



PATIENT

Sadie Mariotti

PRESENTING CLINICAL SIGNS

SPECIES

Canine

BREED

Poodle

SEX

Spayed Female

AGE

13 years

WEIGHT

19 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques,
RVT LVT

HOSPITAL NAME

Pine Creek VC

REFERRING VET

Dr. Denny Nolet

INVOICE

10858

DATE

5/5/22

History: Appointment reason: Abdominal U/S. New client/new PT. Current vet recommends U/S of liver due to blood test results. O will have vet send records. Needs exam from Dr. Dog is Blind. O = Objective Information Gen BAR, MM pink, CRT <2sec Heart No murmur/arrhythmias Lungs Eupneic, no crackles/wheezes GI/GU Soft, non-painful abdomen, no abnormalities on palpation Skin Healthy skin/coat, no ectoparasites noted Mouth / Teeth Periodontal Dz not present EENT WNL, no ocular/nasal discharge M/S BCS: No lameness noted Lymph nodes WNL NS Mentation appropriate

Abnormal PE/Chem/CBC/UA Results: Alkaline Phosphatase (ALKP) 1,401.0 U/L ALT/SGPT (ALT) 226.0

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. The region of the trigone and the visualized portion of the proximal urethra are normal.

The left kidney is normal in size (4.36 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. The cortex is hyperechoic. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

The right kidney is normal in size (4.76 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. The cortex is hyperechoic. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.55 cm at cranial pole) (0.76 cm at caudal pole); 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.

The right adrenal gland is normal size (0.80 cm at cranial pole) (0.52 cm at caudal pole) (2.06 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 normal in size (1.49 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is slightly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.



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Liver

The liver is subjectively enlarged with swollen to slightly irregular peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely heterogenous in appearance. A 5.15 cm isoechoic to slightly heterogenous mass is observed on the right side. The lesion causes capsular expansion. In addition, a 0.96 cm hypoechoic nodule is also observed on the right, adjacent to the diaphragm. 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 thin and smooth. A small amount of echogenic debris is observed within the lumen most of which is gravity dependent and some of which is suspended. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is not distended. The gastric wall in the region of the fundus is normal in thickness with a normal layering pattern. Within the pyloric antral wall, there is a focal thickening of the muscularis layer at the lesser curvature. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. The colonic wall is normal. No obstructive or overt infiltrative disease is noted.

Pancreas

The base and limbs of the pancreas are 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.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. A 0.93 cm medial iliac lymph node is visible. A few prominent mesenteric lymph nodes are also seen, the largest measuring 1.67 cm in length.

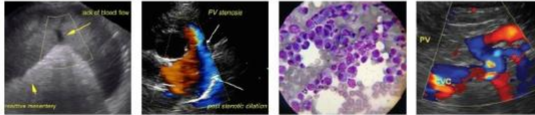
Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Right hepatic mass. Neoplasia (i.e., adenoma, adenocarcinoma) is considered likely. However, a benign process (i.e., excessive regenerative nodular hyperplasia) cannot be completely excluded. The diffuse hepatic parenchyma changes are nonspecific and likely secondary to a benign process (i.e., regenerative nodular hyperplasia, age-related remodeling and/or vacuolar hepatopathy).



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Secondary Findings

- Age-related pancreatic remodeling +/- fibrosis. Mild pancreatitis may be present, particularly if the patient exhibits a positive Murphy's sign.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- Mild left adrenomegaly
- The bilateral renal changes are most consistent with chronic interstitial nephrosis/nephritis.
- The focal thickening of the muscularis layer in the pyloric antral wall could be consistent with hypertrophy, inflammation, or less likely, emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three-view thoracic radiographs are recommended to assess for pulmonary metastases.

If there is no evidence of pulmonary metastatic disease and an aggressive approach is desired, consider hepatic mass removal with submission for histopathology. If surgery is pursued, referral to a board-certified surgeon due to the potential for perioperative complications. An abdominal CT scan would be useful in presurgical planning. If a more conservative approach is desired, consider a repeat ultrasound in 3-4 weeks to assess for progression.

Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.



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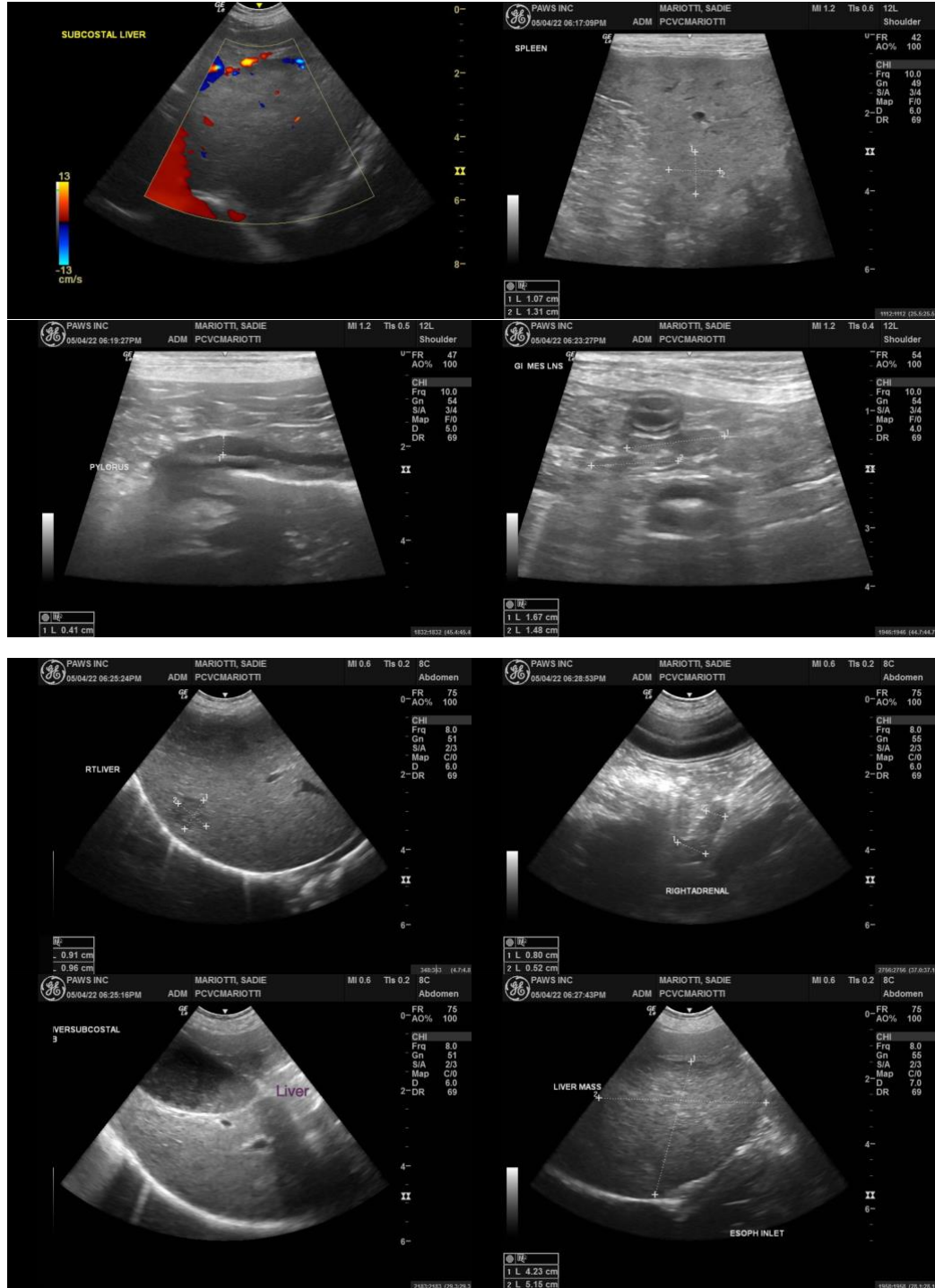
Dr. Denny Nolet

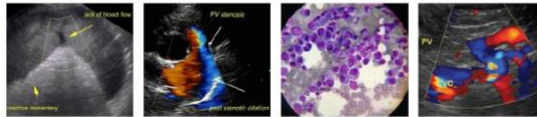
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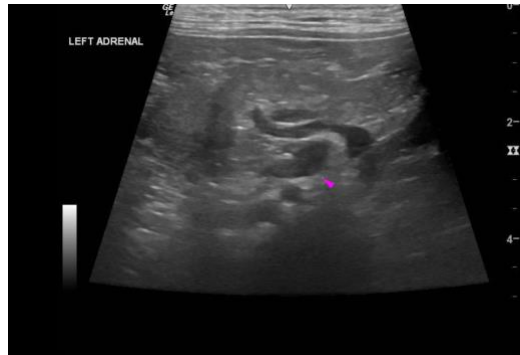
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com

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