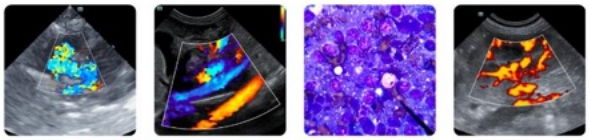


PATIENT
Nitrous Ames

SPECIES
Canine

BREED
Siberian Husky

SEX
Male, neutered

AGE
12 Yrs.

WEIGHT
97.7 lbs.

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

IMAGING PERFORMED BY
Dr. Janel Schietzelt

HOSPITAL NAME
Dreaming Summit AH

REFERRING VET
Dr. Janel Schietzelt

INVOICE
13613

DATE
3/17/26

PRESENTING CLINICAL SIGNS

History:

- Patient presents for routine dental and sedated exam (aggressive)
- Pre-op lab work showed marked elevation in ALP (>2,000), historically elevated at 800 previously
- No PU/PD at home, doing well, found as part of routine workup.
- Owner approved abdominal ultrasound during right before dental procedure while under anesthesia

Abnormal PE/Chem/CBC/UA Results: ALP >2,000 Stress hyperglycemia Remainder NSF 4DX SNAP test negative

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 3-4 cm, are normal.

The prostate is normal in size (1.14 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 (6.00 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 (7.97 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.

Adrenal Glands

The cranial pole of the left adrenal gland is visualized and is normal in size (0.71 cm in width) with a normal shape, glandular echogenicity and detail. Surrounding vasculature is normal.

In the region of the right adrenal gland, a 3.6 x 2.6 cm hypoechoic rounded mass effect is visualized. Surrounding fat is slightly hyperechoic.

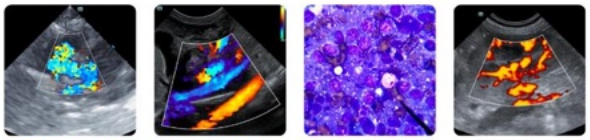
Spleen

The spleen is normal in size (2.01 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. At least one hypoechoic to anechoic nodule is visualized measuring 0.84 cm in its longest dimension. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with relatively smooth peripheral contours. The parenchyma is isoechoic to hyperechoic relative to the spleen and heterogeneous in appearance. A 7.0 x 4.0 cm irregular, hypoechoic swelling/mass is observed mid to right liver at the caudal aspect. 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 to moderate amount of gravity-dependent echogenic debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.



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Gastrointestinal

The gastric lumen is minimally 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 colonic wall is normal. There is no evidence of an obstructive pattern.

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.

Lymph nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Mid to right hepatic swelling/mass at the caudal aspect. Considerations include neoplasia (i.e., adenoma, adenocarcinoma, round cell tumor, sarcoma) vs a benign process (i.e., large regenerative nodule, inflammatory focus, other). The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease, infiltrative neoplasia and other hepatopathies are considered less likely.
- Mass effect in the region of the right adrenal gland. A right adrenal origin is suspected. However, other origins (i.e., lymph node, pancreas, mesentery) cannot be completely excluded. Neoplasia (i.e., adenocarcinoma, pheochromocytoma, other) is suspected with a lower possibility of an inflammatory process. Mild adjacent retroperitonitis is present.
- Gallbladder debris, non-mucocele

Secondary Finding:

- Minor bilateral age-related renal changes
- 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 hypoechoic to anechoic splenic lesion could be consistent with a benign cyst, focus of lymphoid hyperplasia, emerging tumor, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- Given the mass effect in the right adrenal gland, consider the following:
  1. Baseline blood pressure measurement

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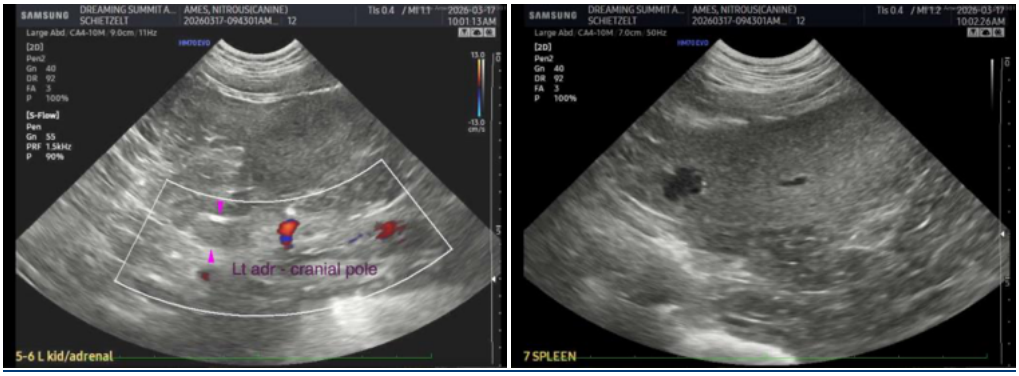
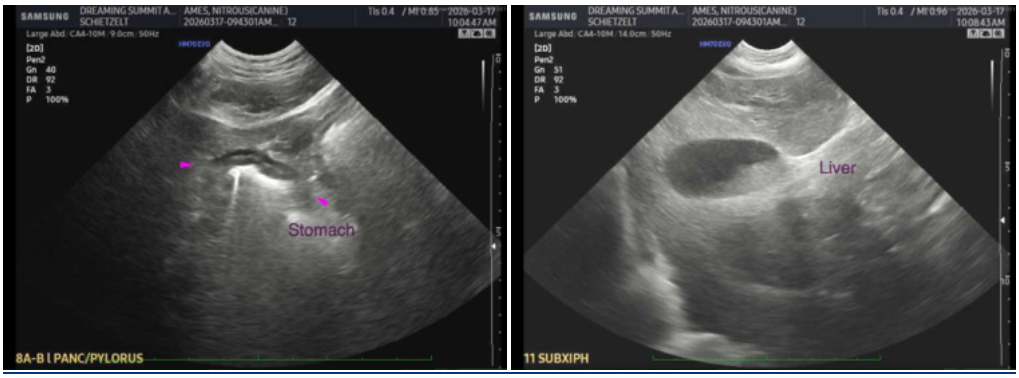
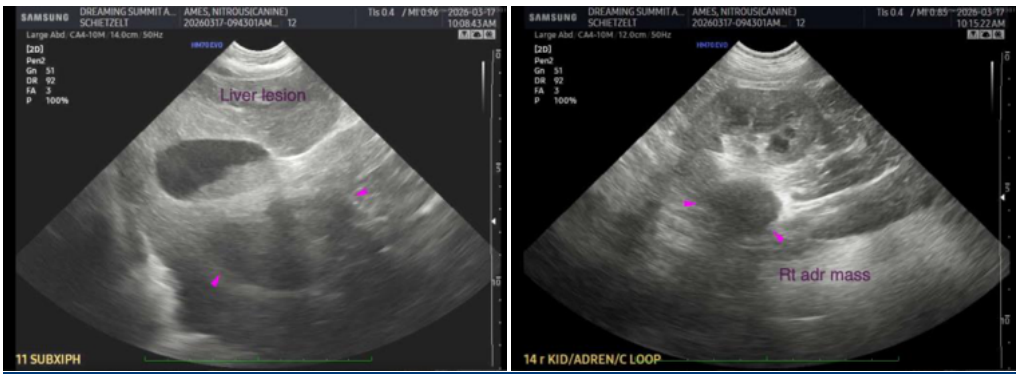
2. Further testing for a functional tumor (i.e., low-dose dexamethasone suppression test, urine/blood metanephrine levels)
3. +/- abdominal CT scan for further evaluation
4. If further testing is not pursued, consider a recheck ultrasound in 2-3 months to assess for growth of the lesion.

- Regarding the hepatic swelling/mass, histopathology would be necessary to get a definitive diagnosis.
- If the patient is to undergo anesthesia, consider avoiding benzodiazepines and using opioids judiciously.







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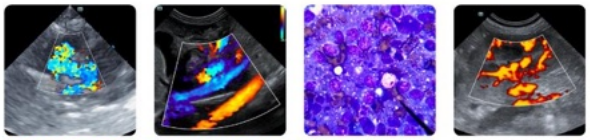

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Educational Teleconsultation Services™

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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