observed at the cranial to mid-aspect. The lesion appears to extend into the phrenicoabdominal vein, which is thickened (up to 0.64 cm in width). The glandular echogenicity and detail at the caudal pole are unremarkable.

The right adrenal gland is mildly enlarged (0.64 cm at cranial pole) (0.78 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

The spleen is normal in size (1.53 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively enlarged with swollen/slightly irregular peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely mottled with numerous varying sized ill-defined hypoechoic nodules throughout the organ, one of the nodules measuring 1.5 cm in its longest dimension. Vascular and biliary tracts are of normal volume with no evidence of congestion.

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

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 colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb of the pancreas is 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

The abdominal lymph nodes are normal/not visible.

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

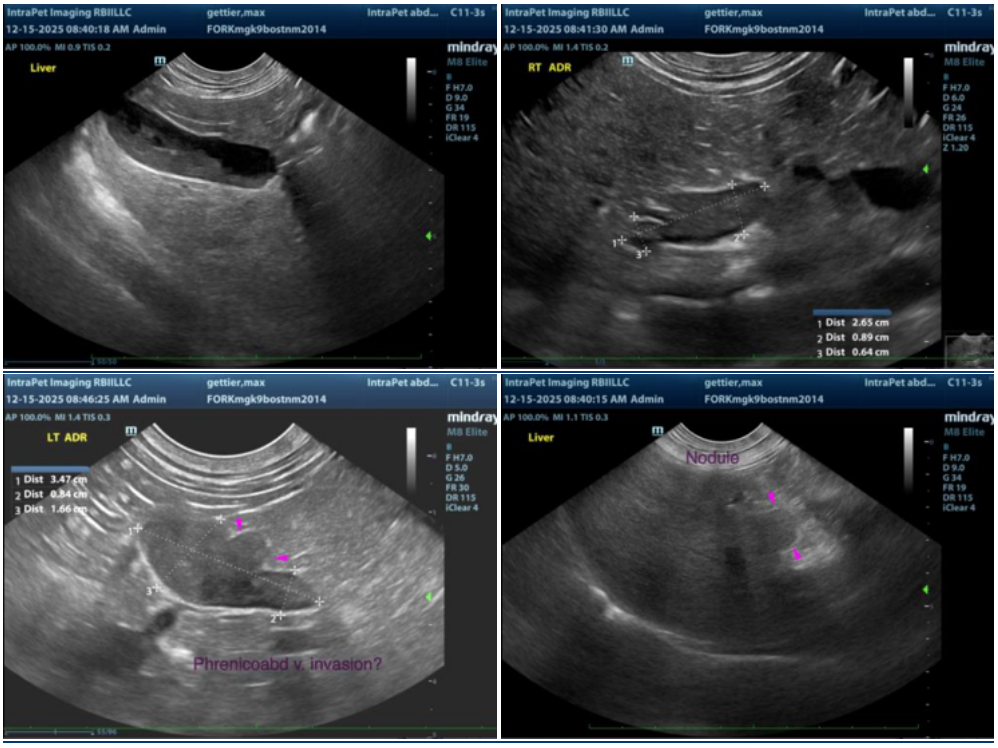
- The hepatic changes could be consistent with a benign process (i.e., regenerative nodular hyperplasia, vacuolar hepatopathy, inflammatory hepatopathy, hepatotoxicosis (i.e., copper)). Alternatively, emerging neoplasia (i.e., lymphoma) cannot be excluded.
- Left adrenal macronodule/mass with suspected extension into the phrenicoabdominal vein. Considerations include adenocarcinoma, pheochromocytoma, other.
- Gallbladder debris/sand, non-mucocele.

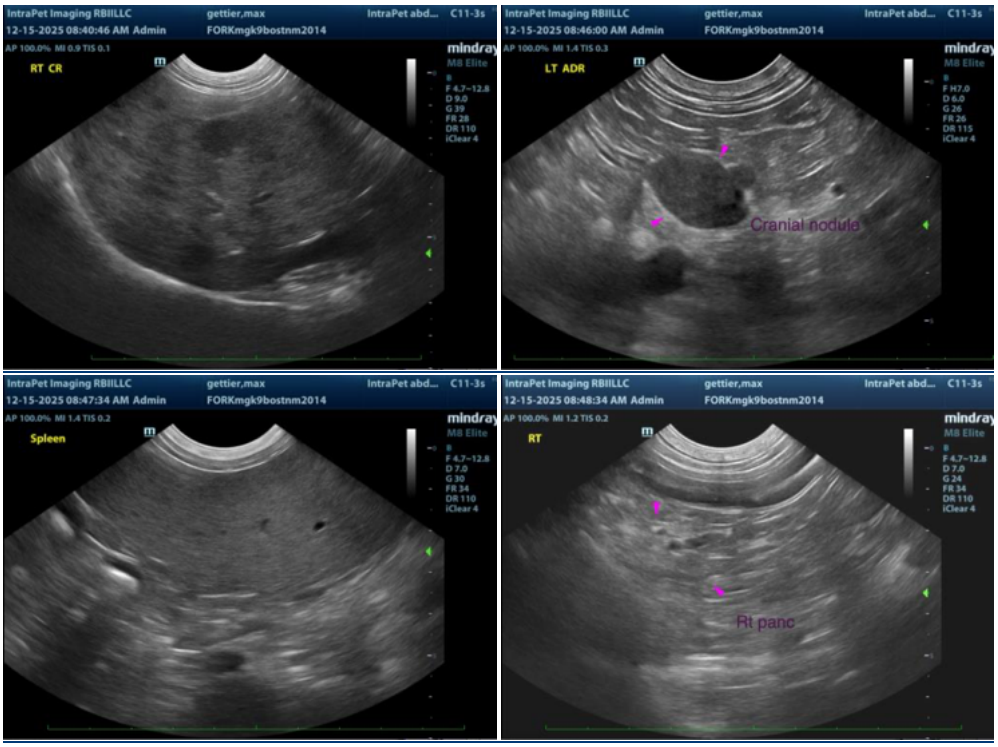
Secondary Findings:

- Bilateral nonspecific, 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.
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the hepatic changes, consider tissue sampling (i.e., aspirates or biopsies) assuming normal clotting status. If biopsies are pursued, aerobic and anaerobic bile cultures and hepatic copper quantitation are also recommended.
- Regarding the left adrenal macronodule/mass, consider the following:
  1. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
  2. Further testing for a functional tumor (i.e., low-dose dexamethasone suppression test, urine/blood metanephrine levels)
  3. Blood pressure measurement
  4. Abdominal CT scan to assess the extent of pathology, particularly if a left adrenalectomy is to be considered. If an abdominal CT scan is not performed, consider a recheck ultrasound in 1-2 months to assess for growth of the lesion.





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