



**PATIENT**

Nellie Ebersbach

**SPECIES**

Canine

**BREED**

Cocker spaniel mix

**SEX**

Female, spayed

**AGE**

7 Yrs.

**WEIGHT**

31.7 lbs.

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Shari Reffi, CVT

**HOSPITAL NAME**

Newton Vet

**REFERRING VET**

Dr. Chun

**INVOICE**

11902

**DATE**

8/18/21

**PRESENTING CLINICAL SIGNS**

History: Hepatomegaly w/mass on liver, pulmonary nodule in caudal lung fields on rads. Lethargic, inappetence, diarrhea x 1wk. Current meds: IVF+2.5% dextrose, Famotidine, Metronidazole, Cerenia  
Abnormal PE/Chem/CBC/UA Results: Gluc 64 (75L); ALT 211 (120H); ALP 197 (140H)

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

*Urinary System*

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone is normal.

The left kidney is normal size (5.67 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (6.03 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

*Adrenal Glands*

The left adrenal gland is normal size (0.41 cm at cranial pole) (0.43 cm at caudal pole) (1.80 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.

The right adrenal gland is normal size (0.44 cm at cranial pole) (0.61 cm at caudal pole) (2.19 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 (1.45 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.

*Liver*

The liver is subjectively enlarged with irregular peripheral contours. A 7.82 x 4.81 cm heterogeneous mass is observed in the left lateral lobe. In addition, a 3.51 x 4.28 cm heterogeneous cavitated mass is observed in the deep left liver. Within the cavitation, suspended echogenic debris is present. At least 3 additional heterogeneous nodules/masses, some with cavitated areas, are observed throughout the hepatic parenchyma. The remaining parenchyma is mottled in appearance. 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 moderate amount of aggregated echogenic gravity-dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.



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***Gastrointestinal***

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The stomach and intestine are free of stasis and exhibit normal peristaltic activity. 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 small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The wall of the descending colon is mildly thickened (up to 0.40 cm) with retention of the normal layering pattern. The colonic lumen is not dilated. There is no evidence of obstruction. No obstructive disease is noted.

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***Pancreas***

The left and right limbs of the pancreas is 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 mesentery in the cranial abdomen is hyperechoic. A small amount of anechoic free fluid is present. Several prominent to enlarged lymph nodes are observed in the cranial abdomen. One of the larger nodes measures 3.59 cm in length. Surrounding mesentery is hyperechoic.

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***Other***

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

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**ULTRASONOGRAPHIC FINDINGS**

**Primary findings:**

- Multiple hepatic masses, some of which are cavitated. Neoplasia is the top differential with lower possibility of non-neoplastic disease (i.e., multifocal abscessation). Regional peritonitis is present.
- The cranial lymphadenopathy may be due to infiltrative neoplasia, lymphoid hyperplasia or reactive lymphadenitis.

**Secondary Findings:**

- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.
- The colonic wall changes are most consistent with inflammation with a lower possibility of emerging neoplasia.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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If an aggressive approach is desired, consider a fine needle aspirate of the mass on the left lateral liver lobe (if clotting status is appropriate). A 25-gauge needle should be used. It should be noted that cytologic evaluation of primary hepatic tumors is often inconclusive. If cytologic evaluation does not provide a definitive diagnosis and an aggressive approach is desired, referral to a board-certified

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veterinary surgeon could be considered to discuss surgical biopsies. An abdominal CT scan would be useful in pre-surgical planning. However, if neoplasia is present, the multifocal nature renders the prognosis as guarded.

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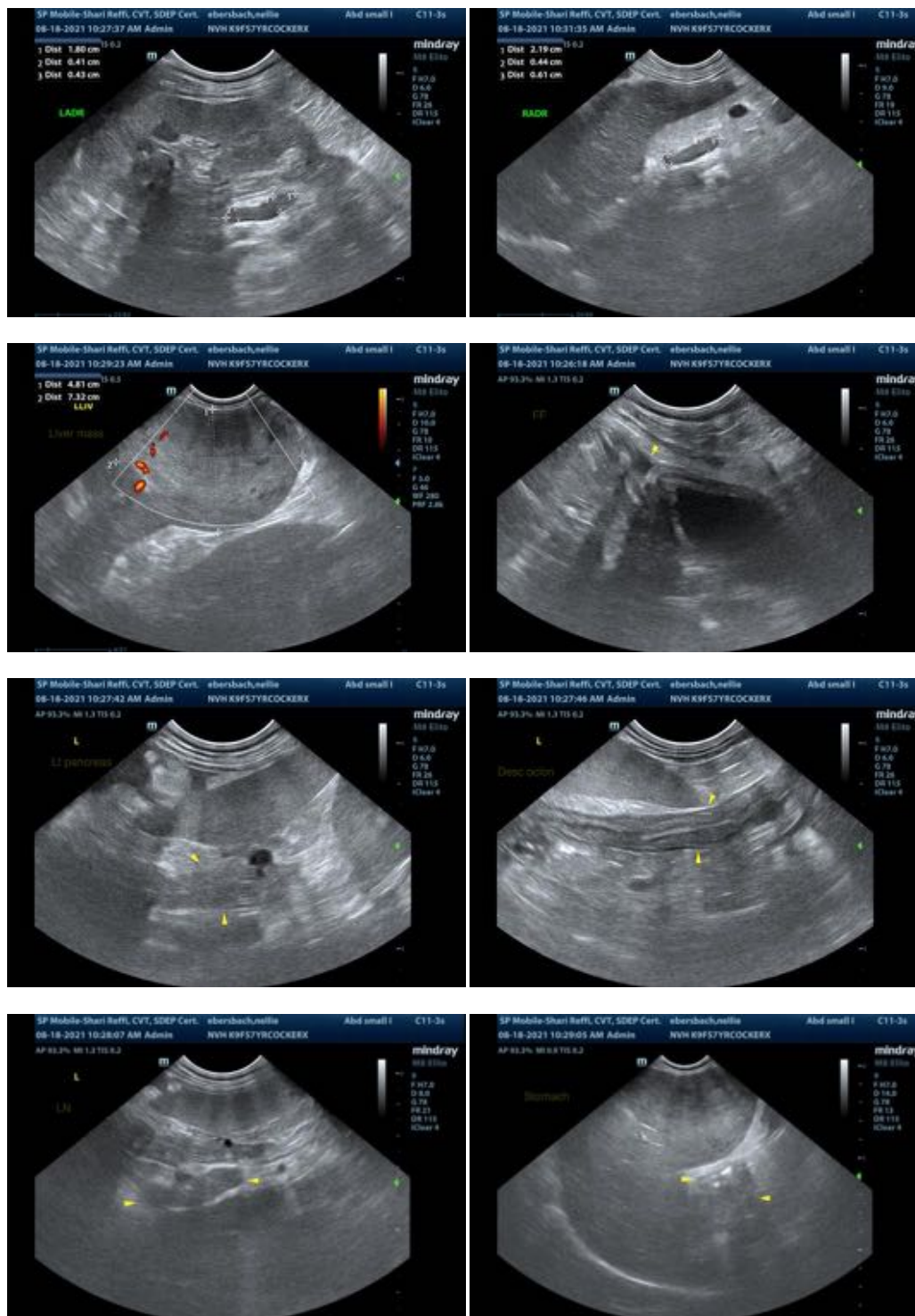
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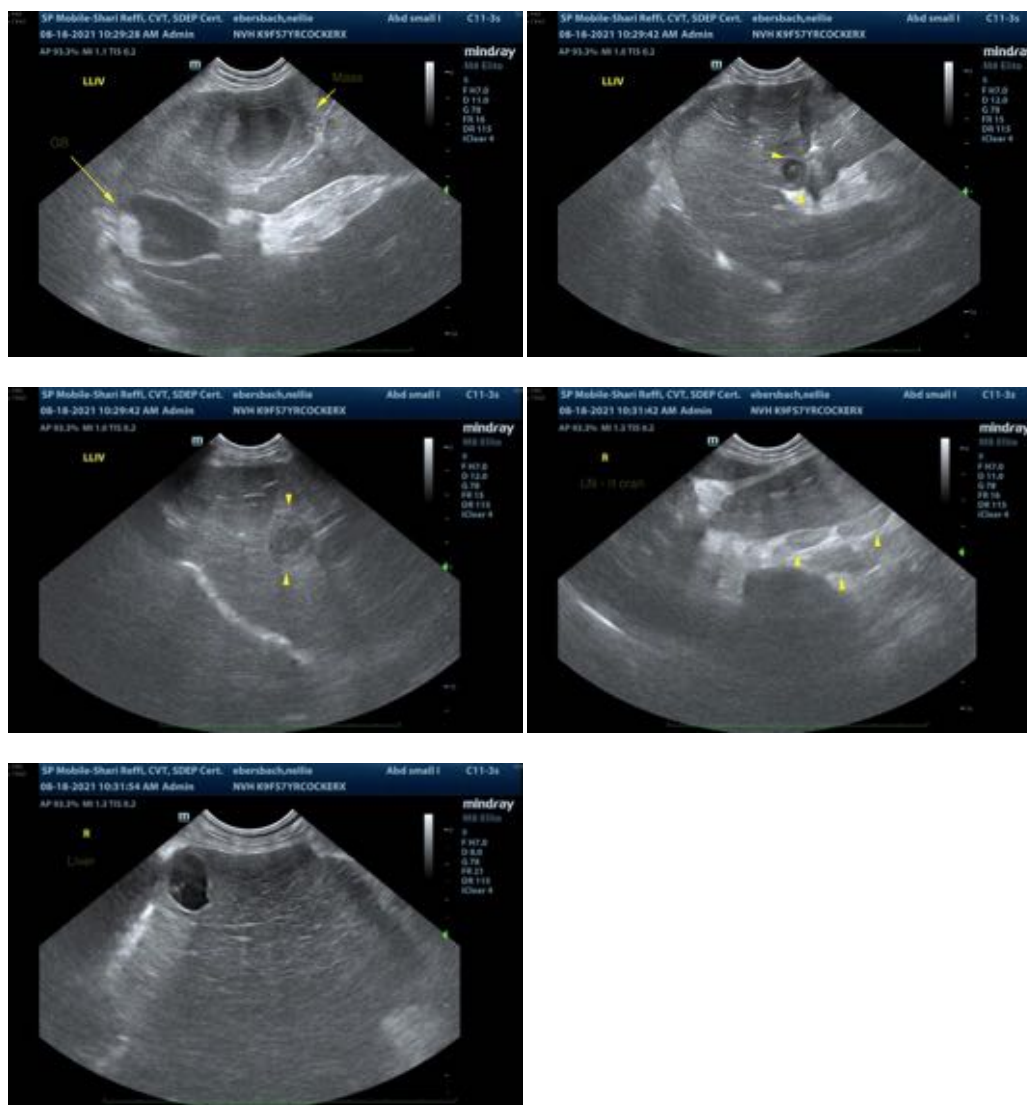
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 ACVIM (*Small Animal Internal Medicine*)

Andrea.nicastro@sonopath.com