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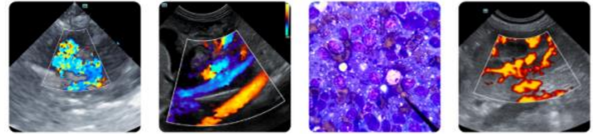
FOSTERING THE ART OF VETERINARY MEDICINE™



Clinical Sonography & Telecytology

Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

Cameron McInnis

SPECIES

Canine

BREED

Shepherd Mix

SEX

Neutered Male

AGE

9

WEIGHT

90.1 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Kendall Helbert

HOSPITAL NAME

South College VC

REFERRING VET

Kendall Helbert

INVOICE

23106

DATE

6-2-26

PRESENTING CLINICAL SIGNS

History: P presented for inappetence. He is currently being treated for AGASACA with oncology at AUCVM - he is receiving chemotherapy and radiation. Most recently, he received carboplatin (5/14/26)

Below is the most recent information from AUCVM:
1. Apocrine gland anal sac adenocarcinoma (AGASACA), right-sided with metastasis to sub-lumbar lymph nodes
- Diagnosed via cytology of right anal sac mass 1/13/26
- Metastasis to sublumbar LN diagnosed via cytology on 1/13/26
- No evidence of pulmonary metastasis on CXR 1/13/26
- Abdominal CT revealed right-sided anal gland mass with severe multifocal cavitary sublumbar lymphadenopathy causing displacement of multiple structures 2/3/26
- Palliative RT, 6Gy x 6 fx weekly, completed on 3/25/26
- 4/23/26 CXR and AUS showed stable metastatic disease and partial response to RT of primary anal gland tumor, chemotherapy with carboplatin initiated 4/23/26

Abnormal PE/Chem/CBC/UA Results: Overall PE unremarkable today. P nadired last week on his CBC (results attached). He was treated with Clavamox 625mg q12h x7d.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface in the region of the apex is slightly irregular. The bladder is mildly distended. Luminal contents are anechoic. No cystic calculi are observed. The region is normal.

The left kidney is normal in size (7.16 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. The cortex is isoechoic- to hyperechoic relative to the spleen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (8.00 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. The cortex is isoechoic- to hyperechoic relative to the spleen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.63. cm at cranial pole) (0.66 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.

The region of the right adrenal gland is evaluated. No obvious pathology is observed in this region.

Spleen

The spleen is subjectively normal in size with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal peripheral contours. The parenchyma is hypoechoic relative to the spleen. On the left side, a 2.1 x 2.0 cm isoechoic- to slightly hypoechoic nodule/mass is

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suspected. The remaining parenchyma is subtly mottled in appearance. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of gravity-dependent, echogenic- to mineralized debris/sand is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. 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. A segment of what appears to be the descending colon is moderately thickened (up to 0.80 cm) with retention of the normal layering pattern. There is no obvious 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
A 5.9 x 3.8 cm heterogenous medial iliac lymph node is visualized. Two- to three enlarged, heterogenous, slightly cystic sublumbar lymph nodes are also seen (one measuring 4.5 x 2.7 cm).

Free Abdomen
There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

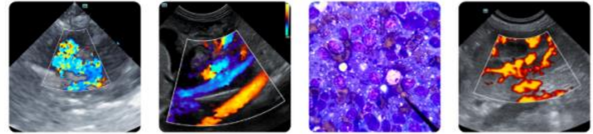
- Medial iliac and sublumbar lymphadenopathy, likely consistent with metastatic disease from the previously diagnosed right anal gland adenocarcinoma.
- Suspected left hepatic nodule/mass. Considerations include regenerative nodule, inflammatory focus, metastatic lesion, emerging primary tumor, other. Mild bilateral nonspecific age-related renal changes

Secondary Findings

- The diffuse hepatic parenchymal changes are most consistent with benign age-related parenchymal remodeling. However, correlation with the patient’s liver values is recommended.
- The descending colonic wall changes are most consistent with colitis, with a lower possibility of emerging neoplasia.
- Gallbladder debris/sand, non-mucocele

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- With regard to the lymphadenopathy, consider a consultation with the patient’s oncologist for further diagnostics and treatment recommendations.



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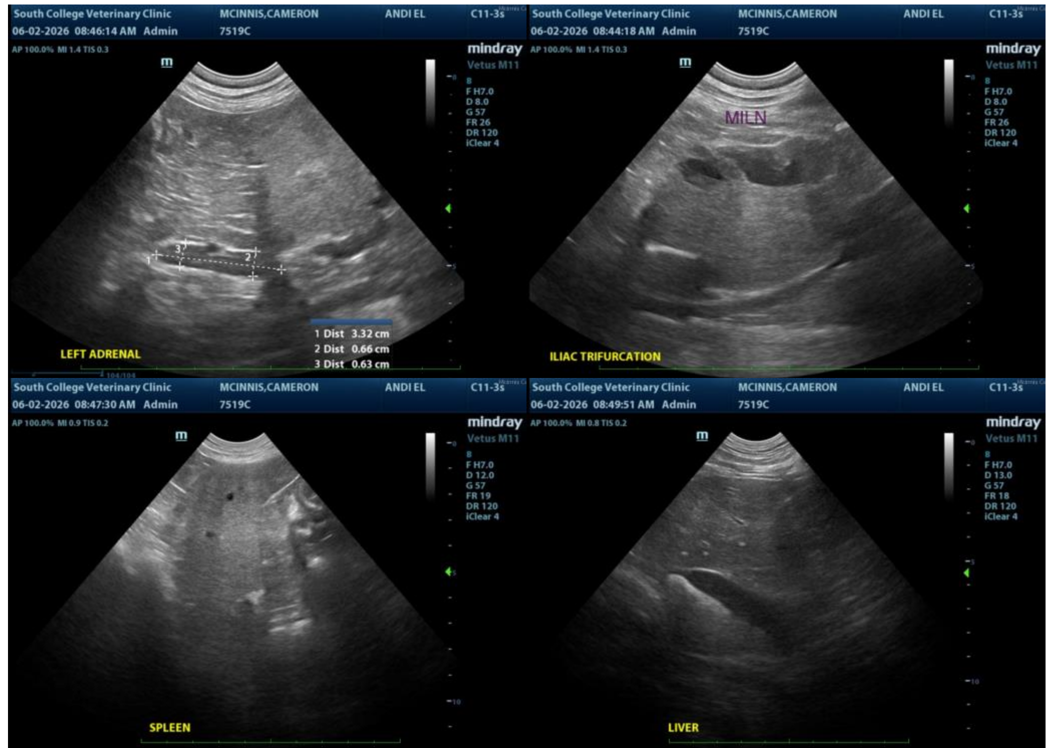
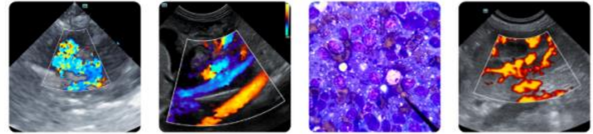
- Regarding the hepatic nodule, consider fine-needle aspiration (if accessible and if clotting status is appropriate). A 25-gauge needle should be used. Alternatively, consider a recheck ultrasound in 2-3 months to assess for growth of the lesion.





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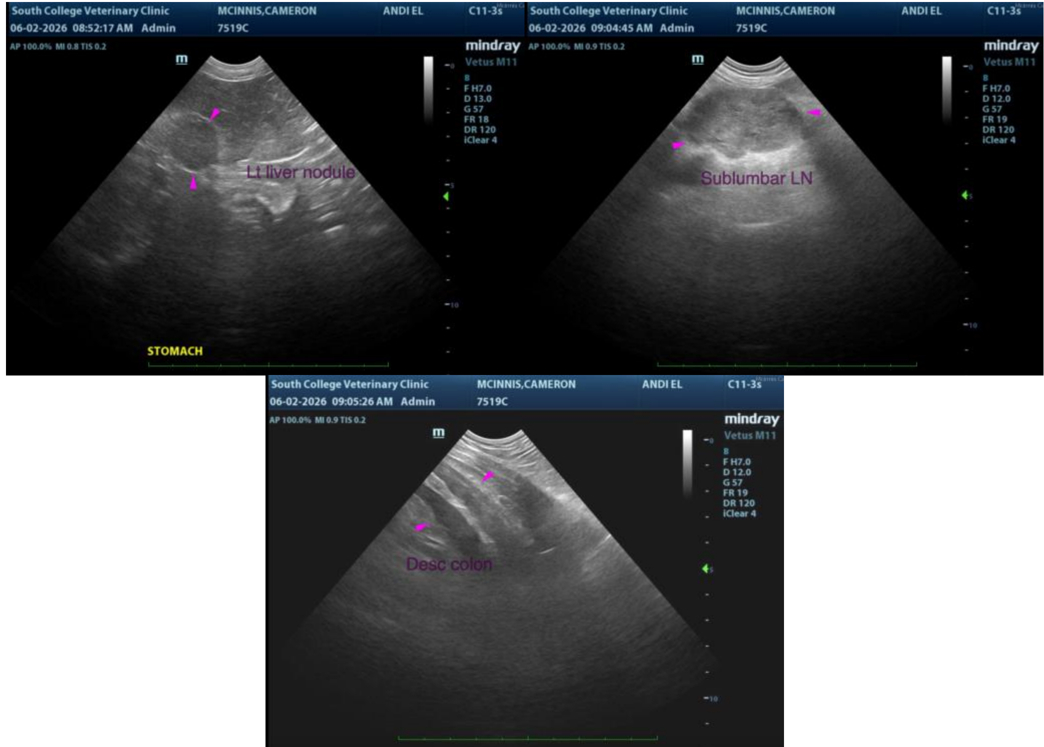

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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