



**PATIENT**

Charlie Fetterolf

**SPECIES**

Canine

**BREED**

Beagle

**SEX**

Male, neutered

**AGE**

12/7/2009

**WEIGHT**

28 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**

Sun Dog Cat Moon

**REFERRING VET**

Dr. Fetterolf

**INVOICE**

13710

**DATE**

5/12/26

**PRESENTING CLINICAL SIGNS**

2/17/2025: Charlie had a non-healing wound and missing 2nd nail LF since November 2024. Several sets of radiographs were performed and showed no bony lysis. Cultures were also performed previously with bacterial growth and treated with abx. But, the infection always seemed to come back. Digit radiographs performed and showed concern for an aggressive lesion with lysis/destruction of P3 on LTL digit 2 (lysis of P2) with soft tissue swelling. Thoracic radiographs performed and were unremarkable. AUS performed by Dr. Simone and showed Mild progression of a previously noted splenic mass (3.05cm x 2.14cm; previously 2.44cm) with development of additional splenic nodules; left hepatic cyst; and nonorganized chloecystic debris.

2/18/2025: Histopathology showed an anaplastic sarcoma with lymph node metastasis (prescapular), differentials melanoma vs histiocytic. IHC requested (Melan-A, PNL-2 and CD204) and melanoma vaccine initiated.

3/21/25: Administered melanoma vaccine #2. Discussed negative IHC stains, indicating concern for melanoma. Recommended FidoCure DNA sequencing along with continued melanoma vaccine. FidoCure report returned consistent with mutations BRCA2, CBL, P53, PTPN11. Recommended starting trametinib along with the vaccine. Still unable to differentiate between melanoma and histiocytic sarcoma based on this information, but many of these mutations common with HS. Pt has a history of atypical hypoadrenocorticism, stage B1 DVD (1-2/6 murmur) Chest rads pending.

**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 4 cm, are normal.

The prostate is normal in size (0.83 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 (5.25 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

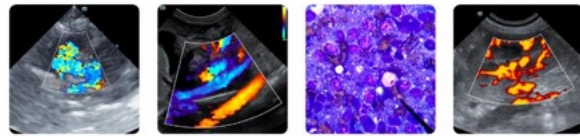
The right kidney is normal in size (4.72 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is subjectively normal in length (0.37 cm at cranial pole) (0.27 cm at caudal pole) with a flattened contour. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is subjectively normal in length (0.55 cm at cranial pole) (0.43 cm at caudal pole) with a flattened contour. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

**Spleen**



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The spleen is enlarged with irregular peripheral contour. A 9.5 x 5.3 cm heterogeneous cavitated mass is observed within the parenchyma at the mid to caudal aspect. The mesentery effacing the serosal surface of the mass is slightly hyperechoic. A 0.57 cm cystic nodule is also seen cranial to mid-spleen. The remaining parenchyma is relatively homogeneous in appearance. Splenic vasculature is normal with no evidence of thrombosis.

**Liver**

The liver is subjectively normal in size with normal peripheral contours. The parenchyma is hypoechoic relative to the spleen and subtly mottled in appearance. A few cystic nodules are observed, one on the left and at least 2 on the right side. One of the larger cysts measures 1.1 cm in its longest dimension. 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.

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

**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 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**

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:**

- Large cavitated splenic mass. Neoplasia (i.e., hemangiosarcoma, hemangioma, hematoma) is suspected. The smaller cystic splenic nodule may represent a benign cyst or a metastatic lesion. Mild adjacent peritonitis is present.
- The cystic hepatic lesions may represent benign parenchymal cysts, metastatic disease, other. The diffuse hepatic parenchymal changes could be consistent with benign, age-related parenchymal remodeling, regenerative nodular hyperplasia, metastatic disease, infiltrative neoplasia, hepatotoxicosis (i.e., copper), fibrosis and/or other hepatopathy.
- The gallbladder changes are consistent with a developing mucocele.



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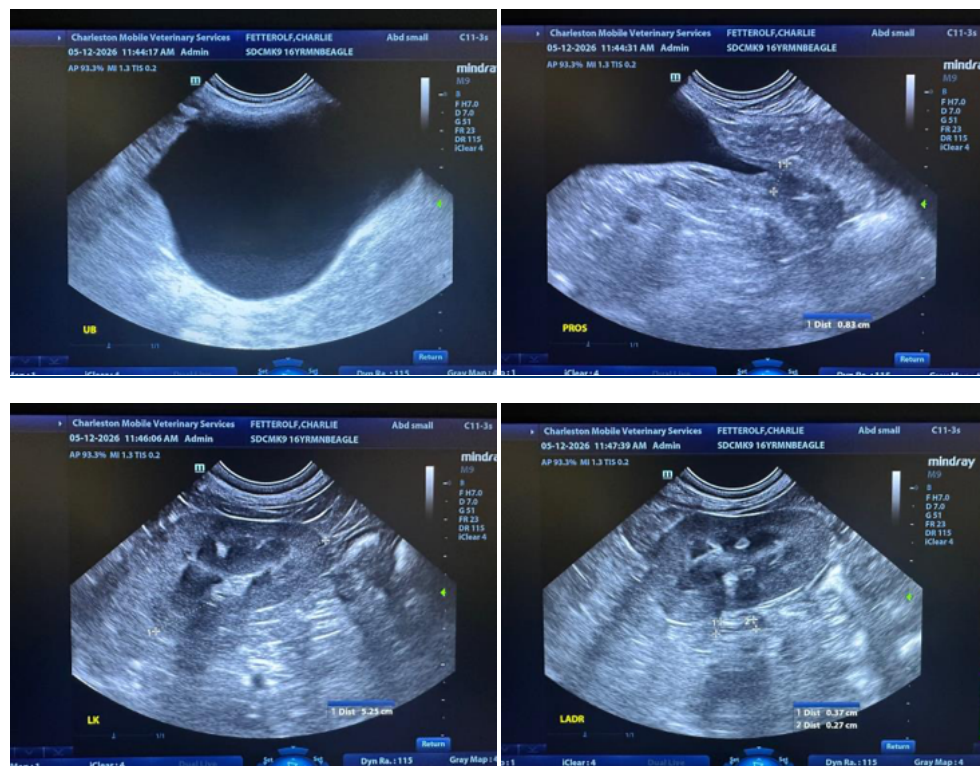
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**Secondary Findings:**

- The bilaterally flattened adrenal glands are consistent with the previous diagnosis of hypoadrenocorticism.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- If there is no evidence of pulmonary metastatic disease, consider splenectomy with submission of the spleen for histopathology. Liver biopsies should also be obtained at the time of surgery, with particular attention to any cystic nodules. The gallbladder should also be assessed for a mucocele at the time of surgery and removed, if indicated and if the patient is stable. Otherwise, Ursodiol therapy should be initiated with serial sonographic monitoring (i.e., every 2-3 months) to assess for progression to a fully formed mucocele).





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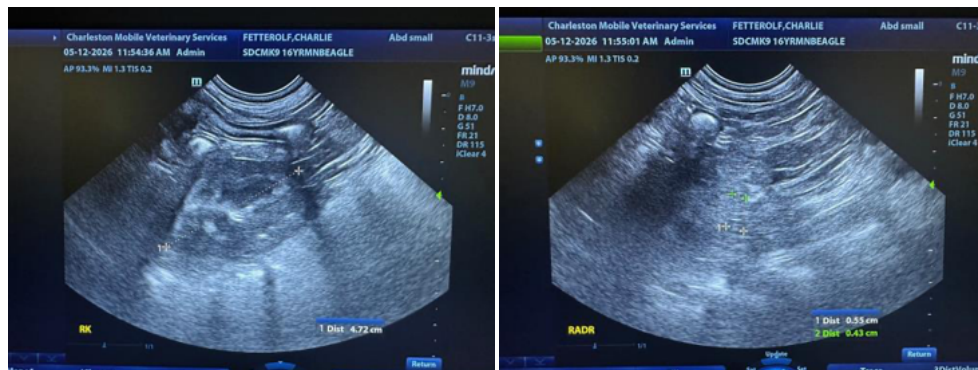
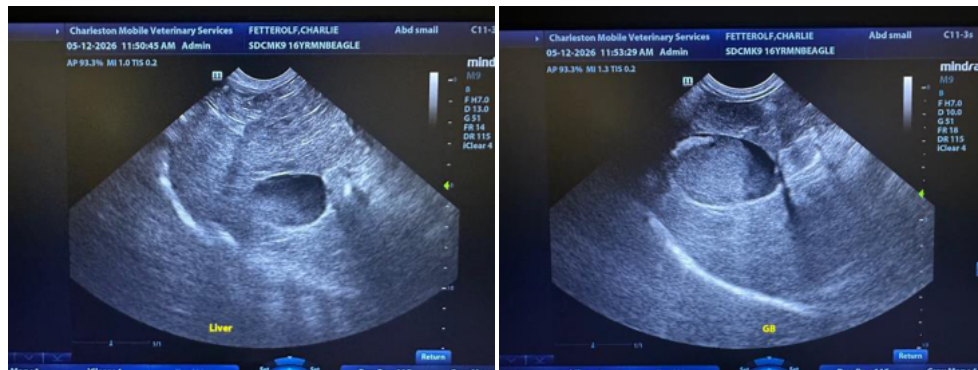
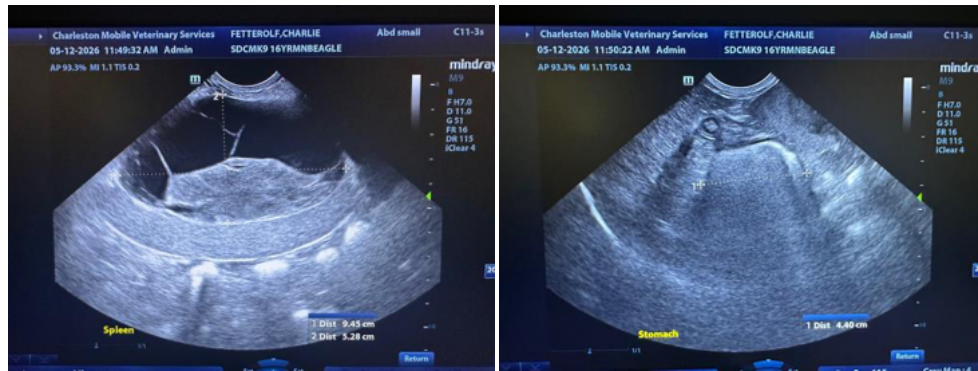
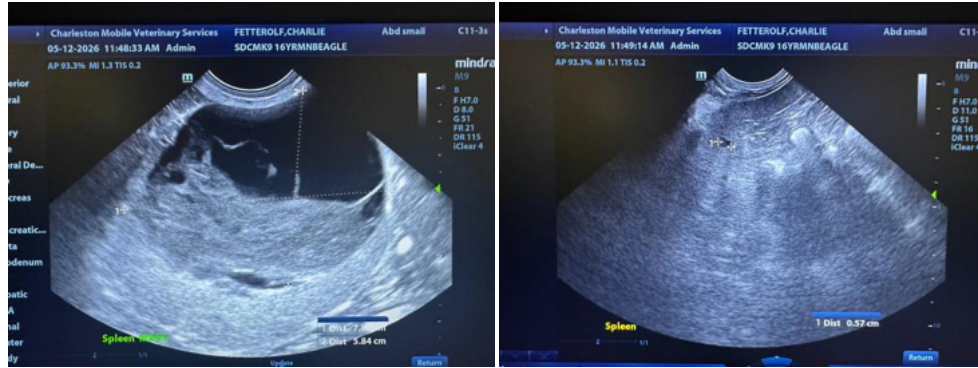
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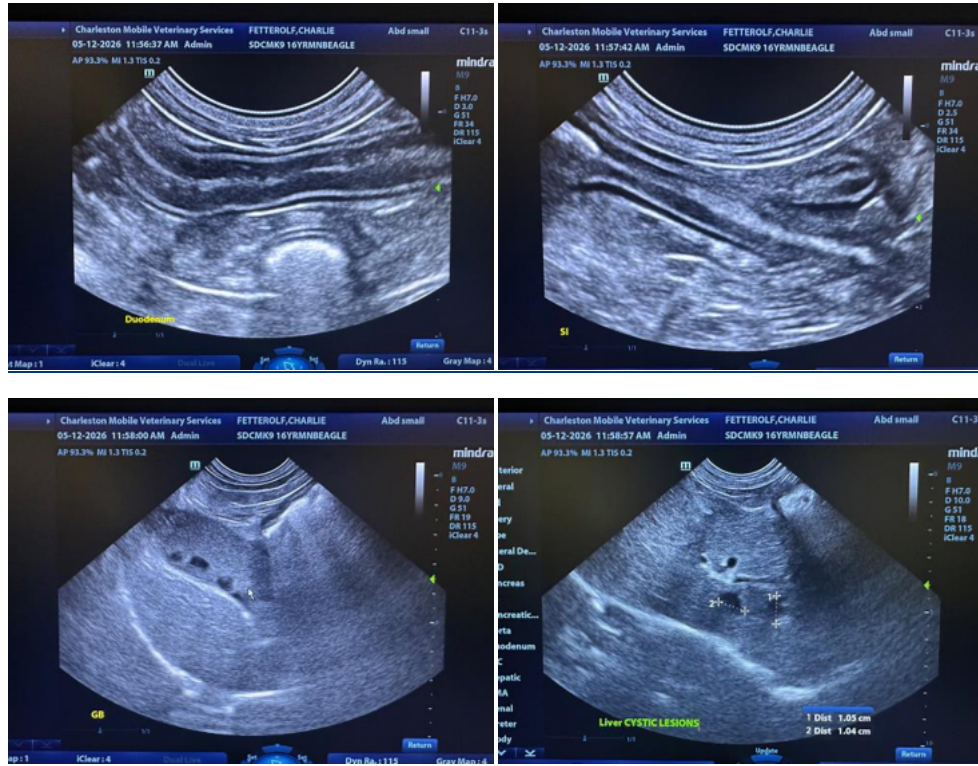
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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](mailto:info@SonoPath.com)