



**PATIENT**

Elsa Mercado

**SPECIES**

Canine

**BREED**

Catahoula Leopard Mix

**SEX**

Female Spayed

**AGE**

04/02/2014

**WEIGHT**

64.3 lb

**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**

Kind Care AH

**REFERRING VET**

Dr Michael Marino

**INVOICE**

22225

**DATE**

12-5-25

**PRESENTING CLINICAL SIGNS**

Clinical Exam Findings: large mass identified as a retropharyngeal lymph node and a smaller mass associated with the subepiglottis (Squamous cell carcinoma)

Abnormal lab-work values: Elevated liver enzymes; ALT 586, ALP >2,000, GGT 108

Current Medications: Provable and Metronidazole

Radiographic Findings

Neck: The swelling is confined to the soft tissues with no evidence of bony involvement or infiltration into the airway structures. The mass is adjacent to the larynx and esophagus.

Chest: The lungs are clear with no evidence of large nodules or metastatic disease. A mild, diffuse interstitial pattern is present, consistent with age-related changes ("old dog lungs"). The heart size is within normal limits. The visible portion of the abdomen appears unremarkable.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder wall is normal in thickness. 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 left kidney is normal in size (6.88 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal 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 (6.27 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal 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 enlarged (1.78 cm at cranial pole) (2.51 cm at caudal pole) (3.79 cm in length) with an irregular shape. The parenchyma is heterogenous, with loss of glandular detail. There is no obvious evidence of vascular invasion.

The right adrenal gland is enlarged (1.71 cm at cranial pole) (1.58 cm at caudal pole) (4.27 cm in length) with swollen peripheral contours. The parenchyma is hyperechoic-to-slightly-heterogenous with loss of glandular detail. There is no obvious evidence of vascular invasion.

**Spleen**

The spleen is normal in size (1.98 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 1.35 x 0.82 cm ill-defined, hyperechoic nodule is observed at the lateral aspect, approximately mid-body. In addition, a 1.07 cm hypoechoic nodule is observed near the caudal pole. Splenic vasculature is normal.

**Liver**

The liver is subjectively enlarged, with swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and mildly heterogenous in appearance. One-to-two, small, ill-defined hypoechoic nodules are visualized within the parenchyma, along with at least one, small, ill-defined hyperechoic nodule. 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-mineralized debris/sand, +/- tiny, nonobstructive choleliths are observed within the lumen. The cystic



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and common bile ducts are normal/not seen.

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**Gastrointestinal**

The gastric lumen is mildly 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 ileocecolic junction and colonic wall are normal. There is no obvious 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**

The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

**Other**

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

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- The hepatic changes are nonspecific and could be secondary to inflammatory disease (i.e., cholangiohepatitis, chronic hepatitis), Leptospirosis, hepatotoxicosis, infiltrative neoplasia (i.e., lymphoma), vacuolar hepatopathy, regenerative nodular hyperplasia, other hepatopathy, or some combination thereof.
- Gallbladder debris/sand +/- tiny, nonobstructive choleliths (non-mucocele)
- Bilateral adrenomegaly. Considerations include bilateral hyperplasia vs bilateral tumors (i.e., adenoma, adenocarcinoma, pheochromocytomas, other).

**Secondary Findings**

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The hyperechoic splenic nodule trends toward the benign (i.e., myelolipoma) with a lower possibility of more insidious splenic pathology. The hypoechoic splenic nodule could be consistent with focal nodular hyperplasia or similar. Alternatively, an emerging tumor cannot be completely excluded.



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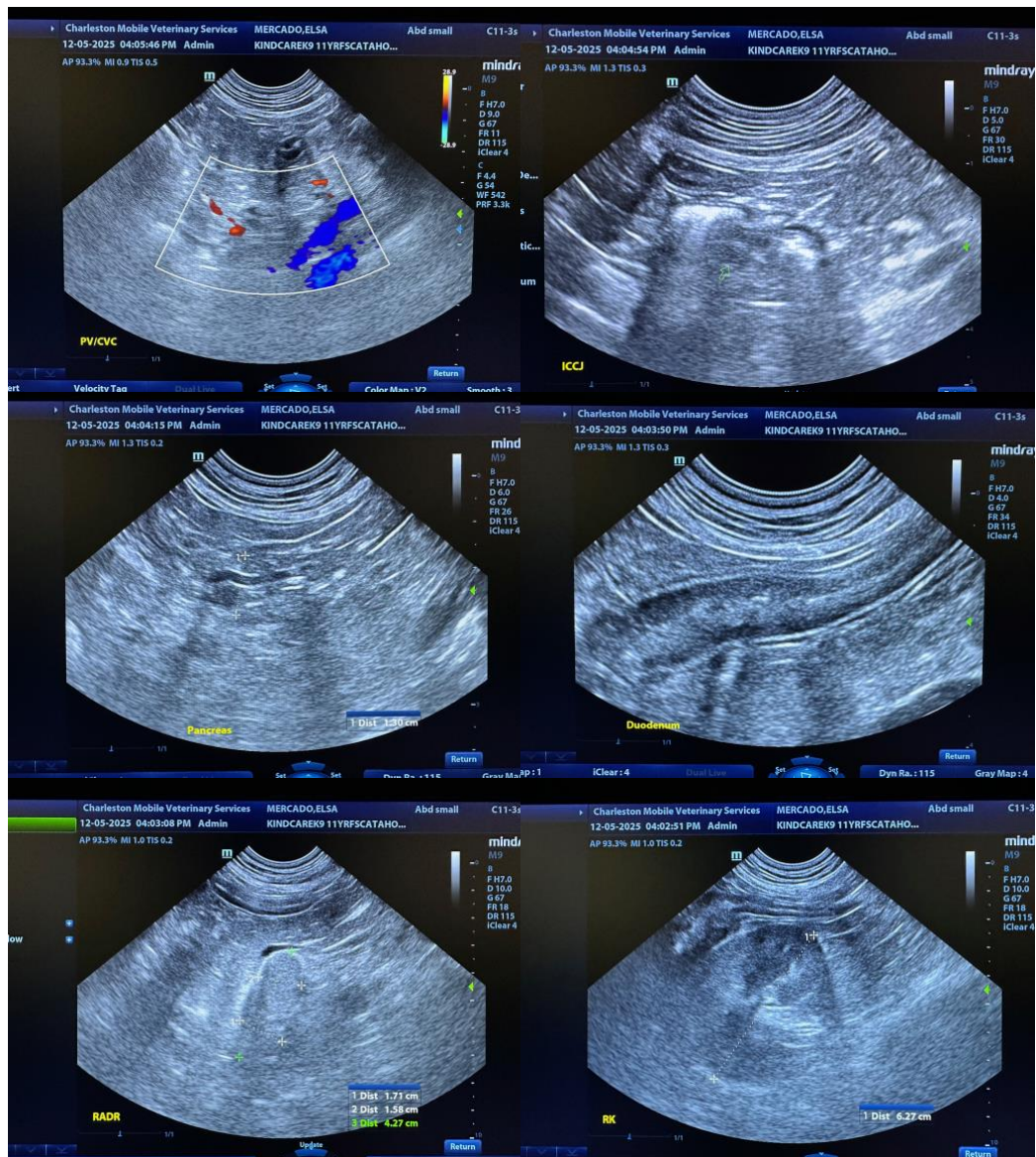
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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- For further evaluation of the liver, consider pre- and postprandial serum bile acids, Leptospiriosis, +/- hepatic tissue sampling (i.e., aspirates or biopsies) along with aerobic and anaerobic bile cultures and hepatic copper quantitation.
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.
- Given the bilateral adrenomegaly, also consider a baseline blood pressure measurement to assess for systemic hypertension.





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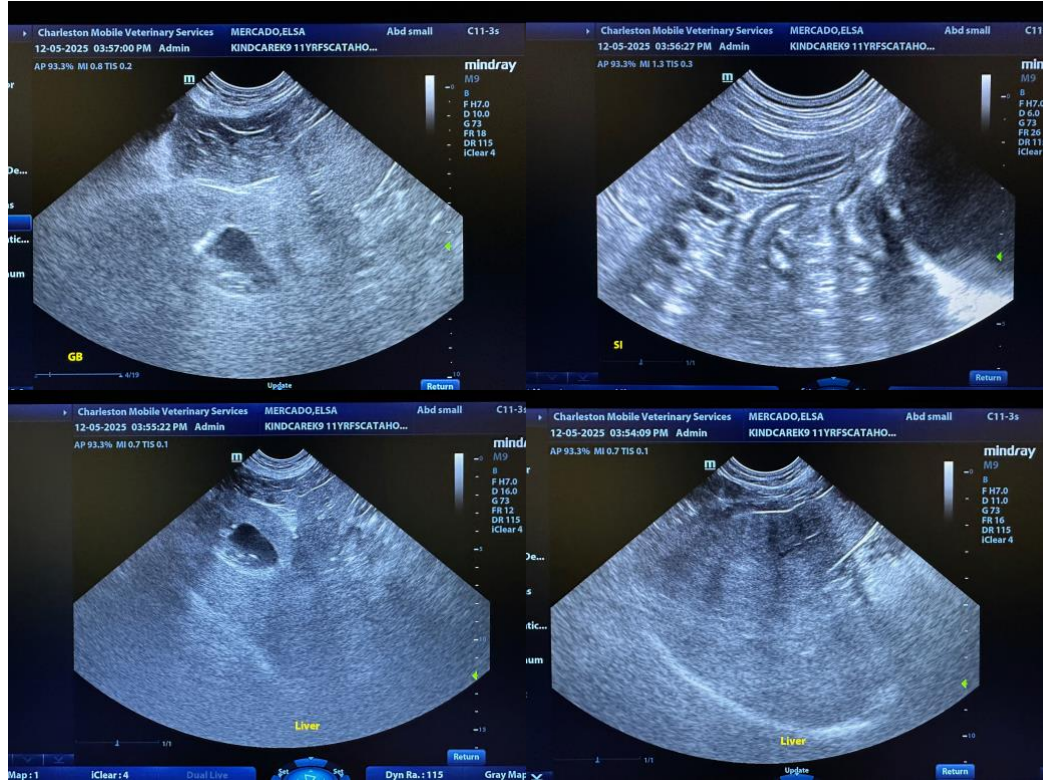
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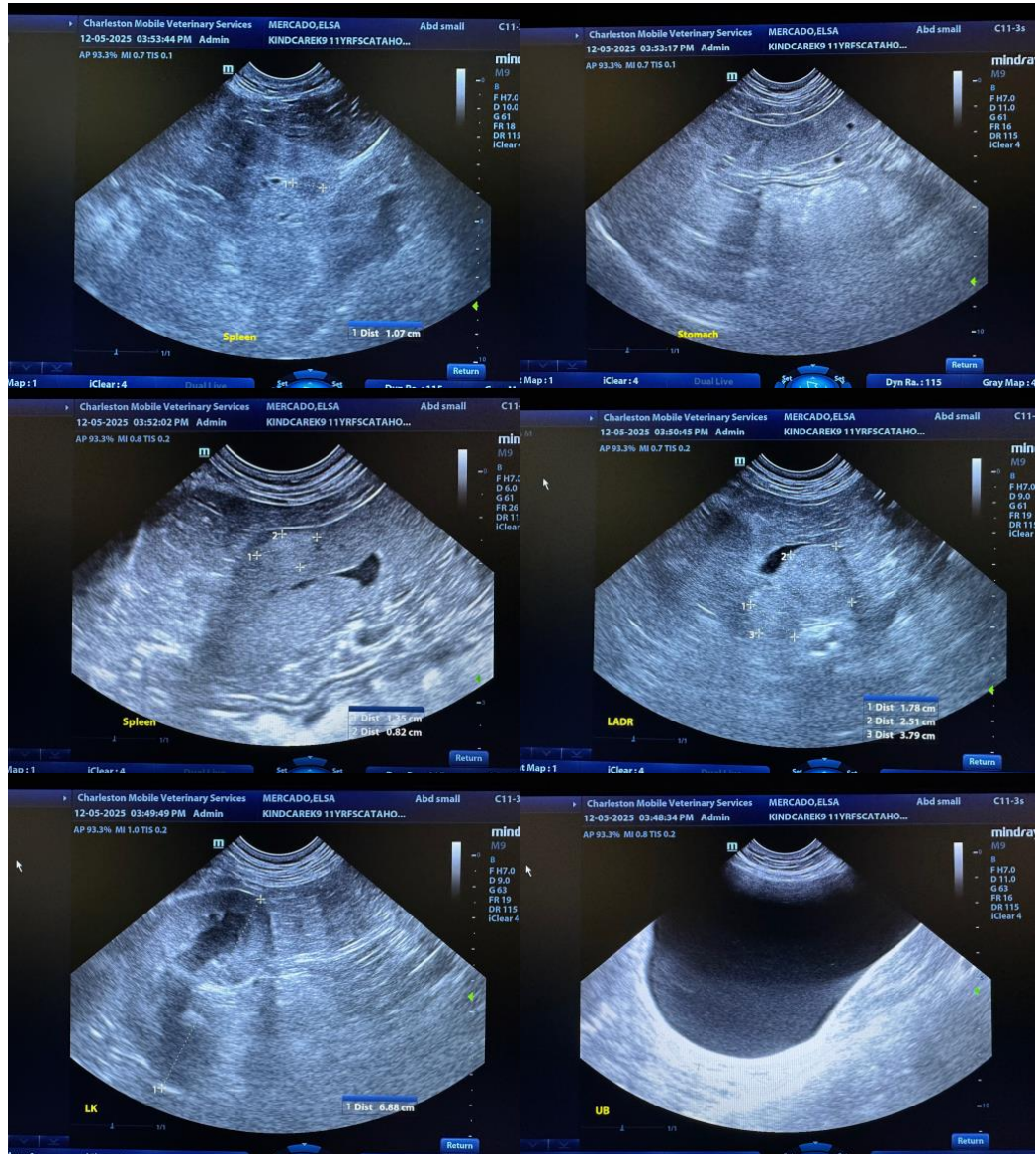
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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](mailto:info@SonoPath.com)