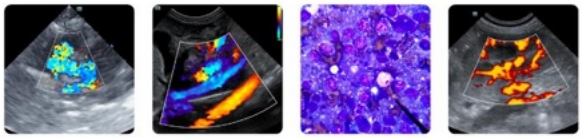

PATIENT

Noah Surratt

SPECIES

Canine

BREED

Queensland Blue Heeler

SEX

Male, neutered

AGE

8/15/13

WEIGHT

41 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

AH of South Carolina

REFERRING VET

Dr. Stone

INVOICE

13425

DATE

12/10/25

PRESENTING CLINICAL SIGNS

Pt has elevated liver, right on the line of having low thyroid with free t4, possible Cushing's. Mild thrombocytosis. ALT 203, ALP 779, total T4 0.9, free T4 borderline low at 0.6.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is mildly to 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 2 cm, are normal.

The prostate is normal in size (0.67 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 (5.66 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 (5.31 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.

Adrenal Glands

The left adrenal gland is normal in size (0.41 cm at cranial pole) (0.56 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 (0.91 cm at cranial pole) (0.53 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 (1.22 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few small meylolipomas are observed in the region of the hilus. Splenic vasculature is normal.

Liver

The liver is prominent to enlarged with smooth peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1:1.

The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is mildly gas 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

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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. The colonic lumen contains shadowing fecal material. There is no obvious 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. See also *Other.*

Lymph nodes

A 2.54 x 0.57 cm medial iliac lymph node is visualized. In addition, a few prominent mesenteric lymph nodes are visualized, one of the nodes measuring 1.60 x 0.33 cm.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

Other

In the right cranial quadrant, adjacent to the diaphragm, a 2.2 x 1.8 cm hypoechoic to heterogeneous vascular mass is visualized. The mass appears to be causing deviation of the proximal duodenum.

In the mid-abdominal region, a 4.2 x 1.5 cm ill-defined hyperechoic area of mesentery is visualized.

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Right cranial abdominal mass, the origin of which is unclear. It may be arising from pancreas, mesentery, the serosal surface of the duodenum, other. Neoplasia (i.e., carcinoma, sarcoma, round cell tumor) is suspected with a lower possibility of a focal inflammatory process.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease, infiltrative neoplasia and other hepatopathies are considered less likely.

Secondary Findings:

- Bilateral nonspecific age-related renal changes
- The area of hyperechoic mesentery in the mid-abdominal region may represent an ill-defined intraabdominal lipoma or liposarcoma. Alternatively, a focus of reactive mesentery is possible.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

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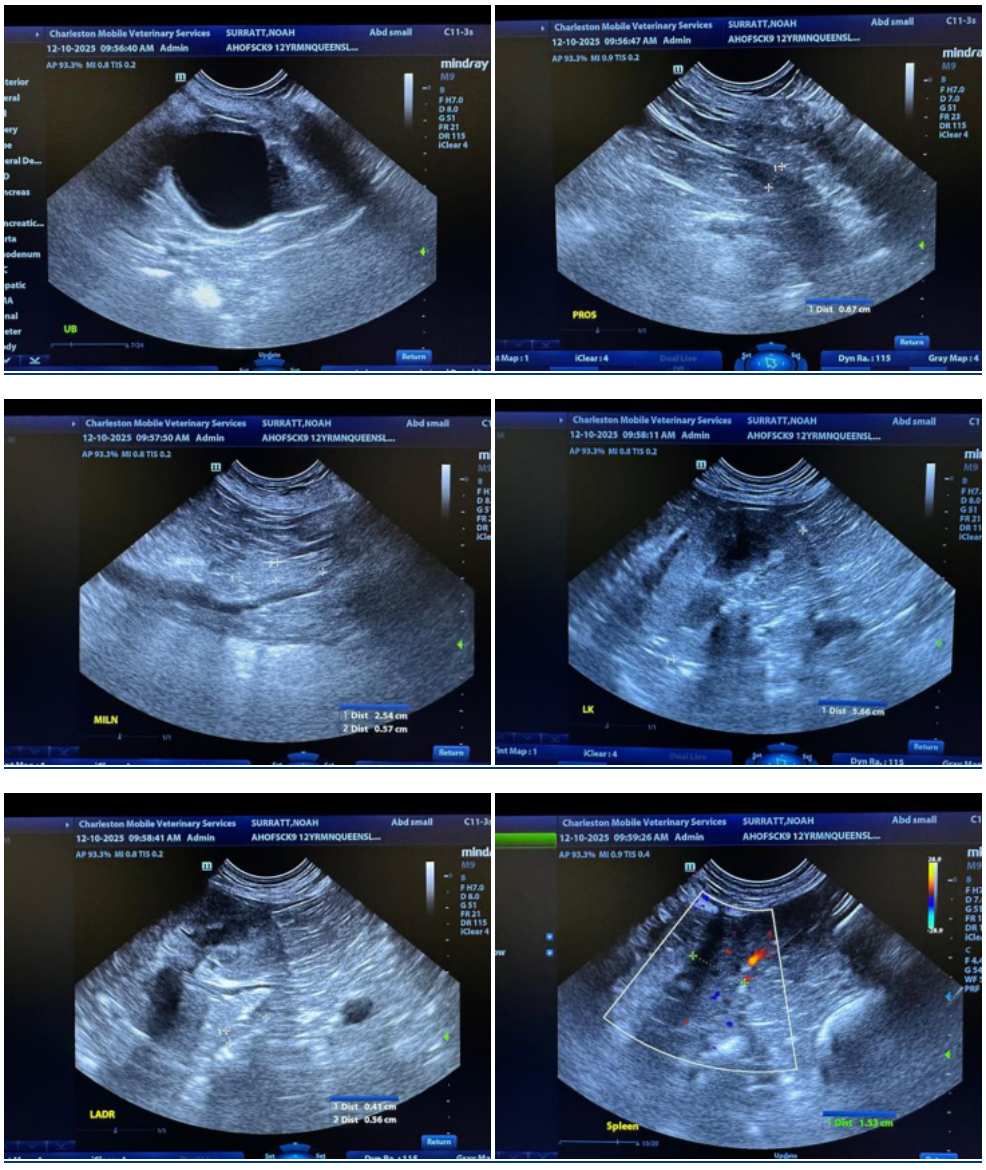
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Regarding the right cranial abdominal mass, consider the following:

1. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
2. Abdominal CT scan for further evaluation
3. Abdominal exploratory with mass removal and submission for histopathology. If pursued, consider obtaining liver biopsies along with aerobic and anaerobic bile cultures and hepatic copper quantitation at the time of surgery. Also consider obtaining biopsies of the hyperechoic mesentery mid-abdomen intraoperatively. Clotting times are recommended prior to anesthesia.



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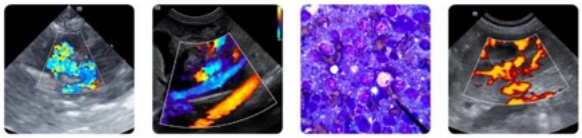

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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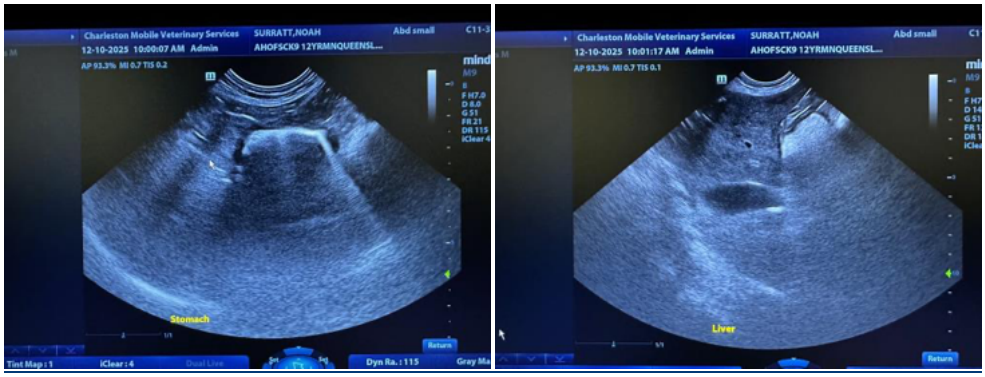

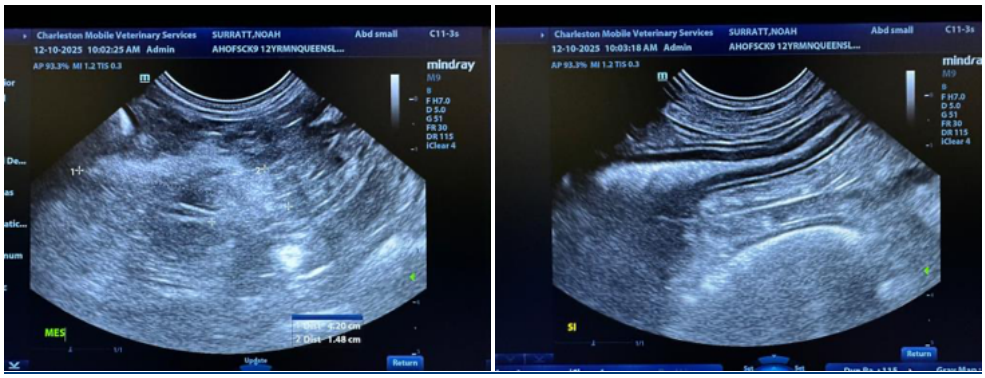

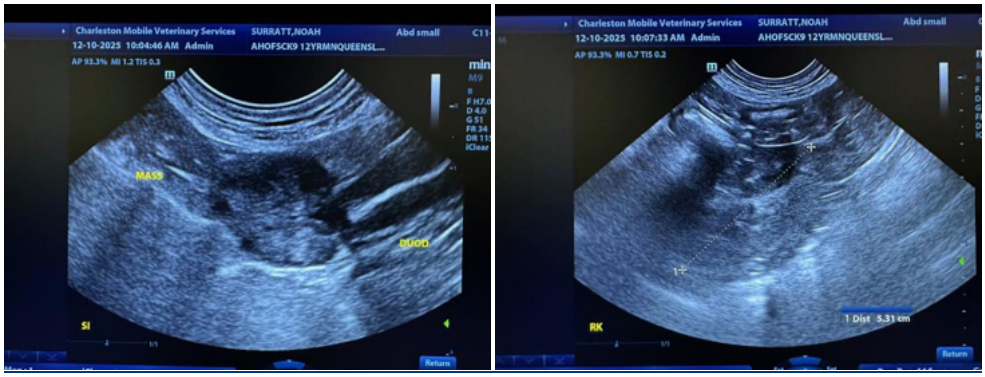

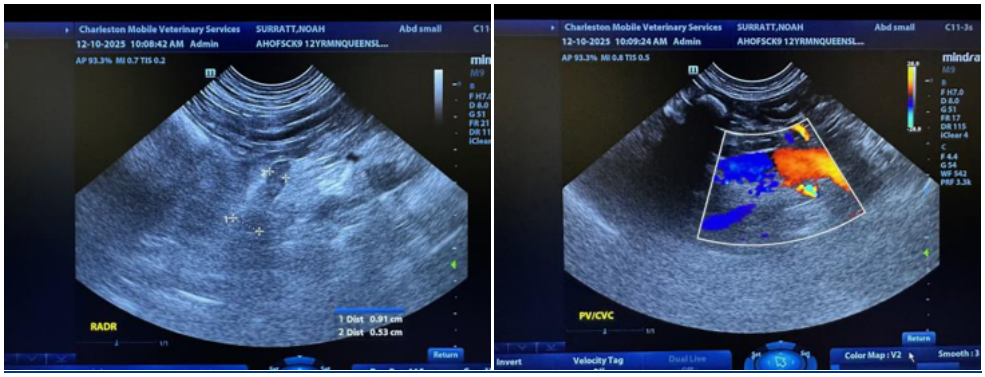

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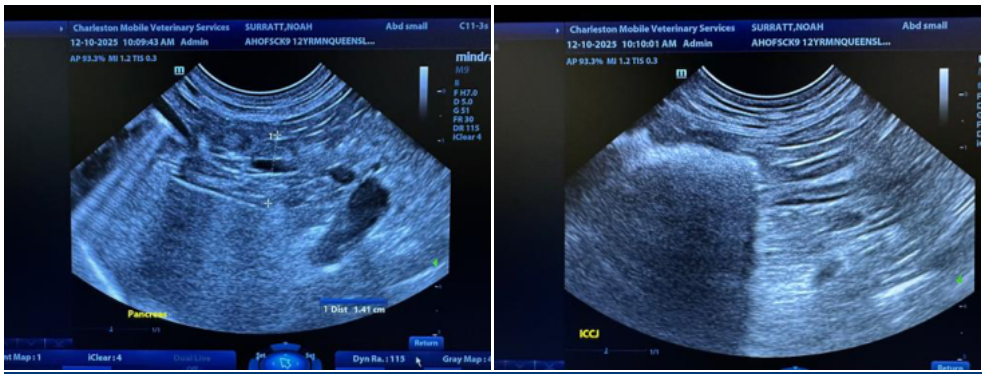

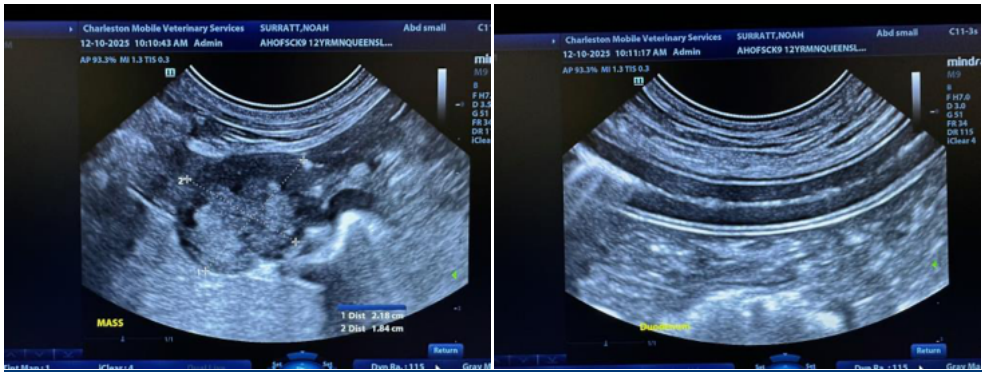

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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