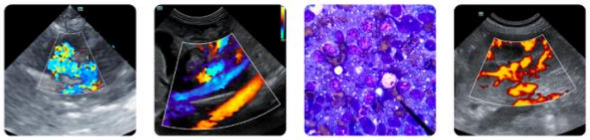


PATIENT

Chikilin Zapien

SPECIES

Canine

BREED

Miniature Pinscher

SEX

Neutered Male

AGE

10 Years

WEIGHT

23 pounds

INTERPRETED BY

Tam Mengine, DVM, DABVP (canine/feline practice)

IMAGING PERFORMED BY

Jasmine Palacios

HOSPITAL NAME

River's Edge Pet Medical Center

REFERRING VET

Dr. Shelby Young

INVOICE

14860

DATE

04/03/26

PRESENTING CLINICAL SIGNS

First seen on 6/7/25 for bloated, uncomfortable abdomen & shaking/restless, AFAST revealed nodular hepatic tumor, non-cavitated, no peritoneal free fluid, spleen appeared wnl. Cost conscious so no other diagnostics performed. Supportive care. Returned on 2/15/26 for similar symptoms, plus V/D. Repeated AFAST, similar findings but with some areas of hypoechoic pocketing, spleen small/wnl. Discussed surgery +/- biopsy, O unable to pursue. Treated with Cerenia. Seen again on 3/6 for intermittent hematochezia and vomiting. Discussed previous AFAST findings, treated with supportive care for diarrhea. Presented again 3/27 for hematemesis, labwork done, recommended full AUS.

Abnormal PE/Chem/CBC/UA Results: See attached labs: CBC - hct 45%, eosinophilia 2.52k, PLT 753k, other leukocytes wnl. Chem 17 - ALT 810, ALKP 551, all else wnl. Lytes wnl. Panc lipase wnl. TT4 wnl.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra (visible to 3.0 cm) are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal). The left kidney measured 5.2 cm in length. The right kidney measured 5.3 cm in length.

Adrenal Glands

Both adrenal glands are enlarged and of normal echogenicity. They have normal phrenic vasculature and are found in the normal location. The left adrenal gland height is 1.1 cm at the cranial pole and 7.3 mm at the caudal pole. The right adrenal gland height is 7.1 mm at the cranial pole and 5.4 mm at the caudal pole.

Spleen

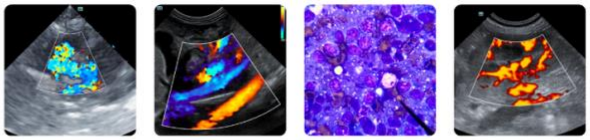
The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.

Liver

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. There is a 7.2 cm x 5.0 cm heterogenous mass located in the mid caudal liver. The surrounding omentum is (hyperechoic. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal



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The stomach is mildly distended with gas. The gastric wall is 1.8 mm with normal deviations due to rugal folds and exhibits appropriate wall layering. The pylorus is of normal appearance.

The small bowel has focal changes to the normal 1:3 muscularis to mucosa ratio. Wall measurements are normal up to 5.1 mm for duodenum and 4.2 mm for jejunum. Overall wall layering is preserved. Intestinal motility appears normal.

The visible portions of the colon are of normal thickness with intact wall layering measuring 1.8 mm. The ileocecal junction was not seen.

Pancreas

The areas of the limbs and body of the pancreas are isoechoic to the surrounding mesenteric fat, with normal capsular appearance. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

Free Abdomen

There is no free fluid noted within the abdomen. There is hyperechoic, inflamed omental fat noted in the region of liver mass. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

The visualized portion of the heart exhibits appropriate systolic function with no masses or effusions noted.

PRIMARY FINDINGS

- Large heterogenous liver mass with associated steatitis with malignancy deemed more likely than a benign origin.
- Focal thickening of the small bowel muscularis layer consistent with nonspecific enteritis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The heterogeneous echotexture and associated inflammation support a malignant origin for) liver mass. Given that it was first identified almost a year ago, it appears relatively non-aggressive, and there is no evidence of metastasis.

The focally thickened small bowel muscularis layer is typical of a nonspecific enteritis. The concurrent eosinophilia raises the possibility of intestinal parasitism, or potentially an eosinophilic enteritis. Ideally, surgical exploratory would be recommended to remove the liver mass and biopsy the intestines.

If this is not feasible, then additional recommendations would include:

❖ fecal parasite testing and empiric fenbendazole treatment

❖ trials with a novel protein or hydrolyzed diet

❖ A complete GI panel, with cobalamin supplementation if indicated.

❖ A resting cortisol level is recommended, and can now be included as part of the GI panel to Texas A&M. Alternately a urine cortisol: creatinine ratio can be used to screen for hypoadrenocorticism

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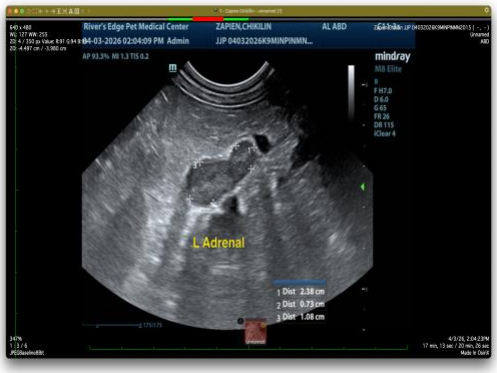
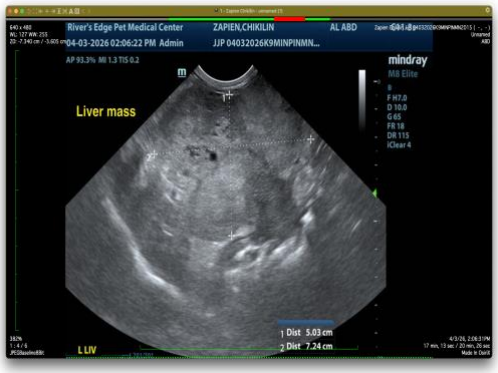
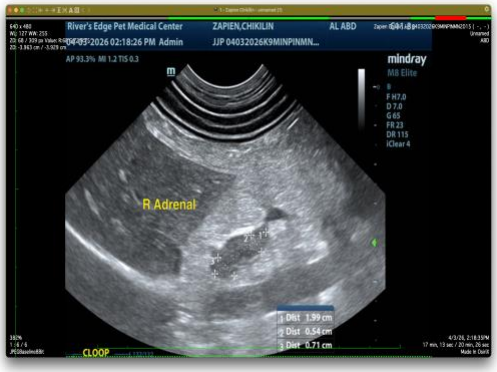
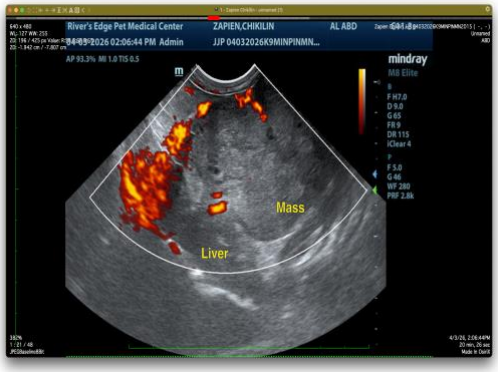
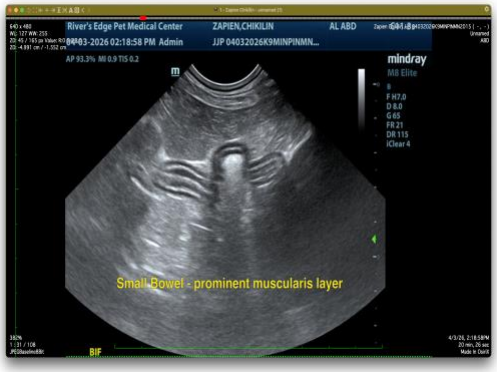
- Empiric therapy with prednisolone at 2-4mg / kg daily could be considered if a diet trial is unsuccessful.
- Treatment with liver support therapies such as SAMe and silymarin.
- Three view chest radiographs should be considered to investigate for the possibility of metastasis, although this may not change the treatment plan if surgical intervention is not an option.

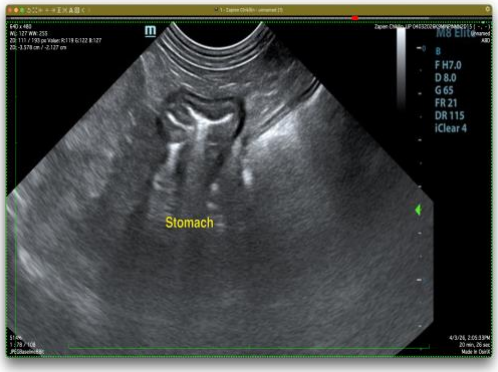












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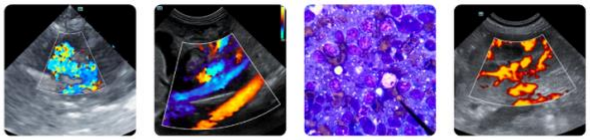

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Tam Mengine, DVM, DABVP (canine/feline practice)

info@SonoPath.com