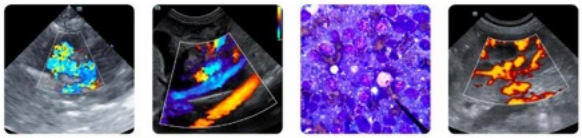


PATIENT

Arnie Erisman

SPECIES

Canine

BREED

Plott Hound

SEX

Male, neutered

AGE

10 Yrs. 10 months

WEIGHT

71.5 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

Saddleback

REFERRING VET

Dr. Klein

INVOICE
13372

DATE
1/6/26

PRESENTING CLINICAL SIGNS

Pt has a history of HGE type signs for years. Recently has had dramatic weight loss. Has a waxing and waning ALT elevation that appears to coincide with the HE episodes. Also has recent hematuria.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. Some of the urinary bladder features are obscured due to mineralization within the lumen and along the ventral wall. The wall is variably thickened (up to 0.41 cm) and irregular. Mineral deposition is observed along both the dorsal and ventral walls. There are suspected cystic calculi. Mineralized sand is also observed within the proximal urethral lumen. The urethral lumen is not overtly dilated.

The prostate is mildly enlarged (2.13 cm in width) with smooth peripheral contours. The parenchyma is homogeneous. Mineralized sand is observed within the prostatic urethra.

The left kidney is normal in size (8.48 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to 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 (8.14 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. At least one small cortical cyst is seen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.84 cm at cranial pole) (0.70 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.

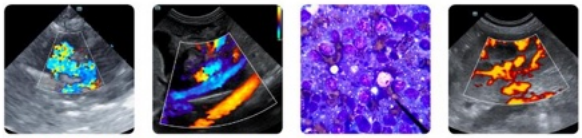
The right adrenal gland is upper limits of normal in size (1.37 cm at cranial pole) (0.85 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.91 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. The parenchyma is isoechoic relative to the spleen and heterogeneous in appearance. A 6.6 x 4.4 cm septated cystic structure is observed deep on the left side. A >12 cm ill-defined, heterogeneous cavitated mass is observed mid to right liver adjacent to the diaphragm. In addition, an 11.3 cm heterogeneous slightly cavitated mass is observed on the right side. A 3.4 cm hypoechoic mass is also seen at the caudal aspect. Vascular and biliary tracts are of normal volume with no evidence of congestion.



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The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of aggregated, echogenic, partially dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is mildly distended with ingesta. 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 ileocecocolic 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 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.

Lymph nodes
A 1.02 x 0.49 cm mesenteric lymph node is visualized.

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:

- Coalescing hepatic masses. Neoplasia (i.e., adenocarcinoma, other) is suspected with a lower possibility of a non-neoplastic process (i.e., large regenerative nodules, inflammatory lesions, other). A large septated cyst is also observed on the left side.
- Urinary bladder wall mineralization with suspected cystic calculi and urethral sand.
- The mild prostatomegaly may be a normal variant for this patient or may be secondary to emerging neoplasia, late in live neutering (if applicable), prostatitis, hyperplasia, other. Correlation with the patient's clinical history is recommended.

Secondary Findings:

- Bilateral nonspecific, age-related renal changes
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The gallbladder changes could be consistent with cholestasis, fasting or an emerging mucocele.
- Mild retained gastric ingesta
- The prominent mesenteric lymph node is likely reactive with a lower possibility of emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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

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2. If an aggressive approach is desired and there is no evidence of pulmonary metastatic disease, consider consultation with a board-certified surgeon to discuss hepatic mass removal or debulking. An abdominal CT scan would be useful in pre-surgical planning. If surgery is not pursued, palliative care is recommended.
3. Regarding the urinary bladder changes, a urinalysis with a culture and sensitivity are recommended.

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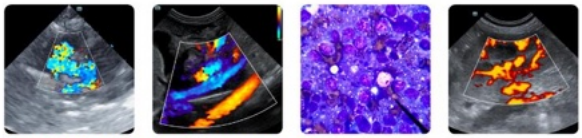

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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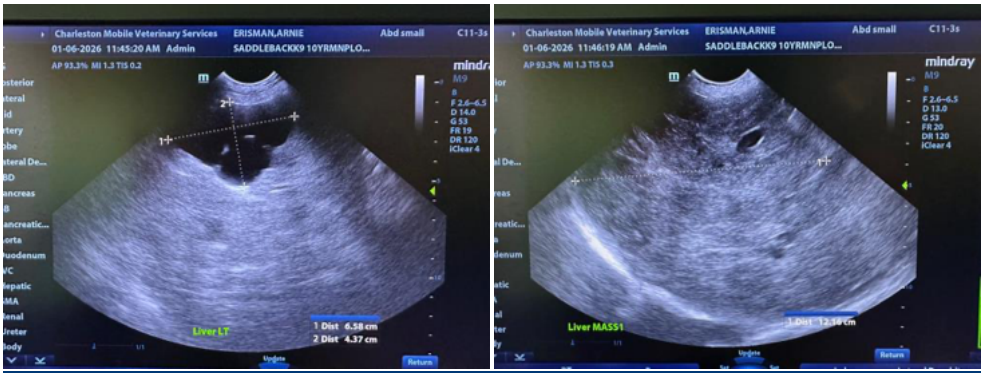

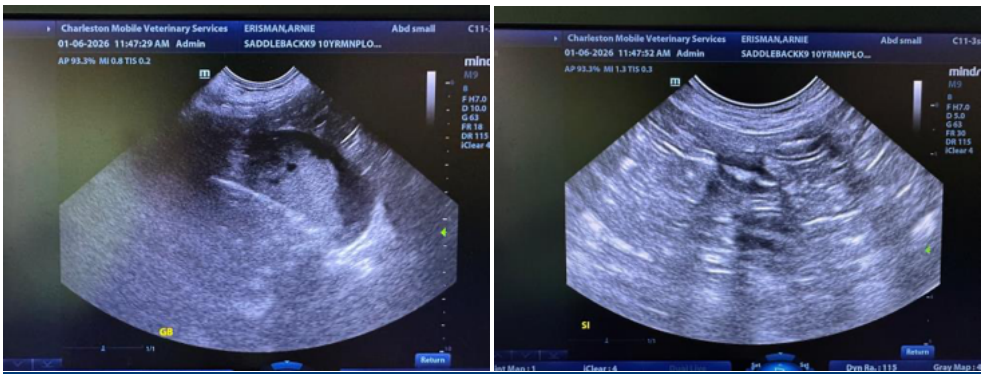

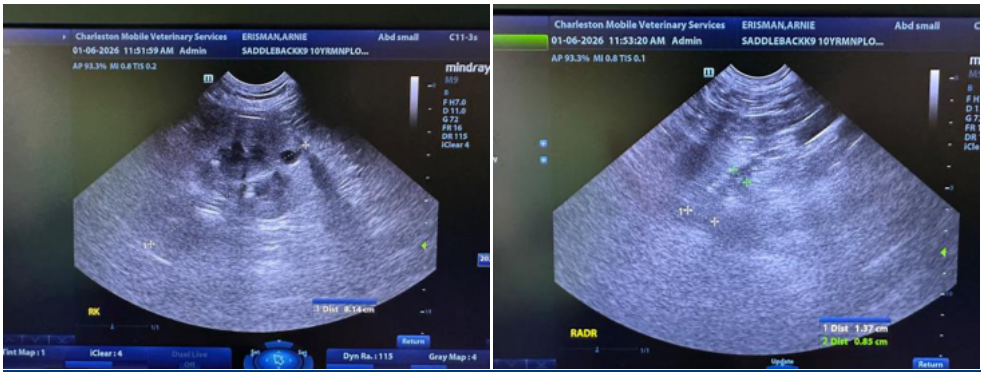

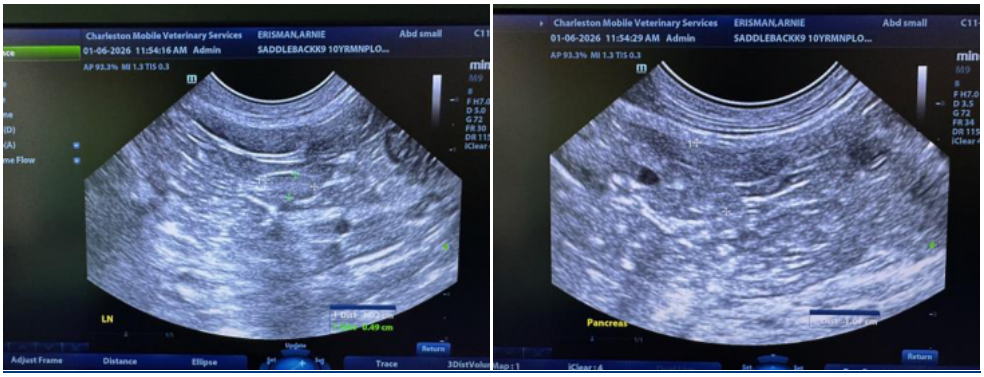

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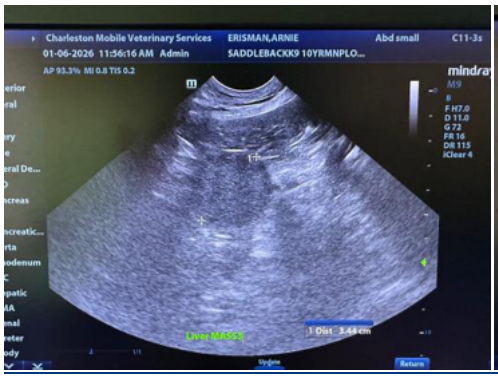

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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