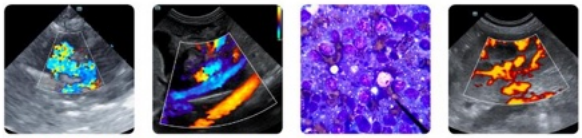

PATIENT

Molly Chaplin

SPECIES

Canine

BREED

Border collie mix

SEX

Female, spayed

AGE

11/13/2011

WEIGHT

38 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Southside AH

REFERRING VET

Dr. Sauls

INVOICE

13402

DATE

1/20/26

PRESENTING CLINICAL SIGNS

- Owner reports the abdomen feels very tight.
- Patient has a known mass on the right side of her body, which has been monitored.
- Owner describes signs of tenesmus or constipation, with the patient producing hard, ball-shaped feces.
- Patient has been lethargic and has changed her resting posture; she no longer lies on her side or back, but remains in a sternal or upright position.
- Owner has observed excessive drooling (ptyalism) at night.
- Patient may ingest items from the ground.
- Owner administered a dose of Vetprofen on Wednesday (01/14/2026) and noted the patient seemed disoriented afterward. A dose was withheld today.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with mostly anechoic urine. The wall in the region of the apex is thickened (up to 1.03 cm) and irregular. The wall tapers to a normal thickness as it extends toward the cystourethral junction. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal in size (6.51 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (6.40 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.56 cm at cranial pole) (0.57 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 right adrenal gland is normal in size (0.69 cm at cranial pole) (0.64 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.

Spleen

The spleen is normal in size (1.30 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 enlarged with irregular peripheral contours. A >17 cm irregular heterogeneous expansile mass is arising from the parenchyma. A large area of fluid accumulation is observed within the mass. Some more normal appearing hepatic parenchyma is observed cranially and on the right side. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1:1.

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The gall bladder is displaced cranially. The wall is normal in thickness. A small to moderate amount of suspended echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly distended with ingesta consistent with a post-prandial presentation. The gastric wall is normal to moderately thickened (up to 0.73 cm). There is questionable loss of the normal layering pattern in the thickened portion. The pyloric outflow tract is patent. 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. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb of the pancreas is enlarged with irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and heterogeneous in appearance. The pancreatic duct is borderline dilated (up to 0.29 cm).

Lymph nodes

1-2 prominent mesenteric lymph nodes are visualized, one of the nodes measuring 2.27 x 0.44 cm.

Free Abdomen

The mesentery throughout the abdomen is hyperechoic. A small to moderate amount of free fluid is present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Large expansile cavitated hepatic mass. Neoplasia (i.e., adenocarcinoma, hemangiosarcoma, other) is suspected with a lower possibility of an inflammatory process. The fluid pockets within the mass may represent necrotic areas, areas of abscessation, cysts, other.
- The gallbladder changes may be due to cholestasis or less likely, an emerging mucocele.
- The urinary bladder wall changes could be consistent with cystitis, artifact secondary to lack of full repletion, emerging neoplasia, other. Correlation with the patient's clinical history is recommended.
- The gastric wall thickening could be consistent with inflammation or emerging neoplasia.
- Diffuse peritonitis with ascites, likely secondary to hepatic +/- pancreatic pathology.

Secondary Findings:

- Mild bilateral nonspecific, age-related renal changes.
- The prominent mesenteric lymph nodes are likely reactive with a lower possibility of emerging neoplasia.
- The pancreatic changes are most consistent with chronic pancreatitis with parenchymal remodeling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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

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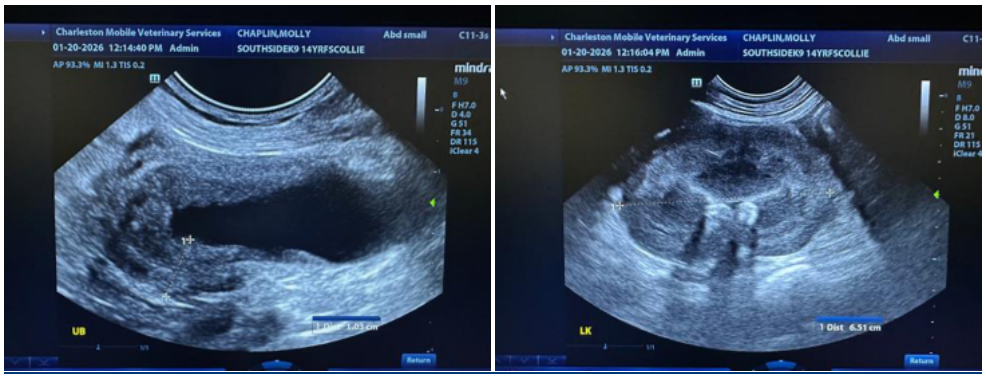
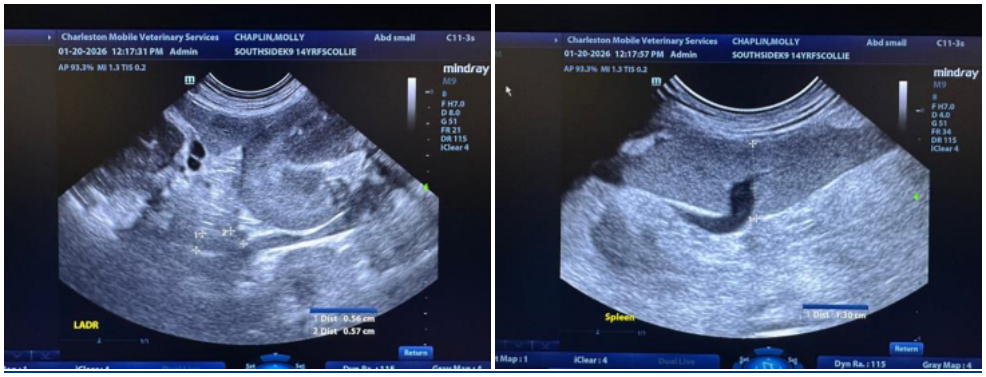
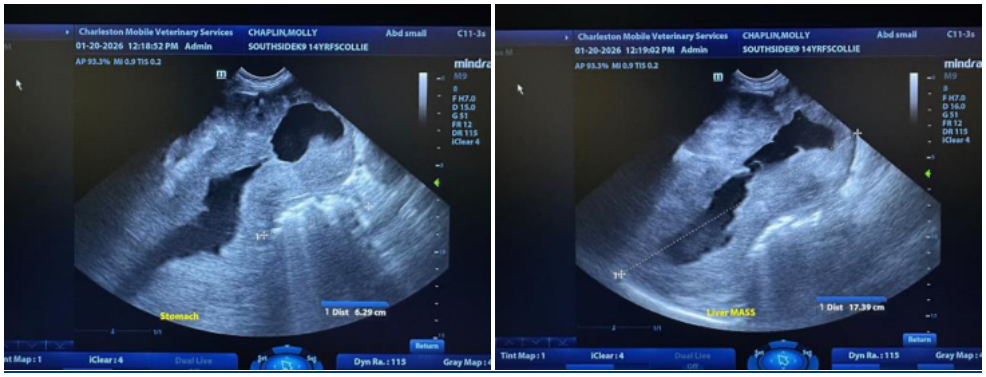
2. Regarding the hepatic mass, complete surgical removal is unlikely. However, if an aggressive approach is desired, consider consultation with a board-certified surgeon to discuss mass debulking with submission for histopathology and cultures. An abdominal CT scan would be useful in pre-surgical planning. Fine needle aspiration of the mass can be considered a prior to surgery, assuming normal clotting status.
3. Regarding the urinary bladder wall changes, consider a urinalysis with culture and sensitivity along with a urine BRAF test to further evaluate for lower urinary tract neoplasia.







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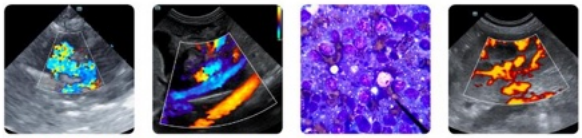

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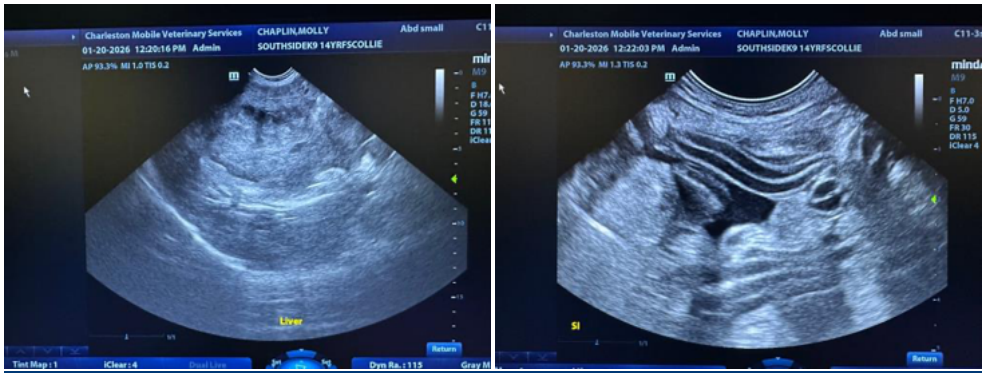

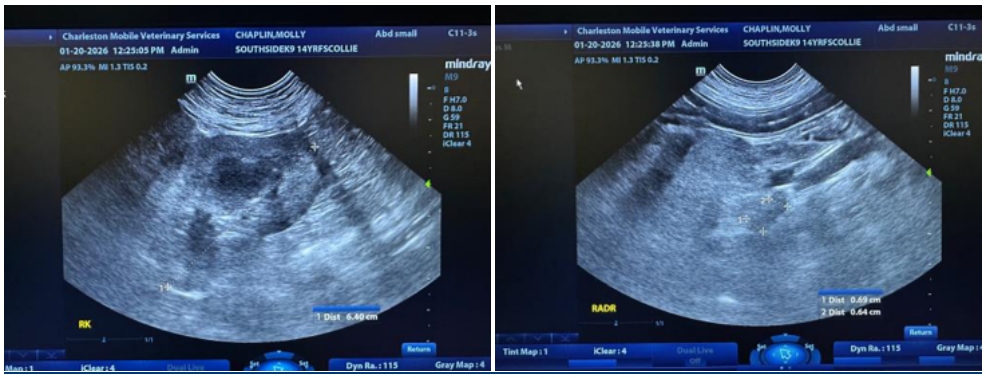

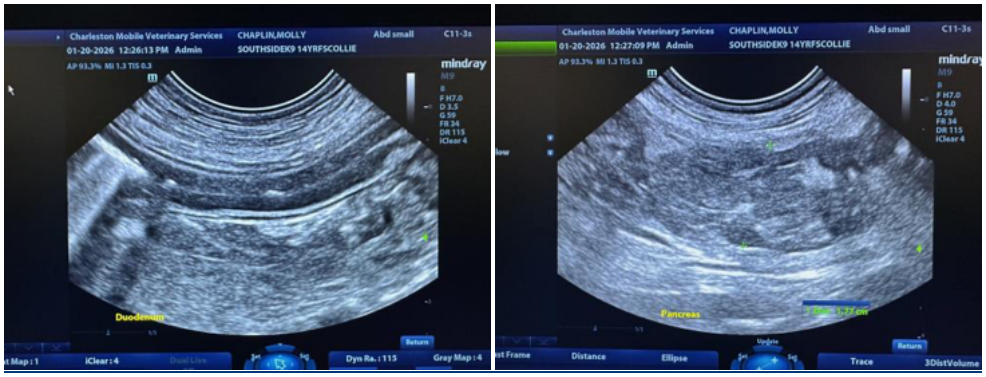

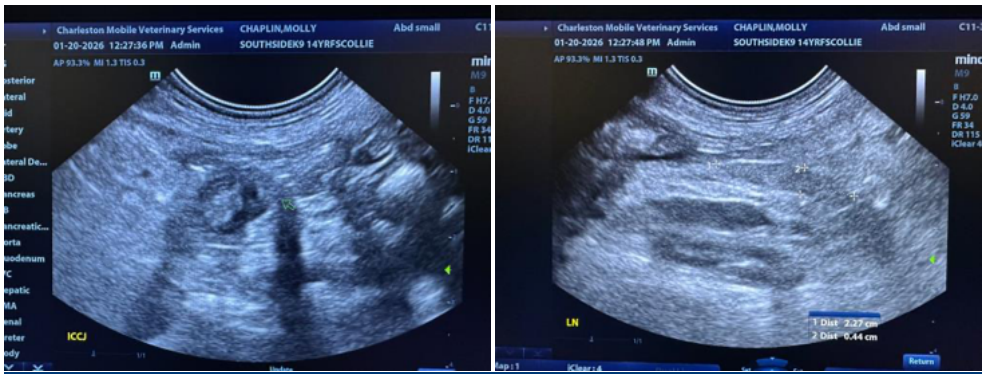

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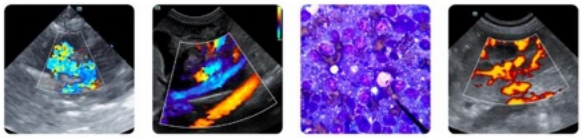

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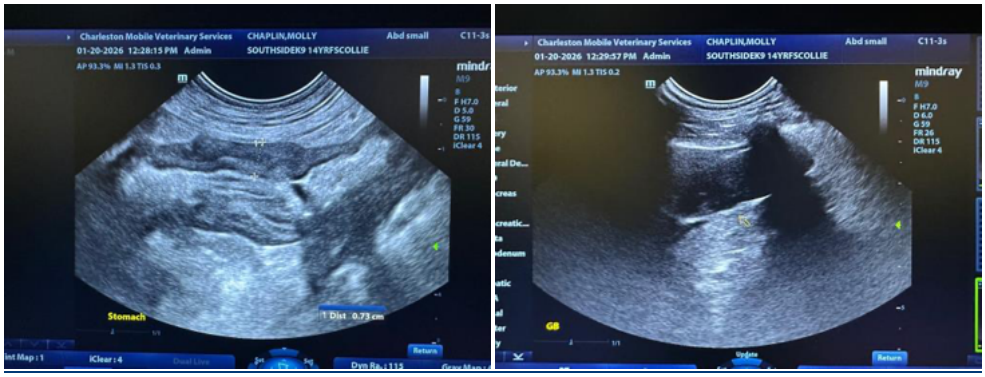

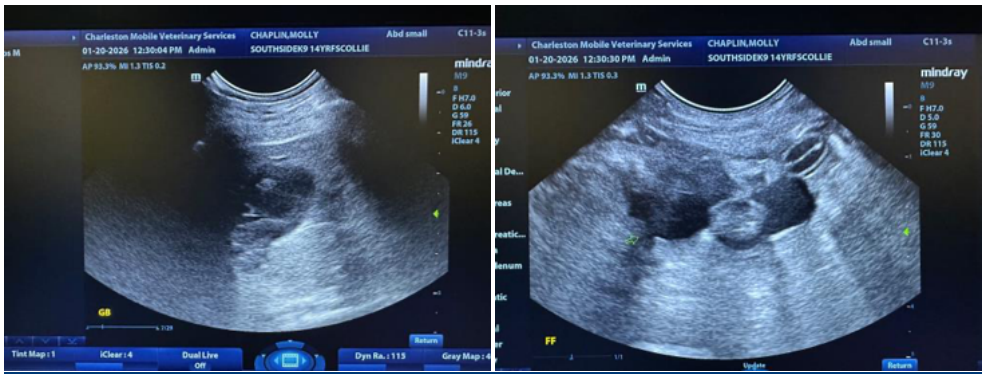

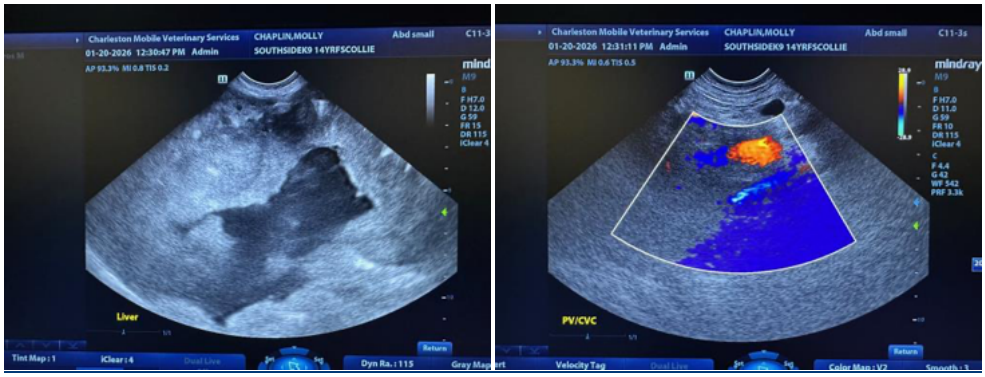

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com