



PATIENT

Ozzie Greer

SPECIES

Canine

BREED

Goldendoodle

SEX

Male, neutered

AGE

9/16/2013

WEIGHT

67 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

Central VH

REFERRING VET

Dr. Reynolds

INVOICE

13430

DATE

1/27/26

PRESENTING CLINICAL SIGNS

Non-ambulatory,
Inappetence
Cranial Abdomen painful

Rectal examination performed by Dr. Nicastro today revealed a large right anal gland mass.

CBC chem WNL, T4 0.7

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 cm, are normal.

The prostate is normal in size (0.93 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (7.99 cm in length) with slightly irregular peripheral contours. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. A 0.85 x 0.80 cm hypoechoic nodule is observed within the cortex. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in length (7.75 cm in length) with an irregular lateral contour. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. 2-3 hypoechoic nodules are visualized within the cortex, at least one of which is expansile. The largest nodule measures 2.23 cm in its longest dimension. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is enlarged (1.16 cm at cranial pole) (1.09 cm at caudal pole) with swollen irregular peripheral contours. The parenchyma is heterogeneous with loss of glandular detail. Surrounding vasculature appears normal.

The right adrenal gland is enlarged (1.49 cm at cranial pole) (1.45 cm at caudal pole) with swollen irregular peripheral contours. The parenchyma is heterogeneous with loss of glandular detail. Surrounding vasculature appears normal.

Spleen

A 2.53 x 2.15 cm hyperechoic to heterogeneous attenuating expansile mass is arising from the caudal aspect. In the remainder of the spleen, the margins are curvilinear. Several smaller hyperechoic nodules are also seen. Splenic vasculature is normal with no evidence of thrombosis. The remaining parenchyma is relatively homogeneous in appearance.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. 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 lumen is moderately distended. The wall is thin and smooth. A small to moderate amount of mobile echogenic debris 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 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 is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is hypoechoic 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.

Lymph nodes

A 2.5 x 1.7 cm periportal lymph node is visualized. At least 2 enlarged rounded, heterogeneous sublumbar lymph nodes are visualized, one of the nodes measuring 2.59 x 1.99 cm. In addition, 2-3 enlarged rounded, heterogeneous medial iliac lymph nodes are seen, one of the nodes measuring 4.07 x 2.33 cm. Surrounding mesentery is hyperechoic. In the left mid-abdomen adjacent to the left kidney, a 4.06 x 2.20 cm irregular hypoechoic lymph node is also seen. A 1.47 x 1.05 cm hyperechoic lymph node is also seen in the cranial abdomen.

Free Abdomen

There is no obvious evidence of free fluid.

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The abdominal lymphadenopathy is concerning for infiltrative neoplasia and may be due to metastatic disease from the right anal gland mass.
- The bilateral renal nodules are also concerning for metastatic disease. However, a benign process (i.e., inflammatory lesions) cannot be completely excluded. Bilateral age-related renal changes are also seen.

Secondary Findings:

- The splenic mass has the characteristics of a meylolipoma. However more insidious splenic pathology cannot be completely excluded.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Bilateral adrenomegaly



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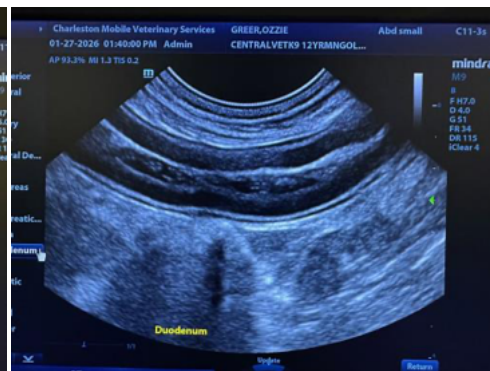
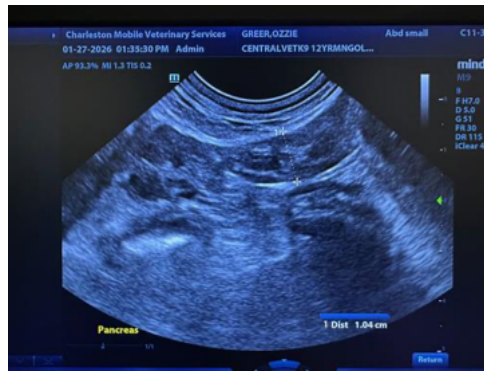
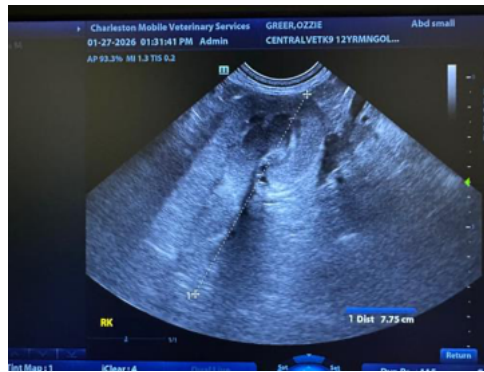
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Three-view thoracic radiographs are recommended to assess for pulmonary metastatic disease.
2. Consider fine needle aspiration of one of the enlarged caudal abdominal lymph nodes (assuming normal clotting status). A 25-gauge needle should be used. Depending on results, consultation with a board-certified oncologist and/or surgeon may be indicated. If further diagnostics are not pursued, palliative care is recommended.





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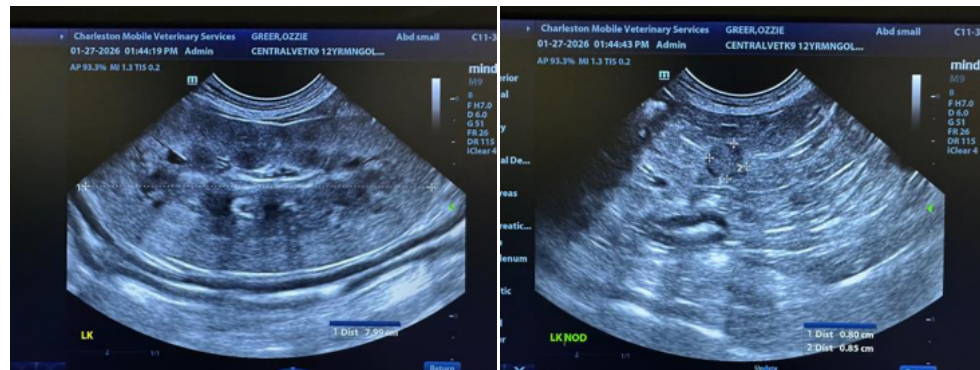
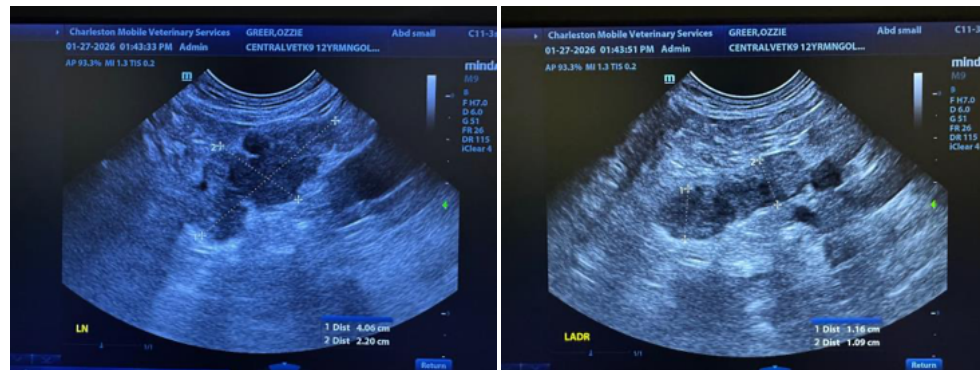
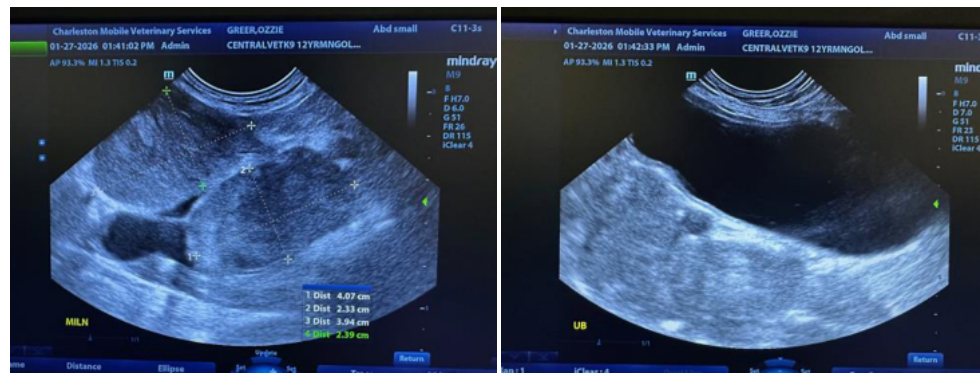
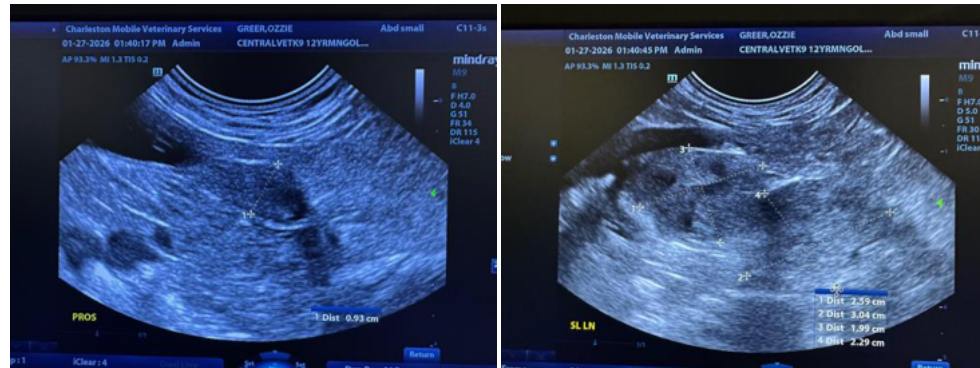
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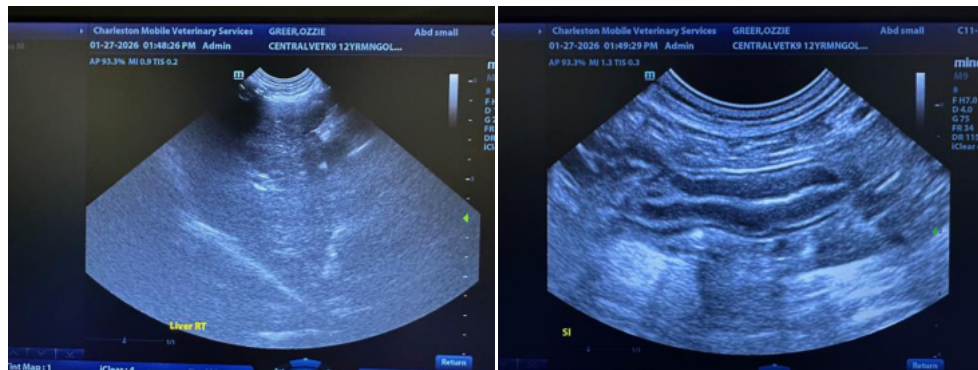
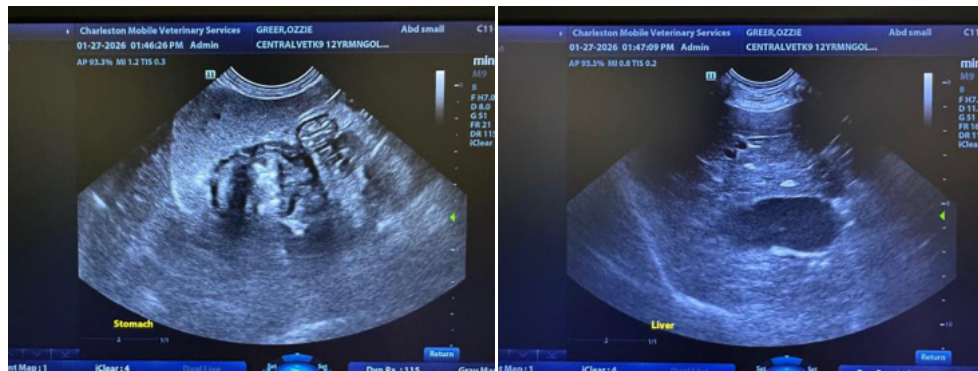
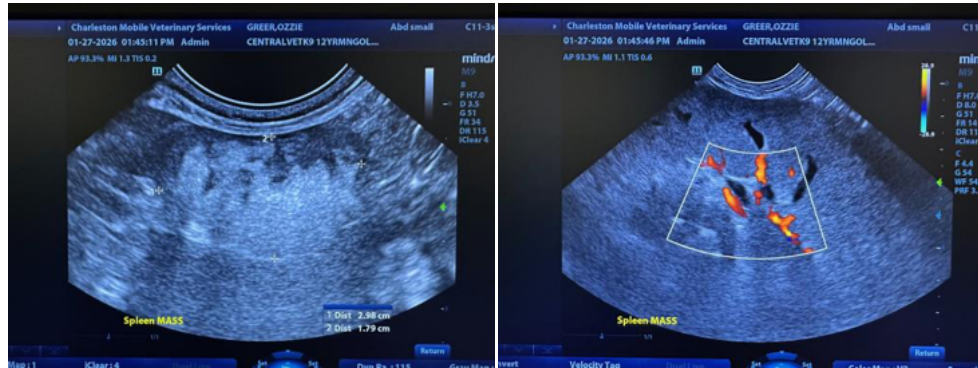
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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