PATIENT

Buddy Aiken

SPECIES

Canine

BREED

Golden Retriever

SEX

Neutered Male

AGE

12

WEIGHT

71 lbs

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

Sun Dog Cat Moon

REFERRING VET

Dr Clayton

INVOICE

22529

DATE

2-9-26

PRESENTING CLINICAL SIGNS

Patient has an approximately 1-week-history of hyporexia/anorexia. Prior history of a cavitated hepatic mass arising from the caudate process of the liver, with a smaller mid-hepatic mass. Also has been azotemic, which has worsened slightly recently. Was recently started on Enalapril for a protein-losing nephropathy. The appetite issues started after that.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with mostly anechoic urine. The wall in the region of the apex is moderately thickened (up to 0.74 cm) with an irregular mucosal surface. The wall tapers to a normal thickness as it extends towards the cystourethral junction. 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 (0.93 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 (6.47 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. Trace pyelectasia is present (0.12 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (6.40 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. Mild-to-moderate pyelectasia is present (0.43 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.72 cm at cranial pole) (0.85 cm at caudal pole) with slightly irregular peripheral contours. Glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is mildly enlarged (1.16 cm at cranial pole) (0.90 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 (1.83 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. At least one, small, myelolipoma is observed in the region of the hilus. Splenic vasculature is normal.

Liver

The liver is enlarged, with irregular peripheral contours. A >10.7 cm cavitated mass is arising from the caudate process. In addition, a 2.1 cm hyperechoic-to-heterogenous mass is seen on the right side. In the remainder of the liver, the parenchyma is isoechoic relative to the spleen and subtly nodular in appearance.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of aggregated, echogenic, partially dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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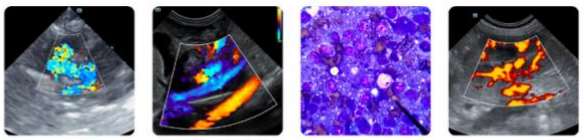

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Gastrointestinal

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 ileocecocolic junction and colonic wall are 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.

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Large, cavitated hepatic mass arising from the caudate process. The mass is larger compared to previous sonograms. Neoplasia (i.e., hemangioma, hemangiosarcoma, adenocarcinoma, other) is suspected, with a lower possibility of a non-neoplastic process. The smaller right hepatic mass could be consistent with a metastatic lesion, emerging primary hepatic tumor, regenerative nodule, inflammatory focus, other. The diffuse hepatic parenchymal changes are nonspecific and could be secondary to regenerative nodular hyperplasia, age-related parenchymal remodeling, metastatic disease, and inflammatory process, hepatotoxicosis (i.e., copper), fibrosis, and/or other hepatopathy.
- The gallbladder changes are suggestive of a developing mucocele.

Secondary Findings

- Bilateral adrenomegaly
- 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 lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The urinary bladder wall changes could be consistent with cystitis or may be artifactual due to lack of full repletion. Correlation with the patient's clinical history and urinalysis findings is recommended.

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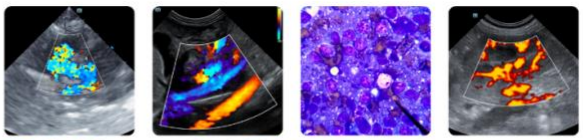

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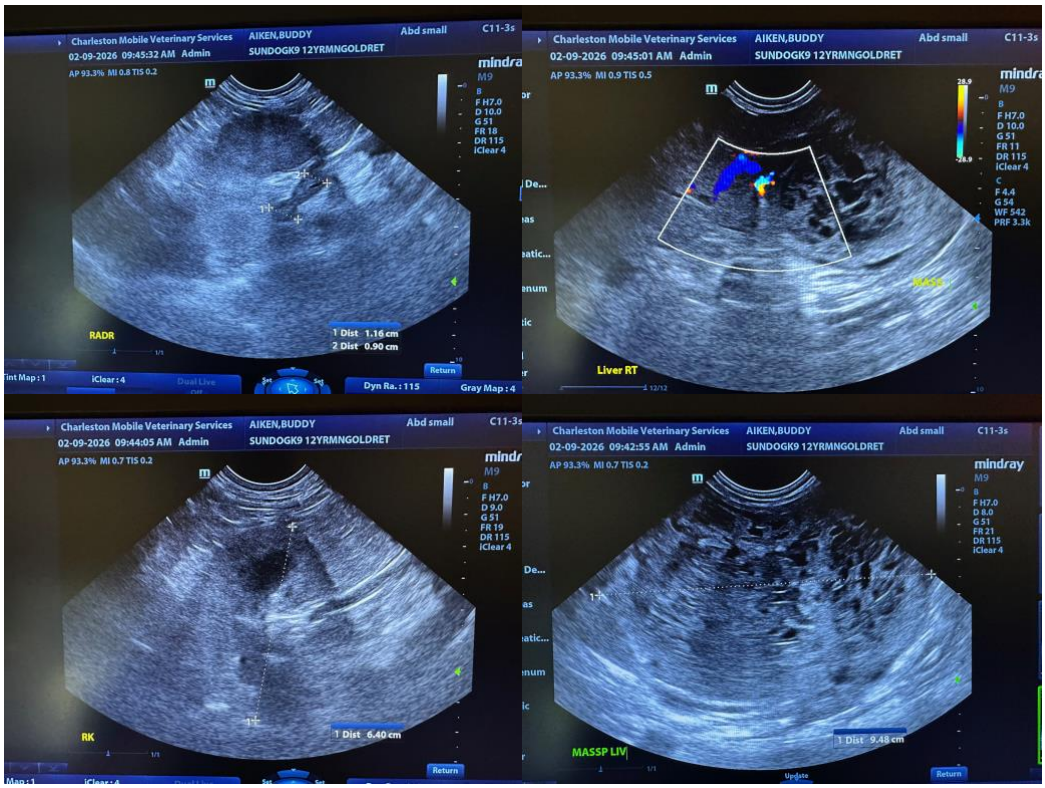
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- Given the anorexia, discontinuation of the Enalapril is recommended in case this a contributing factor. In the meantime, symptomatic care is recommended.
- Consider obtaining a baseline blood pressure measurement to assess for systemic hypertension, particularly in light of the patient's protein-losing nephropathy. If the patient's appetite resumes, consider initiation of an angiotensin receptor blocker (i.e., telmisartan) as treatment for the proteinuria (if the patient will tolerate it).
- Yunnan Bayaio is recommended for the hepatic mass if surgical removal or debulking is not pursued,



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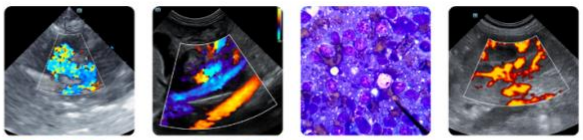

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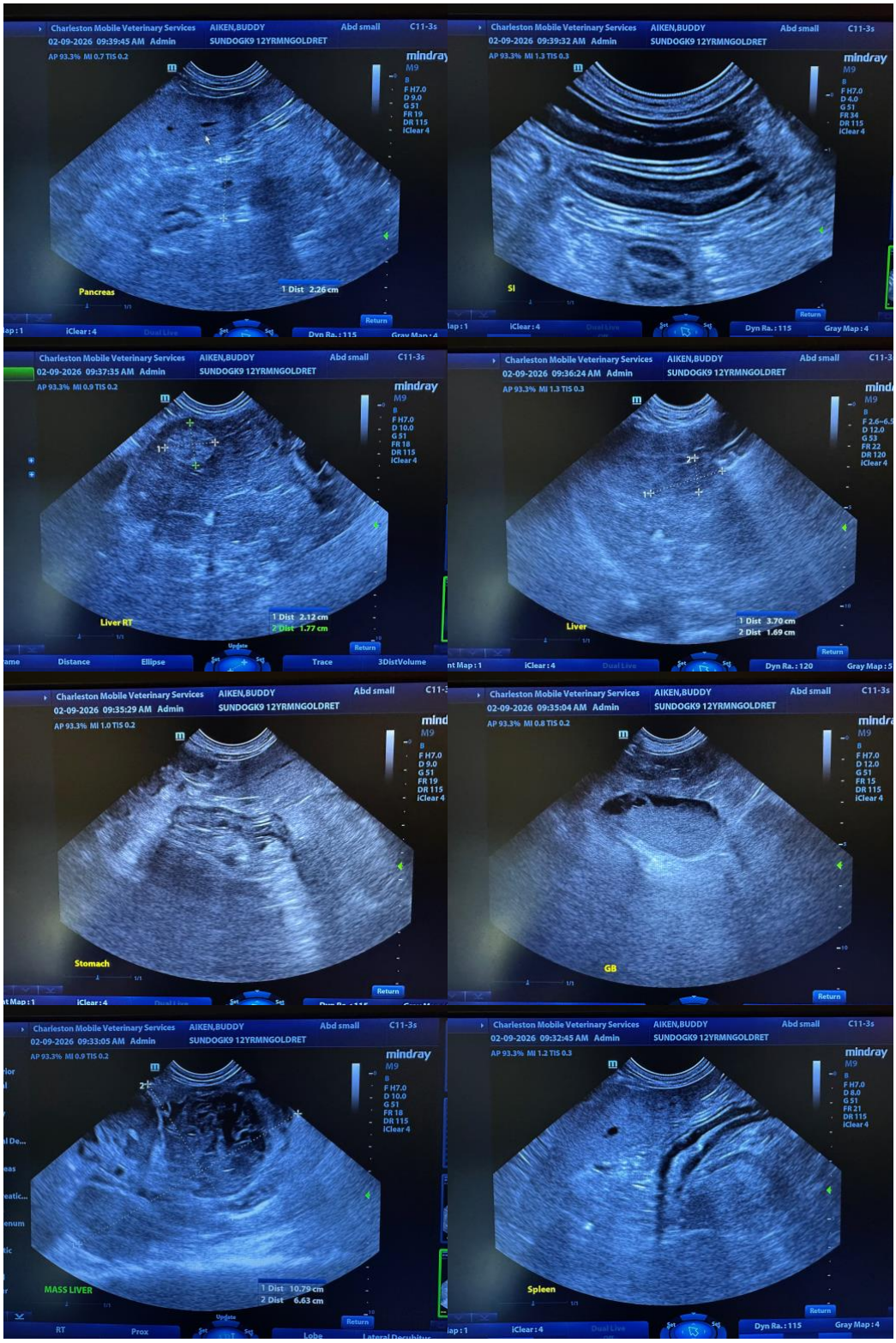

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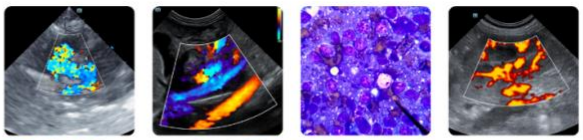

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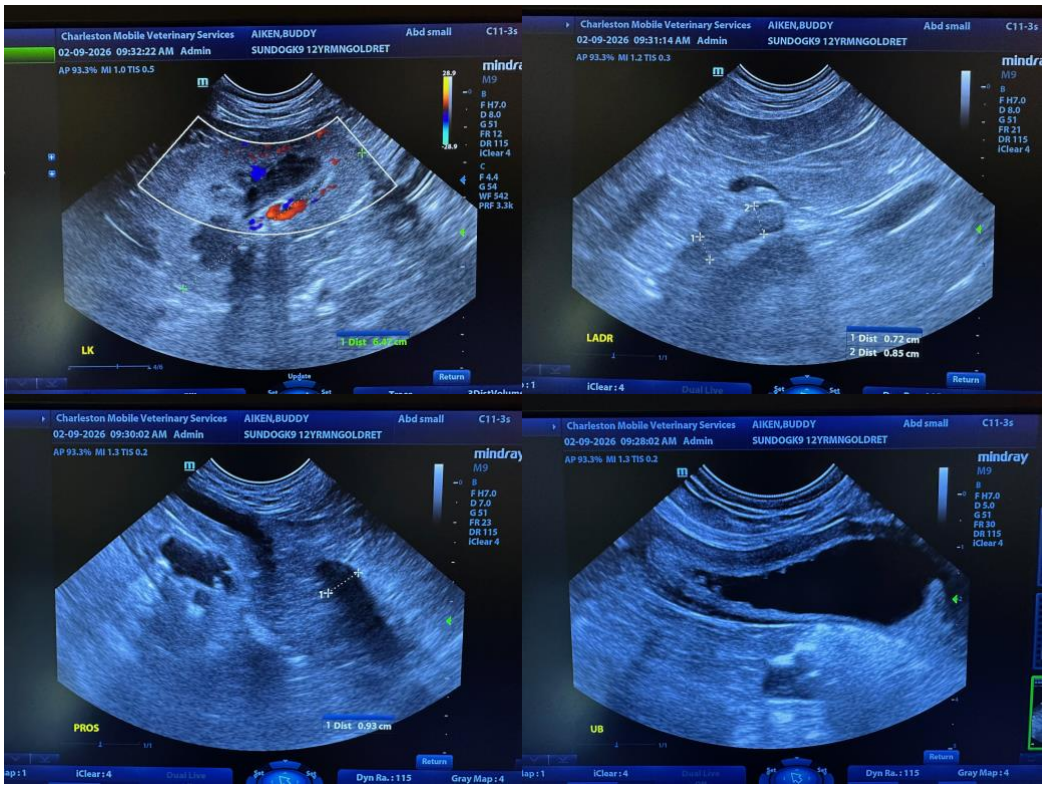

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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