

PATIENT

Sheldon Harrison

SPECIES

Canine

BREED

Standard Poodle

SEX

Male, neutered

AGE

13 Yrs.

WEIGHT

53 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh

HOSPITAL NAME

West Hills AH

REFERRING VET

Dr. Glaze

DATE

4/24/23

INVOICE

14835

PRESENTING CLINICAL SIGNS

History: Wellness scan. Elevated cPL. All other values WNL with the exception of mild elevation in ALT. Patient not symptomatic for pancreatitis. O considering laryngeal tieback for GOLPP. Primary Question/Differential to Be Answered in This Exam Pancreatic dz
Abnormal PE/Chem/CBC/UA Results: cPL 637. Mildly elevated ALT over time. 2/22 152. 4/22 165. 5/22 148. CBC WNL, USG 1.042, no proteinuria, inactive sediment.

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 (0.85 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (7.19 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (7.54 cm in length) with a normal shape and smooth peripheral contours. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A 2.85 cm cystic structure is observed approximately mid-kidney and is suspected to be arising from the lateral cortex. The cyst causes some disruption of the normal cortical and medullary architecture. There is no obvious evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.45 cm at cranial pole) (0.56 cm at caudal pole) (2.34 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 (1.17 cm at cranial pole) (0.55 cm at caudal pole) (2.84 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 (2.11 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 normal in size with normal curvilinear peripheral contours. The parenchyma is isoechoic to slightly hypoechoic relative to the spleen. A 3.72 cm slightly hypoechoic mass/lesion is observed deep on the left side. The lesion does not appear to cause capsular expansion. The remaining



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parenchyma is homogenous. 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 to mineralized debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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Gastrointestinal

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 segmentally gas distended. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

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Pancreas

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The right limb 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.

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Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

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ULTRASONOGRAPHIC FINDINGS

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Primary Findings:

- The deep left hepatic mass/lesion could be consistent with a large benign regenerative nodule, inflammatory focus or an emerging tumor (i.e., adenoma, adenocarcinoma, round cell tumor, other). The diffuse hepatic parenchymal changes are non-specific and may be secondary to inflammatory disease, hepatotoxicosis (i.e., copper), fibrosis, reactive hepatopathy, other hepatopathy.

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Secondary Findings:

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Bilateral, chronic renal changes with a large right cystic structure.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

REFERRING VET

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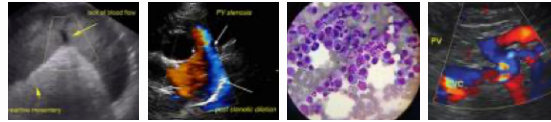
- Consider fine needle aspirates of the liver (if clotting status is appropriate) with particular attention to the deep left mass like lesion. Alternatively, excisional biopsy of the hepatic lesion along with biopsies of other hepatic lobes can be considered, if clotting status is appropriate. If biopsies are pursued, aerobic and anaerobic bile cultures should be obtained along with acquisition of additional hepatic tissue samples for potential copper quantitation.

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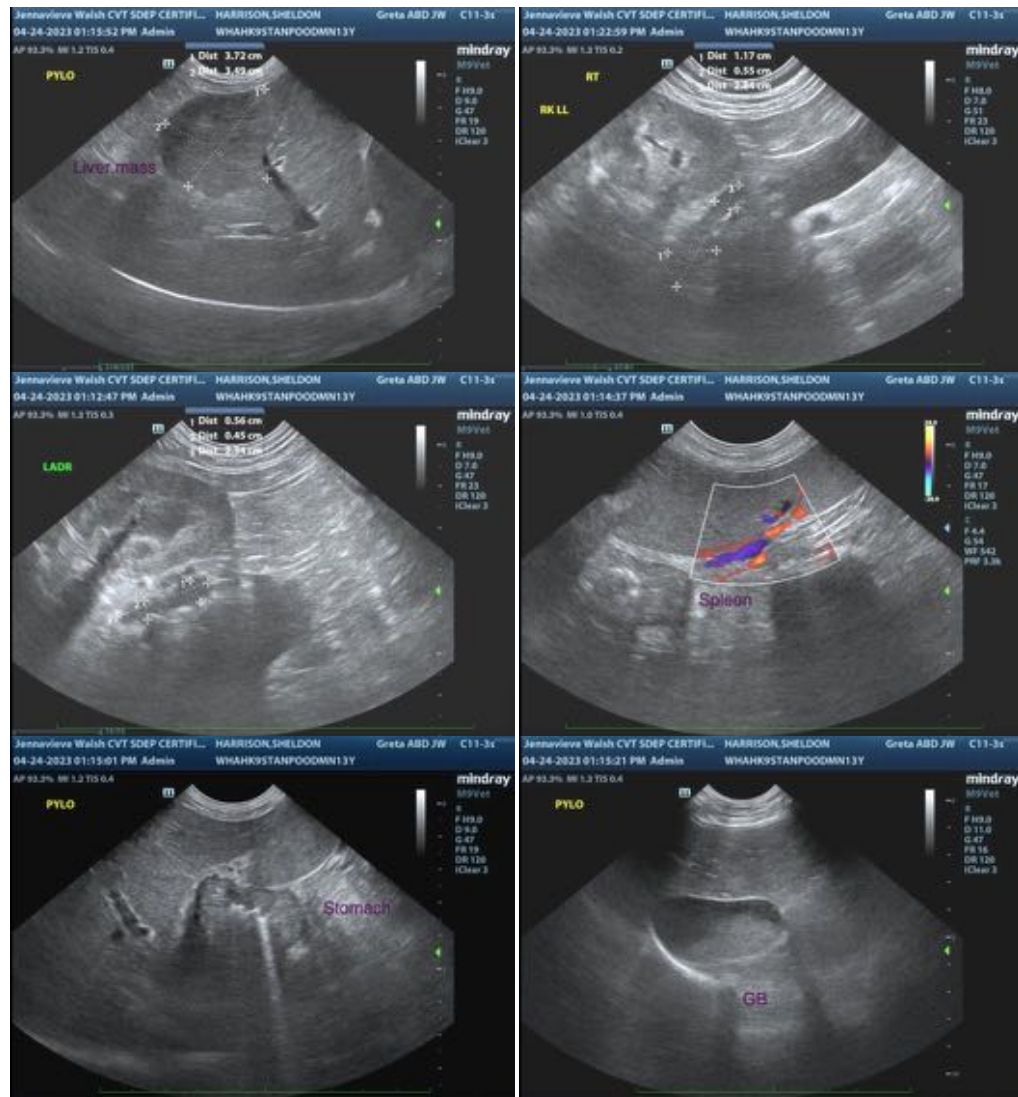
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- If a more conservative approach is to be taken at this time, consider rechecking liver values in 2-3 months along with a recheck ultrasound to assess for growth of the hepatic lesion.
- If the patient is to undergo anesthesia for a tie back surgery, benzodiazepines should be avoided and opioids used judiciously.





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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