



PATIENT PRESENTING CLINICAL SIGNS

Mila Feliciano

History: The patient presented for an abdominal ultrasound to evaluate a possible mass. Pt presented on 3-11-23 for a senior exam and BW and during the exam, the PE showed that pt has a possible mass on the cranial abdomen. Radiographs were done and they showed a cranial mass. The BW showed elevated liver enzymes above and the u/a showed bacterial cystitis. We sent enrofloxacin to treat cystitis while waiting for abdominal ultrasound done today. Since we saw the patient 2 days ago, pt has worsened, and is acting sick and became icterus.

SPECIES

Canine

BREED

French Bulldog

Abnormal PE/Chem/CBC/UA Results: PE: Abdominal mass on the cranial left abdomen. Hepatomegaly. Today the pt is icterus. CBC: RBC 3.70 M/ μ L (5.65 - 8.87) HCT 21.8 % (37.3 - 61.7) HGB 7.7 g/dL (13.1 - 20.5) PLT 562 K/ μ L (148 - 484) CHEM: BUN 31 mg/dL (7 - 27) TP 8.7 g/dL (5.2 - 8.2) ALB 4.7 g/dL (2.2 - 3.9) ALT 573 U/L (10 - 125) ALKP > 2000 U/L (23 - 212) LIPA 2306 U/L (200 - 1800) U/A: rods USG 1.036 , WBCs 3+, RBCs 2+ FNA: of the liver or spleen were done and pending.

SEX

Female, spayed

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

AGE

11 Yrs.

The urinary bladder is moderately distended. The wall in the region of the apex is thickened (up to 0.60 cm) with an irregular mucosal surface. The wall tapers to a normal thickness as it extends towards the cystourethral junction. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone is normal.

WEIGHT

16.3 lbs.

The left kidney is normal size (4.36 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. A small cortical cyst is observed at the cranial pole.

INTERPRETED BY

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

The right kidney is normal size (5.22 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

IMAGING PERFORMED BY

Dr. Ferrer

The left adrenal gland is enlarged at the cranial pole and normal in size at the caudal pole (0.82 cm at cranial pole) (0.47 cm at caudal pole) (2.96 cm in length). A 1.41 x 0.82 cm hyperechoic nodule is observed at the cranial aspect. The glandular echogenicity and detail at the caudal aspect are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

HOSPITAL NAME

Paseos VC

The right adrenal gland is mildly enlarged (0.82 cm at cranial pole) (0.57 cm at caudal pole) (2.26 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.

REFERRING VET

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Spleen

The spleen is enlarged with irregular peripheral contours. An approximately 3.1 cm isoechoic mass is arising from mid-spleen. The lesion causes capsular expansion. In the remainder of the spleen, the margins are curvilinear and the parenchyma is homogeneous. Splenic vasculature appears normal with no evidence of thrombosis.

INVOICE

14722

Liver

DATE

3/13/23



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The liver is subjectively enlarged with irregular peripheral contours. A >8 cm irregular isoechoic to slightly heterogeneous mass is observed on the left side. The lesion has small cavitated areas and causes capsular expansion. In the remainder of the liver, the parenchyma is isoechoic relative to the spleen and relatively homogeneous in appearance. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1:1. The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of echogenic to mineralized debris is observed within the lumen, some of which is gravity-dependent and some of which is stranding/suspended. The cystic and common bile ducts are visible. The common bile duct is mildly dilated (up to 0.43 cm) near the distal aspect and can be followed to the level of the duodenal papilla, which is normal in size (0.46 cm in width). There is no obvious evidence of an intraluminal obstruction.

Gastrointestinal

The gastric lumen is not distended. The gastric wall is normal to borderline thickened (up to 0.40 cm) with retention of the normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with retention of the normal layering pattern. There is mild thickening of the submucosal layer in some segments. Discreet masses are not identified. The ileocecolic junction is normal. The wall of the descending colon is normal to mildly thickened (up to 0.38 cm) with retention of the normal layering pattern. No obstructive disease is noted. See *Other*.

Pancreas

The base of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic 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.

Free Abdomen

Trace free fluid is observed. A 2.41 cm medial iliac lymph node is visualized. A few prominent mesenteric lymph nodes are also seen, the largest measuring 1.69 cm in width. Surrounding mesentery is hyperechoic. See *Other*.

Other

A >5 cm hypoechoic to heterogeneous slightly cavitated mass is observed in the caudal abdomen. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Large splenic and hepatic mass. Neoplasia (i.e., round cell tumor, sarcoma, adenocarcinoma) is considered likely with a lower possibility of a non-malignant process (i.e., multifocal inflammatory disease). The origin of the mass in the caudal abdomen is unclear. It is suspected to be an enlarged lymph node. However, a mass of other origin (i.e., mesenteric, bowel) is also possible. Again, neoplasia is suspected with a lower possibility of a severe inflammatory process.

Secondary Findings:

- The urinary bladder wall changes are suggestive of cystitis.



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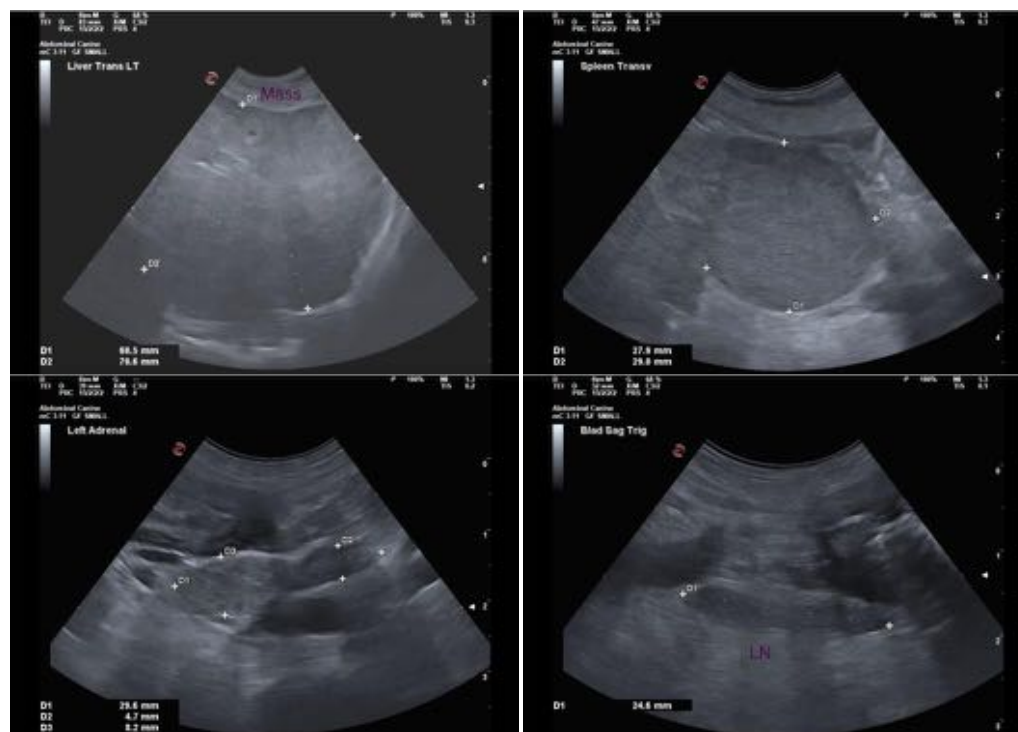
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- Bilateral chronic, age-related renal changes.
- Bilateral adrenomegaly. The left adrenal nodule may represent a benign nodular hyperplasia or an emerging tumor.
- Gallbladder debris could be consistent with fasting, cholestasis, or less likely, an emerging mucocele.
- Age-related pancreatic remodeling.
- The well-defined prominent abdominal lymph nodes could be consistent with infiltrative neoplasia or reactive change.
- The gastric, small intestinal, and colonic wall changes are most consistent with an inflammatory process with a lower possibility of emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Thoracic radiographs are recommended to assess for lymphadenopathy in the chest.
- If cytology results from the spleen and liver are inconclusive, consider an aspirate of the caudal abdominal mass or more advanced diagnostics (i.e., PARR, biopsies).





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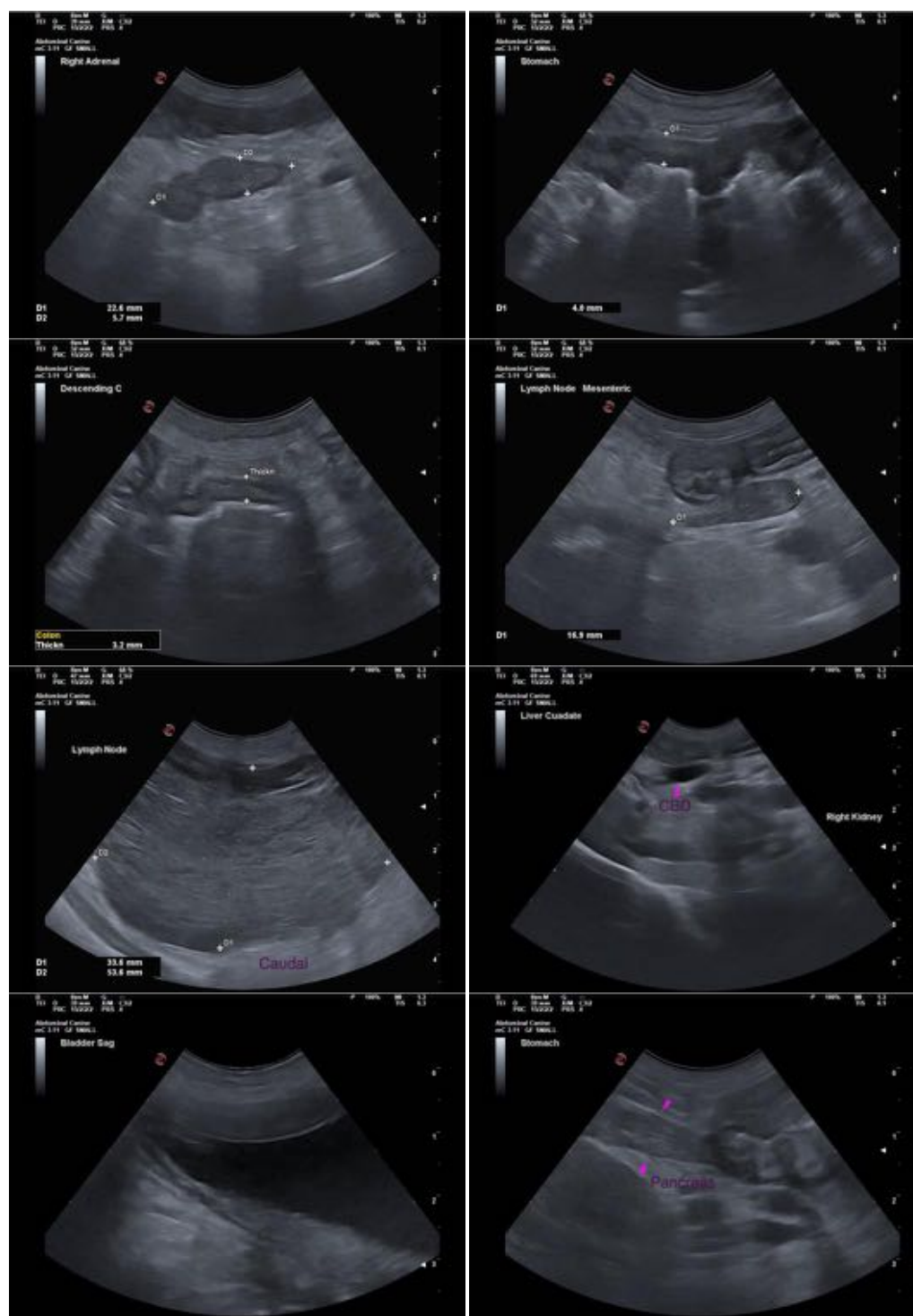
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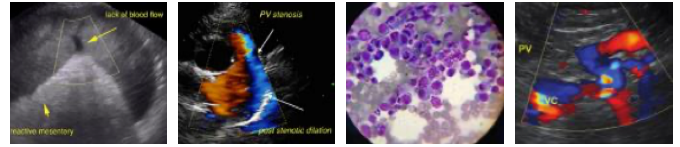
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.



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Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com

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