



**PATIENT**

Giles Sherlow

**SPECIES**

Canine

**BREED**

Mixed Breed

**SEX**

Neutered Male

**AGE**

13 Years

**WEIGHT**

25 Lbs.

**INTERPRETED BY**

Andrea Nicastro, DMV,  
Diplomate DACVIM  
(Small Animal  
Internal Medicine)

**IMAGING PERFORMED BY**

Dr. Scott

**HOSPITAL NAME**

Ho Ho Kus VH

**REFERRING VET**

Dr. Eisenberg

**INVOICE**

10279

**DATE**

2/4/22

**PRESENTING CLINICAL SIGNS**

History: Long hx of gastric mass (see prev ultrasound done on 8/27/2020) doing well overall but recent Pu/PD  
Abnormal PE/Chem/CBC/UA Results: PE WNL cbc/chem mild azotemia, UPC 2.1

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder, trigone, and pelvic urethra are 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 (0.81 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 (5.50 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter.

The right kidney is normal size (5.00 cm in length); normal shape and architecture with 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.

**Adrenal Glands**

The left adrenal gland is enlarged (1.30 cm at cranial pole) (0.72 cm at caudal pole); with a slightly irregular shape. The cranial pole is prominent. Glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is borderline enlarged (1.09 cm at cranial pole) (0.69 cm at caudal pole) (2.95 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 subjectively normal in size (1.04 at the level of the hilus) with normal curvilinear peripheral contours. The parenchyma is of appropriate echogenicity and echotexture. Pinpoint hyperechoic to mineralized foci are observed throughout the organ. Splenic vasculature appears normal with no evidence of thrombosis.

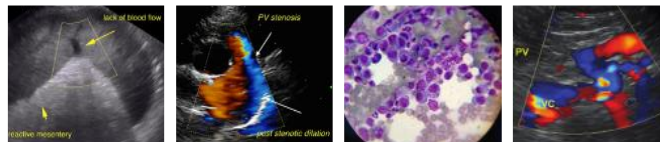
**Liver**

The liver is subjectively prominent in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and diffusely mottled in appearance. A 1.33 cm ill-defined hyperechoic nodule is observed on the left side. 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 mildly thickened (up to 0.30 cm) and hyperechoic. A moderate amount of aggregated echogenic suspended sludge in a partially stellate pattern 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. A 5.75 x 3.96 cm heterogenous cavitated mass is arising from the lesser curvature. The pyloric outflow tract is patent. The small



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intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. The colonic wall is normal.

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**Pancreas**

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

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**Free Abdomen**

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

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**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

**SEX**

- The gastric wall mass is similar in size to the previous sonogram. Neoplasia is suspected with a lower possibility of a focal inflammatory process.
- The gall bladder changes are most consistent with a developing mucocele.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely. However, correlation with the patient's liver values is recommended.

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**Secondary Findings**

- Mild bilateral adrenomegaly
- Dystrophic mineralization of the spleen. This is typically a benign, incidental finding, often associated with endocrinopathies.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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- Given the presence of the gastric mass, three-view thoracic radiographs are recommended to assess for pulmonary metastatic disease.
- Regarding the gall bladder changes, consider initiation of ursodiol therapy with serial sonographic monitoring (i.e., every 4-6 weeks), of the gall bladder to assess for progression. Alternatively, cholecystectomy can be considered, as gall bladder mucoceles can rupture at any point, resulting in bile/septic peritonitis. If surgery is pursued, referral to a board-certified surgeon is recommended due the potential for perioperative complications. The gastric mass could also be removed at the time of surgery.

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- Given the patient's clinical signs and adrenal changes, consider further testing for Cushing's disease (i.e., low-dose dexamethasone suppression test or ACTH stimulation test). A baseline blood pressure measurement is also recommended.

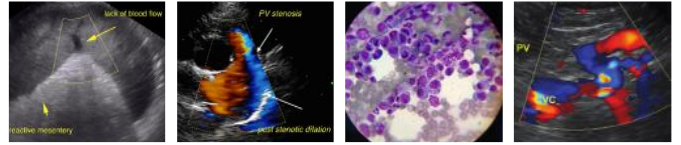
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- Given the proteinuria, consider initiation of an angiotensin receptor blocker, omega-3 fatty acids, +/- anti-thrombotic agent (i.e., clopidogrel) and a prescription renal diet.

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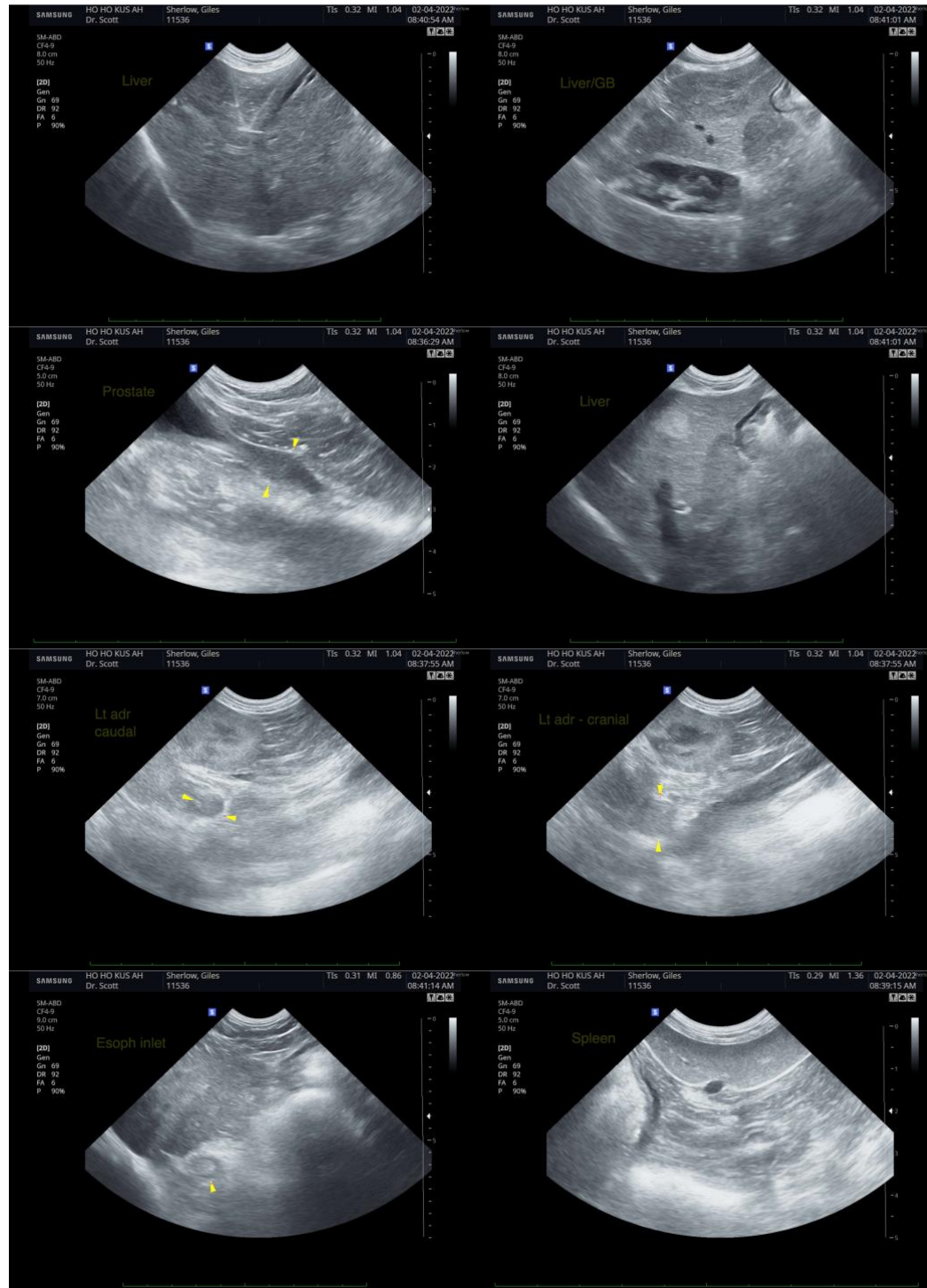
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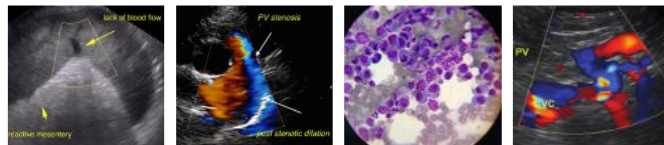
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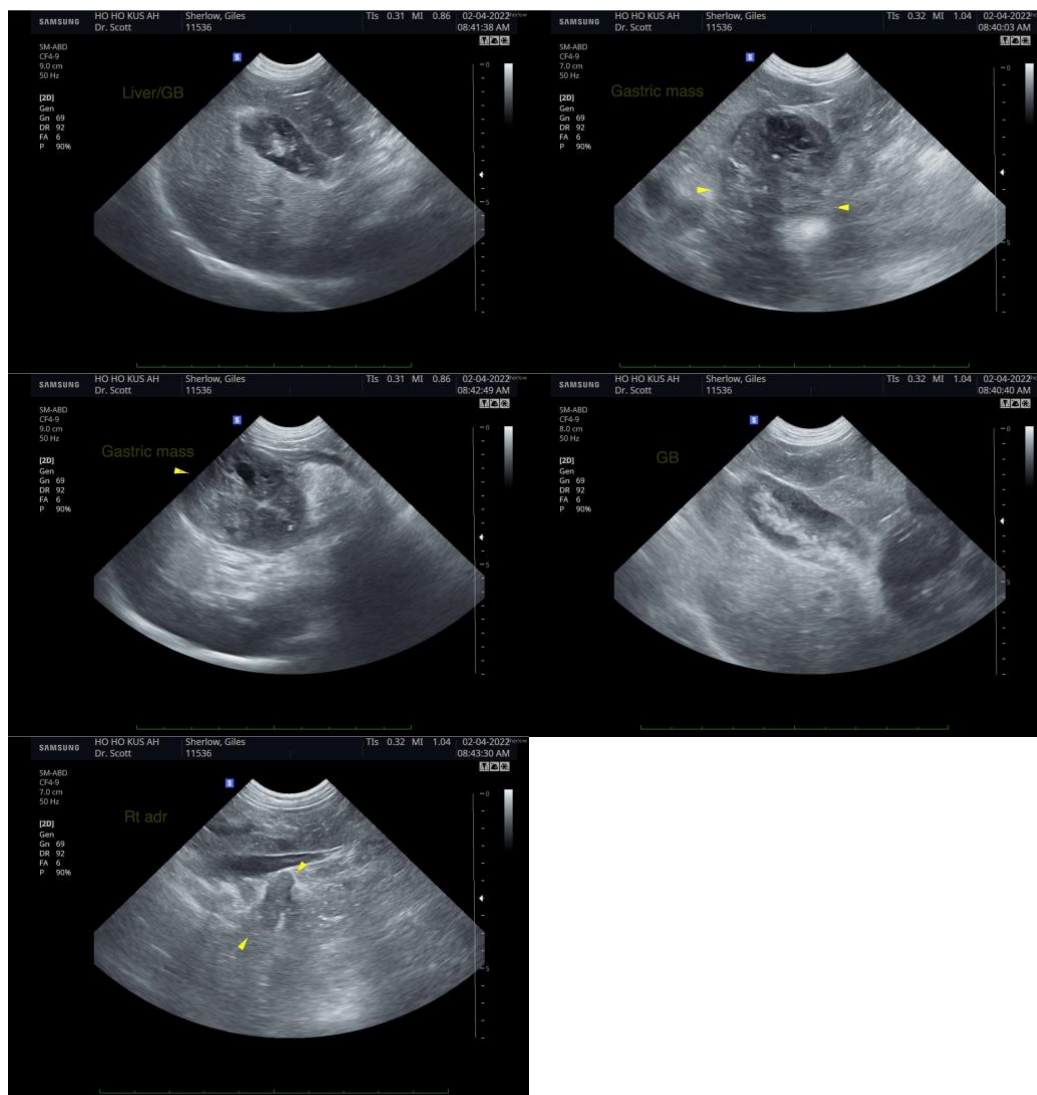
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)**  
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