



PATIENT

Damien Bowen

SPECIES

Canine

BREED

Lab mix

SEX

Neutered Male

AGE

10 Years

WEIGHT

37 kg

INTERPRETED BY

Andrea Nicastro, DVM,
Diplomate ACVIM
(Small Animal Internal)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Roundhill AH

REFERRING VET

Dr. Carl Kelly

INVOICE

12903

DATE

1/24/22

PRESENTING CLINICAL SIGNS

History: Was seen at Sierra Vet Specialist on 1-16-22 for diarrhea for 4 days and anorexia for 2 days. Vomited once on 1-19-22 for the first time. Ate small pieces of bacon and milk bones after. Dribbling urine since 1-15-22. Abdomen painful to palpate and urinary bladder very full and distended. CPL was normal. Radiographs showed a very enlarged bladder. Owner reported he thinks he has been passing a "decent" amount of urine although was seen straining to urinate. Gave sedation to place urinary catheter, large amount of urine came out in kennel. During catheter placement a large amount of urine also came out. Dr. Kelly palpated mass on the floor of the pelvic canal. Suspect IVT or prostate mass. Slight chance of infection or inflammation. Attached chemistry panel

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is distended. The ventral wall is mildly thickened (up to 0.52 cm) and there is a smooth mucosal surface. Some echogenic debris is suspended within the lumen. No cystic calculi are observed. The region of the trigone is normal. The urethra is catheterized.

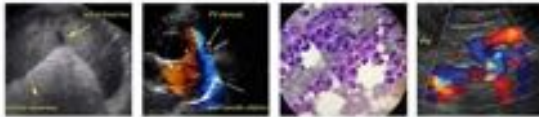
The prostate is enlarged (5.58 cm length x 3.29 cm width) with a slightly irregular shape. The parenchyma is heterogeneous with foci of mineralization. No distinct focal lesions are observed. A urinary catheter was passed during the study and is visible within the prostatic urethra and urinary bladder lumen. The mesentery surrounding the prostate is hyperechoic. Trace free fluid is observed in the retroperitoneal region.

The left kidney is prominent in size (8.52 cm in length) with normal curvilinear peripheral contours. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. Severe hydronephrosis is present (3.49 cm) in the longitudinal plane. There is no evidence of nephroliths or infarcts. Diffuse hydroureter is present (up to 0.60 cm in diameter). A small amount of subcapsular fluid is present as well as a small amount of retroperitoneal fluid.

The right kidney is normal size (7.87 cm in length) with normal curvilinear peripheral contours. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. Severe hydronephrosis is present (2.39 cm) in the longitudinal plane. There is no evidence of nephroliths or infarcts. Diffuse hydroureter is present (up to 0.60 cm in diameter). A small amount of subcapsular fluid is present as well as a small amount of retroperitoneal fluid.

Adrenal Glands

The left adrenal gland is normal size (0.67 cm at cranial pole) (0.58 cm at caudal pole) (2.58 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.



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One still image of the right adrenal gland is available for interpretation. The caudal pole is visualized and is normal in size (0.85 cm in width) with normal shape, glandular echogenicity and detail. Surrounding vasculature appears normal.

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Spleen

The spleen is normal in size (2.18 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.

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Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

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Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly fluid 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 thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

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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.

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Free Abdomen

Retroperitoneal fluid is present. At least one enlarged rounded hypoechoic to slightly heterogeneous sublumbar lymph node is visualized measuring 1.85 cm in length. In addition, 1-2 prominent medial iliac lymph nodes are seen, the largest measuring 1.87 cm in length.

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Other

A brief echocardiogram reveals no evidence of pericardial effusion.

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ULTRASONOGRAPHIC FINDINGS

INVOICE

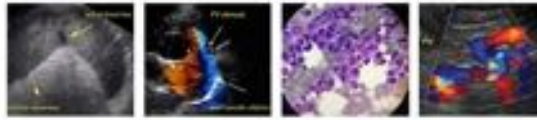
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Primary Findings:

- Prostatic mass effect with probable prostatic urethral obstruction. Neoplasia (i.e., adenocarcinoma, transitional cell carcinoma) is considered likely. There is secondary bilateral hydronephrosis/hydroureter.

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- The urinary bladder wall thickening is most consistent with cystitis.
- Retroperitonitis is present, likely secondary to urinary tract pathology.

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- The caudal abdominal lymphadenopathy, particularly the sublumbar nodes is concerning for metastatic neoplasia with a lower possibility of reactive lymphadenitis or lymphoid hyperplasia.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- A urine BRAF test is recommended to further evaluate for lower urinary tract neoplasia. If results are inconclusive, consider traumatic urethral catheterization with collection of prostatic cells for cytologic evaluation. While awaiting test results, a tub cystostomy should be considered to allow bladder evaluation. Consultation with a board-certified oncologist is also recommended.

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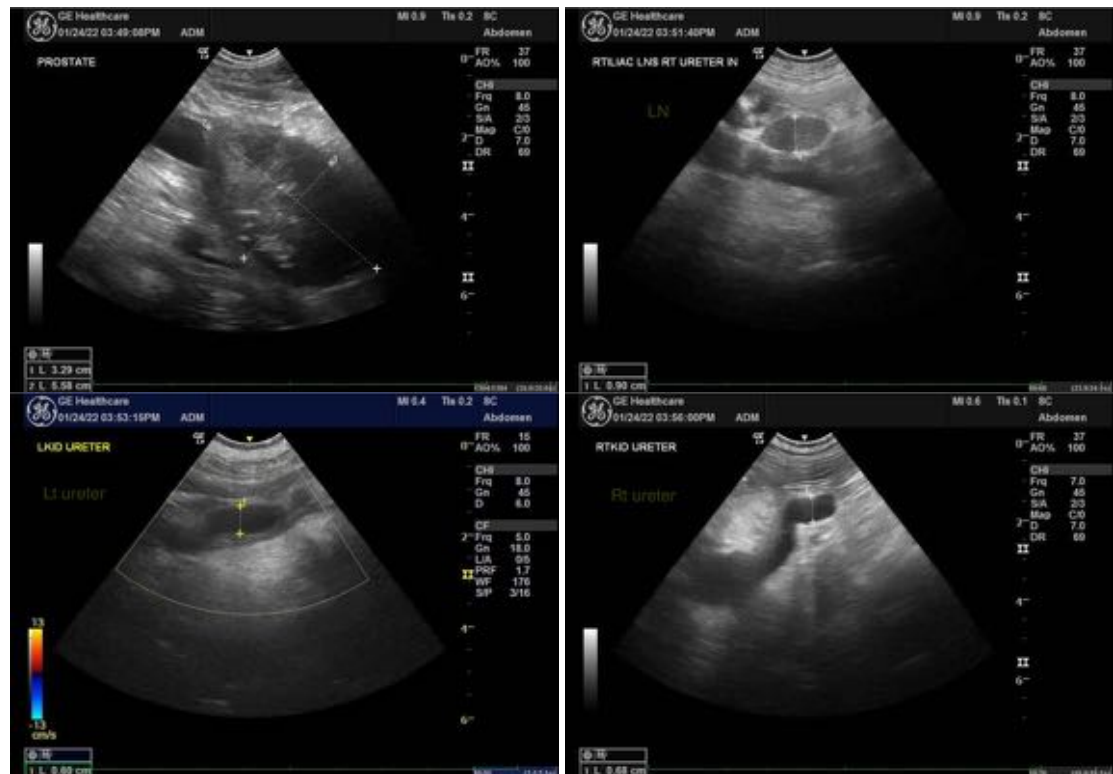
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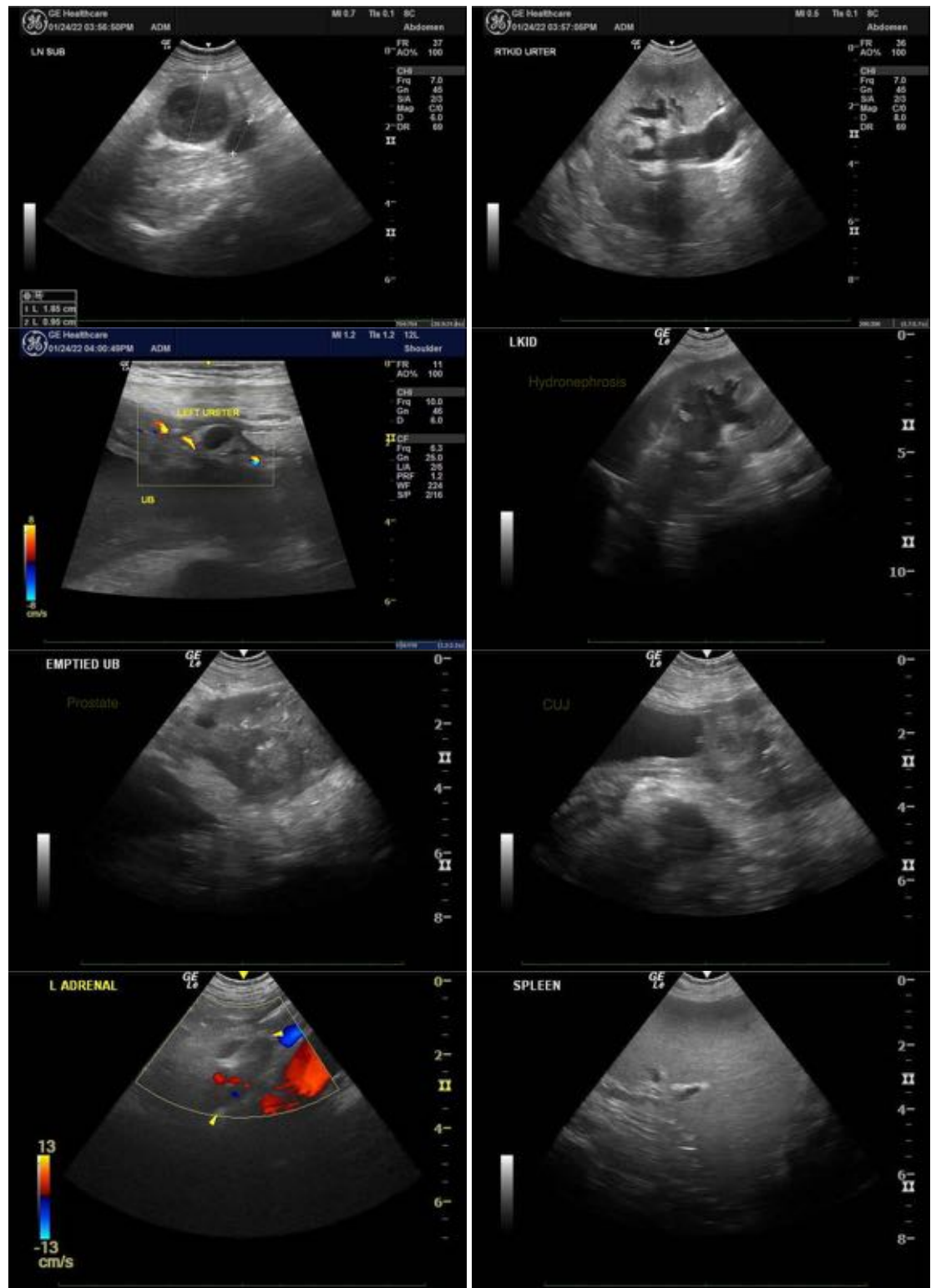
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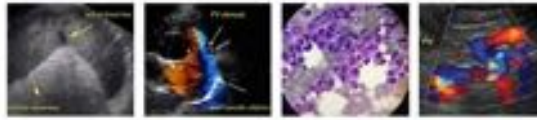
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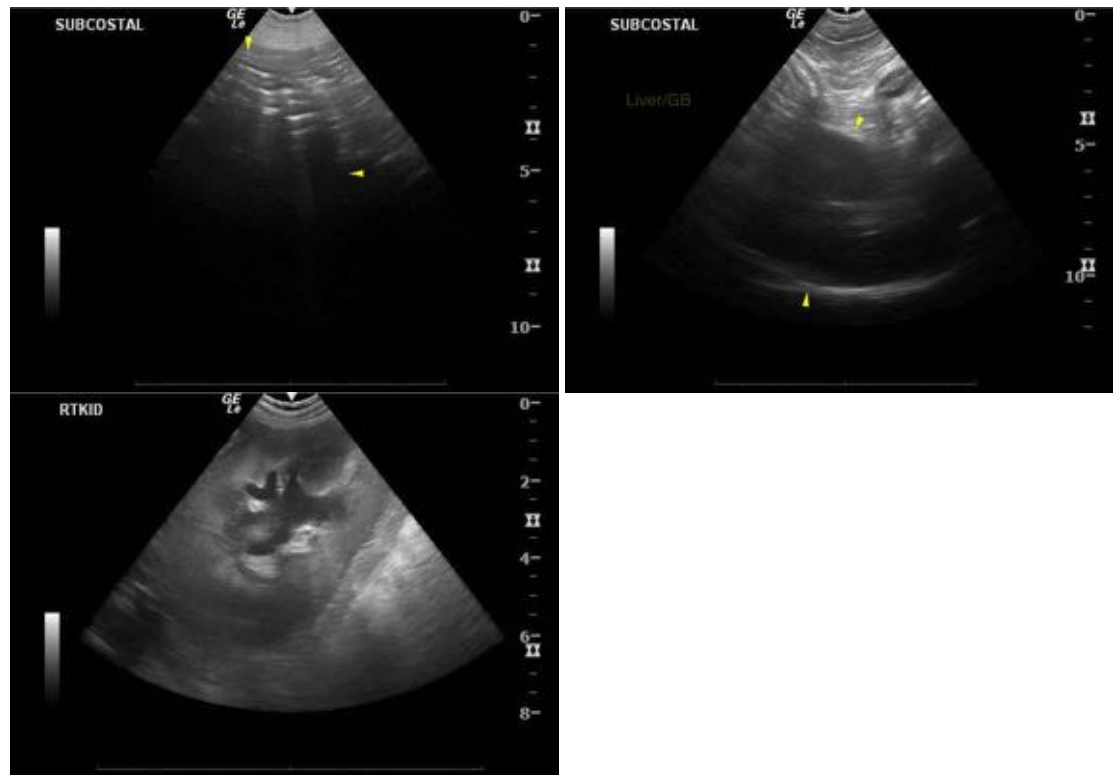
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, DVM, Diplomate ACVIM (Small Animal Internal Medicine)

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