



**PATIENT**

Diesel Hendrickson

**SPECIES**

Canine

**BREED**

Mastiff

**SEX**

Male Intact

**AGE**

05/22/2018

**WEIGHT**

70.9 kg

**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**

BluePearl Summerville

**REFERRING VET**

Christina Kitzmiller DVM

**INVOICE**

23061

**DATE**

5-22-26

**PRESENTING CLINICAL SIGNS**

Clinical Exam Findings/History: Presented for lethargy and labored breathing. Clinical signs began over the weekend with lethargy and a decreased appetite; his food intake was reduced by about half from 5-6 cups per day to 3 cups. On Tuesday morning, he vomited water and mucus one time, and the owner noted the onset of heavy breathing, described as deep, more effortful, and open-mouthed. The owner reports that he visited his pDVM on Tuesday and Thursday, with radiographs and bloodwork being performed today prior to referral. Stools have been slightly loose but remain formed.

PE abnormalities/notable findings: QAR, slightly fractious with handling, BCS 6/9, moderate tachypnea and dyspnea, muffled bronchovesicular sounds ventrally, intact male with both testicles descended, no obvious murmur ausculted

Abnormal lab-work values:

CBC: NEU 12.91k (H), PLT 85k (L), rest WNL  
Chem: Glob 5.0 (H), ALP 240 (H), rest WNL

POCUS: Moderate bilateral pleural effusion. Pulmonary A-lines dorsally with no B-lines detected. No pericardial effusion detected. Unable to view specific cardiac chambers due to patient size and compliance. No peritoneal effusion detected.

Current Medications: Butorphanol 14 mg IV; unknown joint supplement

Radiographic Findings - 4 lateral projections of the thorax and abdomen, performed today at pDVM office:

1. Tubular soft tissue mass dorsal to the sternum on the lateral projections. Shortening and sclerosis of the fourth sternebra. Retraction and rounding of lung margins with fluid opacity in the pleural space. Cardiac silhouette is poorly visualized but normal in size. Pulmonary vasculature is normal.
2. Enlargement and rounding of the hepatic silhouette. Visible aspect of the spleen, kidneys, and urinary bladder are normal. Gastrointestinal tract contains visible gas and fluid but overall is within normal limits of size and margination. Serosal detail is adequate.
3. Moderate spondylosis deformans at the lumbosacral junction.

Assessment:

1. Ventral thoracic mass. Consider mediastinal origin (thymoma, round cell neoplasia, mediastinitis) or less likely pulmonary origin (primary pulmonary neoplasia, granuloma, bronchopneumonia).
2. Pleural effusion, nonspecific.
3. S4 Sclerosis. Ddx summation artifact, congenital anomaly, osteomyelitis.
4. Non-specific hepatomegaly. Differential diagnoses include metabolic/vacuolar hepatopathy, benign etiologies (nodular hyperplasia, extramedullary hematopoiesis, and neoplasia).

Recommendations:

1. For further evaluation, recommend collimated VD projection of the thorax, diagnostic thoracocentesis, and thoracic CT. Also consider additional imaging of the abdomen (ultrasound, CT) and ultrasound-guided FNA of the liver.

Specialist: Dr. Adam Schlax, DACVR

**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 5.0 cm, are normal.



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The prostate is enlarged (5.58 cm in width) with smooth peripheral contours. The parenchyma is slightly hyperechoic relative to surrounding omental fat, and mildly heterogenous, with a few, small, cystic lesions. The prostatic urethra appears is not overtly dilated.

**SPECIES**

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The left kidney is normal in size (9.58 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.

**BREED**

Mastiff

The right kidney is normal in size (7.12 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.

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**Adrenal Glands**

The left adrenal gland is normal in size (0.78 cm at cranial pole) (0.83 cm at caudal pole) with a slightly irregular shape. Glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

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The right adrenal gland is normal in size (1.46 cm at cranial pole) (0.71 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.

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**Spleen**

The spleen is normal in size (2.00 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

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**Liver**

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

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The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen.

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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 duodenal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Within one segment of jejunum, a 1.8 x 1.1 cm hyperechoic- to heterogenous intraluminal nodule/mass is visualized. In the remainder of the jejunum, the wall is normal in thickness with a normal layering pattern and appropriate mural detail. The ileoceocolic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

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**Pancreas**

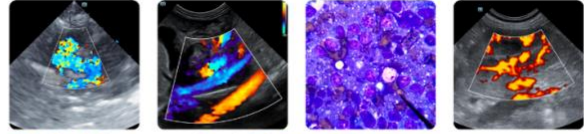
The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

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**Lymph Nodes**

A 3.81 x 0.65 cm medial iliac lymph node is visualized. One- to two prominent mesenteric lymph nodes are also seen (one measuring 2.06 x 0.77 cm). A 3.04 x 1.15 cm periportal lymph node is also visualized.



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**Free Abdomen**

There is no evidence of free fluid.

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**Other**

The testicles are subjectively normal-in-size and symmetrical (left 4.01 x 2.04) (right 3.83 x 1.75). Within the left testicular parenchyma, a 1.87 x 1.15 cm isoechoic- to slightly heterogenous nodule is visualized. In the right testicle, a 1.85 x 1.44 cm hyperechoic- to heterogenous nodule is visualized.

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Pleural effusion is seen in the visualized portion of the thorax.

**ULTRASONOGRAPHIC FINDINGS**

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**Primary Findings**

- Focal intraluminal jejunal nodule/mass. Differentials include tumor (i.e., adenoma, adenocarcinoma, leiomyosarcoma, round cell tumor) vs an inflammatory focus, vs other.
- Pleural effusion

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**Secondary Findings**

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- Bilateral testicular nodules. Rule out benign vs neoplastic lesions.
- The prostate changes are most consistent with benign prostatic hyperplasia. Bacterial prostatitis is also a differential but considered unlikely in the absence of lower urinary tract signs.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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- For further evaluation of the jejunal mass, consider an abdominal CT scan +/- exploratory with excisional biopsy.
- Further recommendations should be based on the echocardiogram report.

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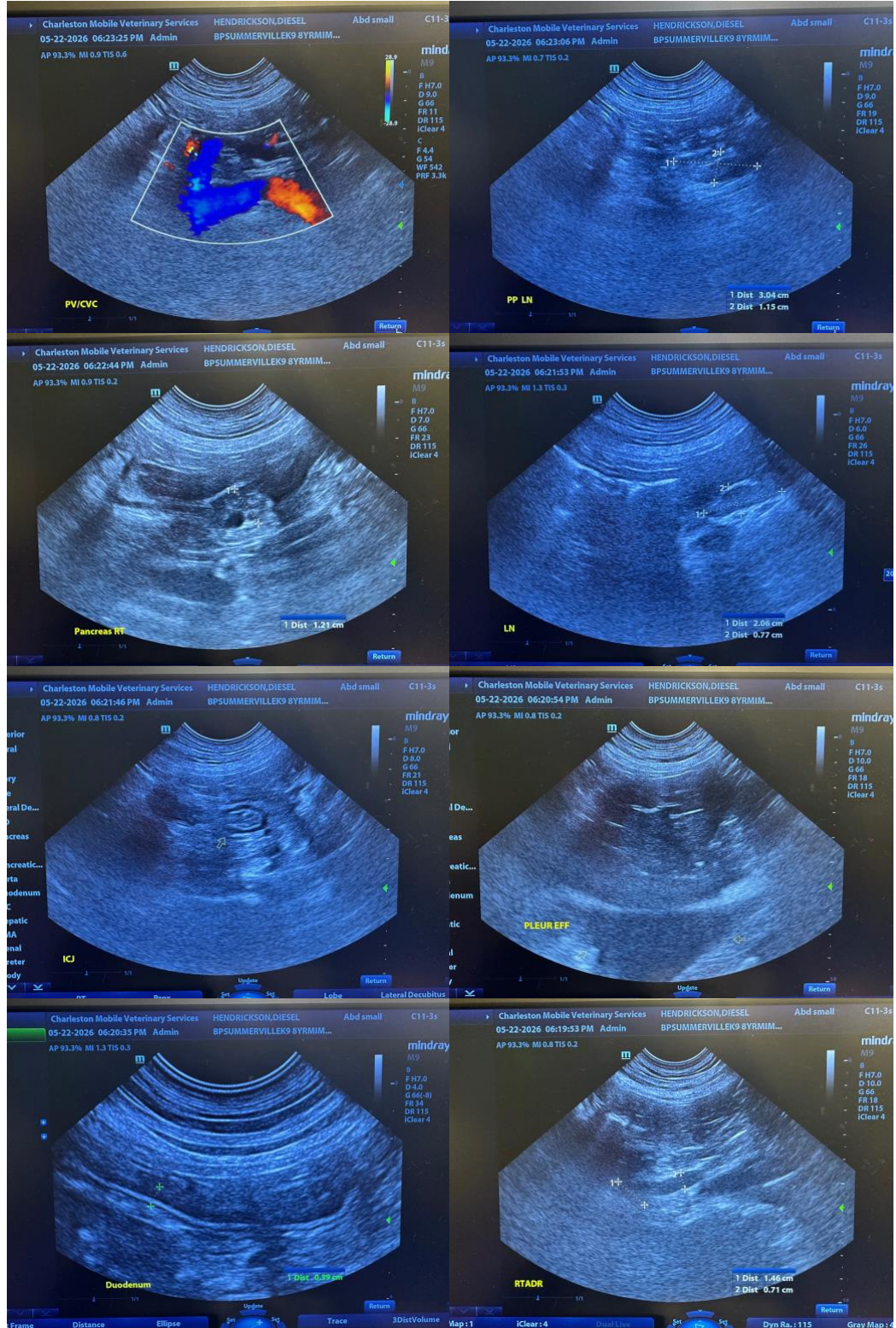
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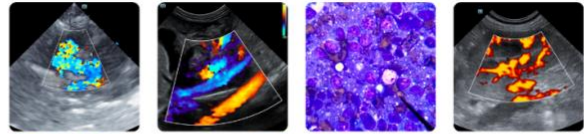
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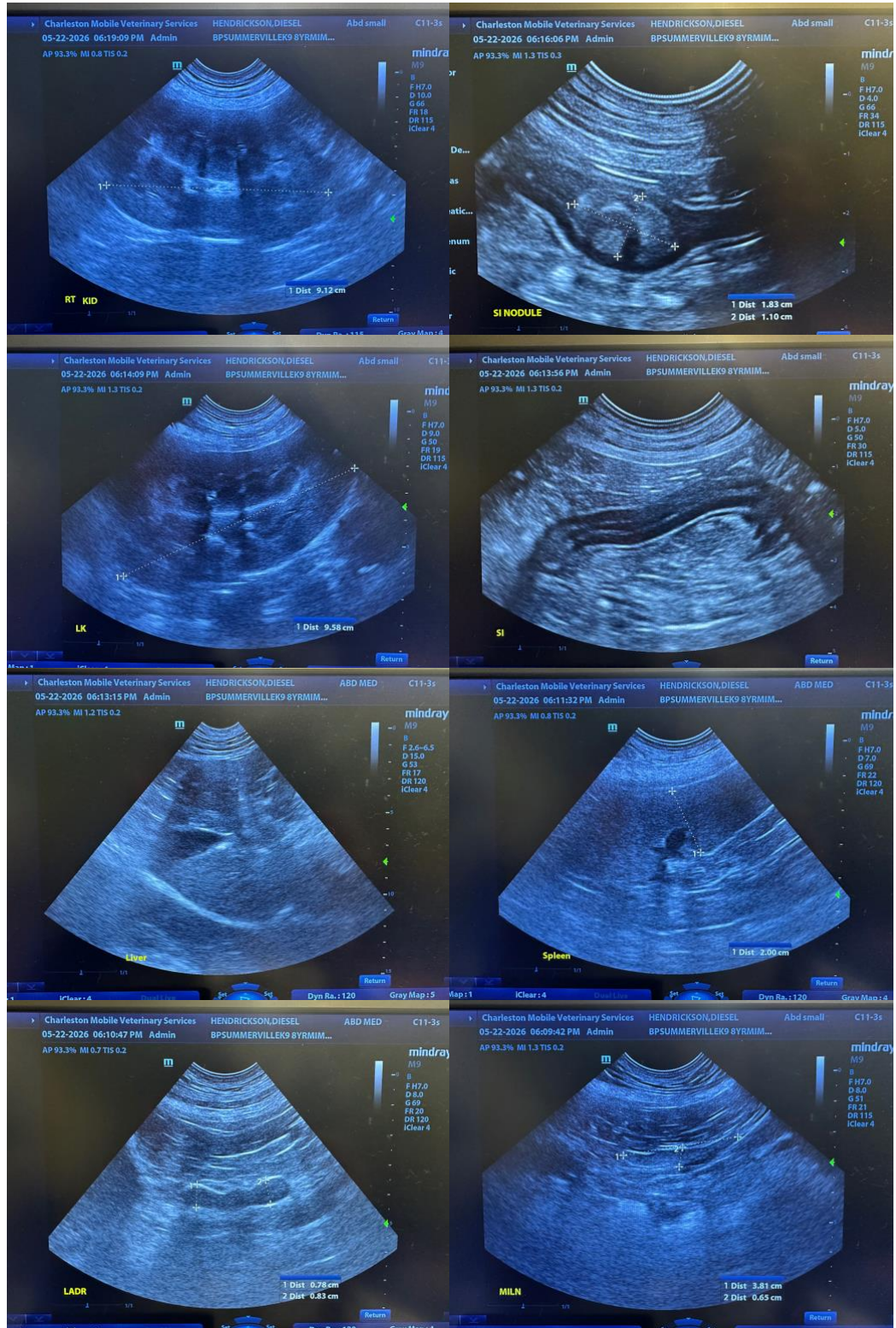
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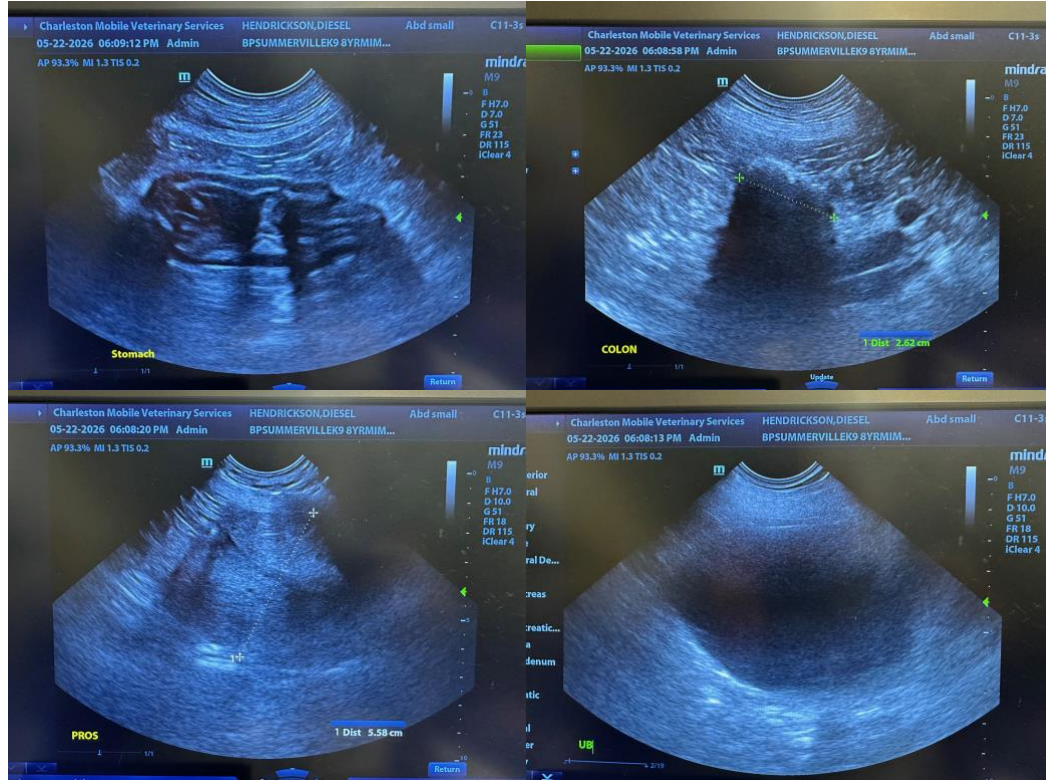
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 Nicastrò, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)**  
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