



PATIENT

Beau Higgins

SPECIES

Canine

BREED

Dachshund

SEX

Male, neutered

AGE

2/2010

WEIGHT

17.2 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

West Ashley VC

REFERRING VET

Dr. Tierney

INVOICE

13330

DATE

11/11/25

PRESENTING CLINICAL SIGNS

Seen at SVRC for possible pancreatitis, elevated WBC (see record) Presented to WAVC for recheck min improvement unsure cause of elevated WBC unable to get urine. Did start Enrofloxacin due to elevated WBC and o reluctance to proceed with diagnostics. o called today and said she would like to proceed with abdominal ultrasound - scheduled for Tuesday with recommendation to go back to cvrc if not doing well. Urinalysis performed 10/31/25 one day after starting antibiotics- USG 1.014, 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 distended. A scant amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 3.5 cm, are normal.

The prostate is normal in size (0.79 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal to mildly enlarged (5.29 cm in length) with a slightly irregular shape. Several varying sized cortical cysts are seen. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Mild pyelectasia is present (0.22 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal. A scant amount of subcapsular fluid is observed at the cranial pole. The mesentery surrounding the kidney is hyperechoic. Trace retroperitoneal fluid is observed.

The right kidney is normal in size (5.52 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. A few small cortical cysts are seen. Mild to moderate pyelectasia is present (0.36 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

In the region of the left adrenal gland, a 4.2 x 3.8 cm irregular, heterogeneous, slightly cavitated mass is visualized. The mesentery surrounding the mass is hyperechoic. Trace retroperitoneal fluid is observed.

The right adrenal gland is normal in size (0.62 cm at cranial pole) (0.45 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 (1.16 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few meylolipomas are observed in the region of the hilus, one of the lesions measuring 0.48 cm in its longest dimension. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and mottled in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of



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congestion. The portal vein to caudal vena cava ratio is approximately 1:1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated, echogenic, gravity-dependent debris/sludge 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 ileoceocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Lymph nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

A trace amount of free fluid is observed in the left retroperitoneal space.

Other

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

ULTRASONOGRAPHIC FINDINGS

- Mass in the region of the left adrenal gland. Neoplasia (i.e., adenocarcinoma, pheochromocytoma, hemangiosarcoma) is suspected with a low possibility of a non-neoplastic process. Adjacent retroperitonitis is present. The mass appears to be resulting in inflammation of the left kidney, manifested as subcapsular fluid. Obvious invasion into the left renal parenchyma is not definitively identified. There is evidence of bilateral chronic renal changes with pyelectasia and cortical cysts. The pyelectasia may be secondary to parenchymal remodeling, pyelonephritis, PU/PD (if applicable) or some combination thereof.
- The hepatic parenchymal changes could be consistent with a benign process (i.e., age-related parenchymal remodeling, inflammatory disease, hepatotoxicosis (i.e., copper) or other hepatopathy). Alternatively, metastatic disease from the suspected left adrenal mass cannot be excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If an aggressive approach is desired, consider the following:
 1. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
 2. Baseline blood pressure measurement to assess for systemic hypertension
 3. Further testing for a functional tumor (i.e., low-dose dexamethasone suppression test, urine/blood metanephrine levels)
 4. An abdominal CT scan to evaluate the extent of the mass +/- consultation with a board-certified surgeon. If surgery is pursued, liver biopsies should be obtained to assess for micrometastatic disease.
- If further testing is not pursued, palliative care is recommended.



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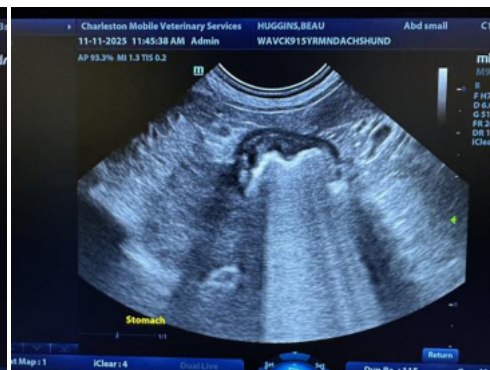
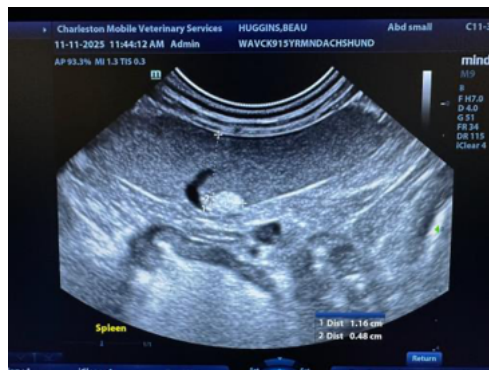
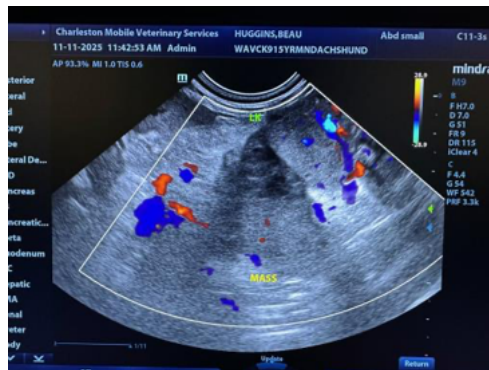
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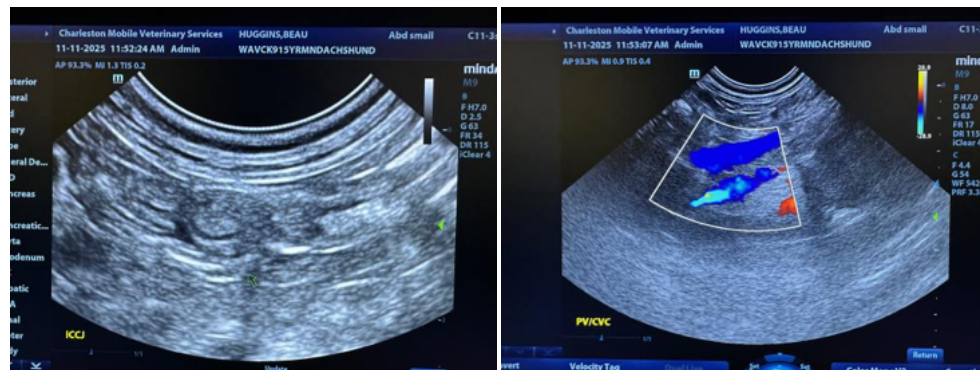
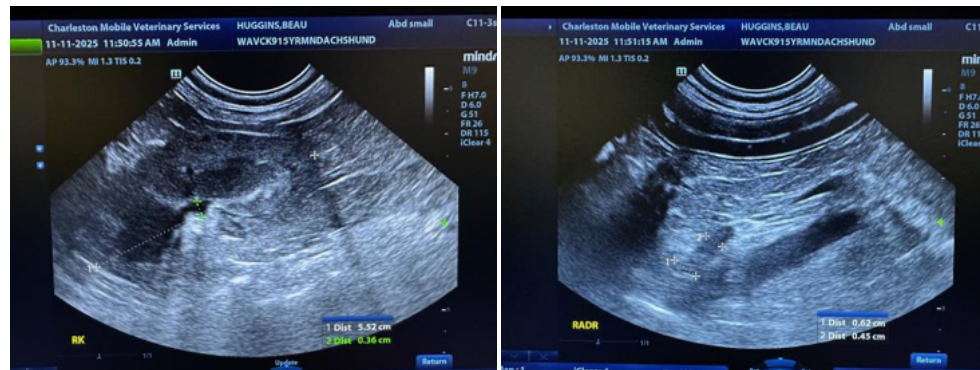
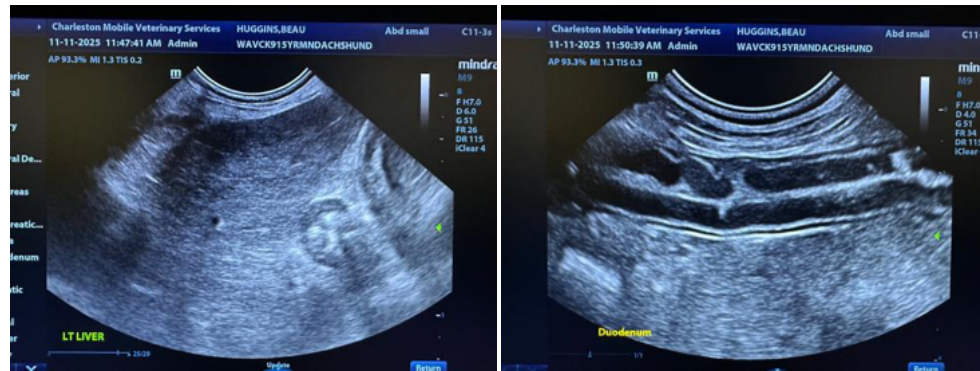
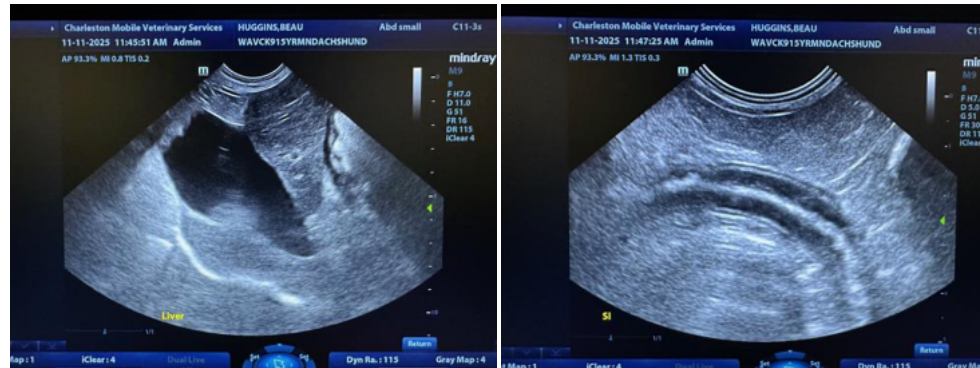
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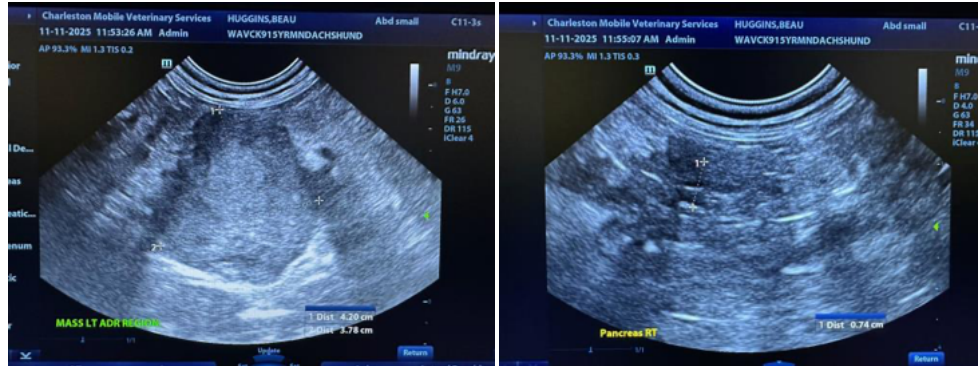
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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