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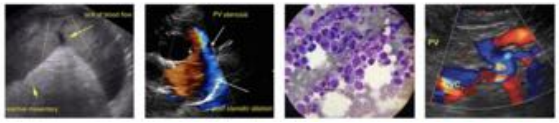


Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

PATIENT

Beau Herchak

SPECIES

Canine

BREED

Mixed

SEX

Neutered Male

AGE

10.14.2010

WEIGHT

49 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

Foxbank VH

REFERRING VET

Andi Winney

INVOICE

11916

DATE

10.28.22

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Pt presented for weight loss, restlessness, and difficult mobility. O also reports chronic soft stool and intermittent melena. pt is drooling a lot and eating dirt. On examination on 10/14 pt has a grade III heart murmur, notable hindlimb OA and muscle atrophy. pt's bloodwork was wnl on 10/14 except for thrombocytopenia. 4dx negative. single lateral radiograph (due to pt attitude) showed no obvious masses. pt was started on prednisone, doxycycline and sucralfate. Recheck examination on 10/21, pt seemed more comfortable, no melena noted and platelet count had returned to normal. Recommended AUS as next steps to determine source of weight loss, pica and drooling.

Abnormal lab-work values: thrombocytopenia- resolved
Current Medications: prednisone, sucralfate to be stopped on 10/26/22
Radiographic Findings: no significant findings

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** is mildly to moderately distended with anechoic urine. The wall is diffusely thickened (up to 0.50 cm) with an irregular mucosal surface. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The **prostate** is normal in size (1.06 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The **left kidney** is normal size (6.12 cm in length); normal shape and architecture with 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 size (7.56 cm in length); normal shape and architecture with 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 size (0.83 cm at cranial pole) (0.73 cm at caudal pole); 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.

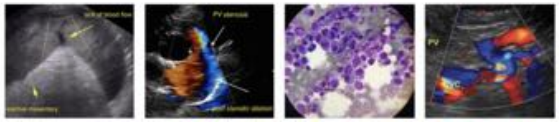
The **right adrenal gland** is normal size (1.33 cm at cranial pole) (0.78 cm at caudal pole) (2.71 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is normal in size (2.04 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.

Liver

The **liver** is subjectively prominent in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogenous in appearance. No focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.



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The **gall bladder** lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated, echogenic, suspended debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The **gastric lumen** is mildly to moderately distended with ingesta. 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 retention of the normal layering pattern. There is evidence of mucosal speckling in some segments. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains shadowing fecal material. There is no evidence of an obstructive pattern.

Pancreas

In the region of the body of the **pancreas**, an approximately 5.20 cm irregular, ill-defined, hypoechoic to heterogenous cystic mass effect is visualized. The mass is somewhat vascular in appearance. The mesentery effacing the serosal surface is mildly hyperechoic.

Free Abdomen

There is no evidence of free fluid The abdominal **lymph nodes** are normal/not visible.

Other

A brief echocardiogram was performed. A 1.62 cm irregular, echogenic mass is arising from the septal wall of the left ventricle, +/- invading the pulmonic valve. There is no evidence of chamber enlargement, pericardial or pleural effusion in the visible window.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Large mass in the region of the pancreas. Neoplasia (i.e., adenocarcinoma) is suspected with a lower possibility of a benign process. Adjacent peritonitis is present.
- Right ventricular mass. This lesion may represent a metastatic lesion or a primary cardiac tumor (i.e., hemangiosarcoma, other).

Secondary Findings

- Bilateral, age-related renal changes
- The urinary bladder wall changes are most consistent with cystitis. However, correlation with the patient's urinalysis findings is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three-view thoracic radiographs are recommended to assess for pulmonary metastases.

Due to the location of the pancreatic mass, it is not amenable to aspiration. Therefore, if a tissue sample is desired, surgical biopsies are recommended. However, given the likelihood of concurrent neoplasia in the heart, palliative care should be considered in lieu of aggressive diagnostics.

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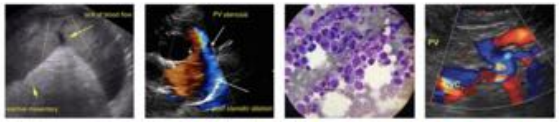

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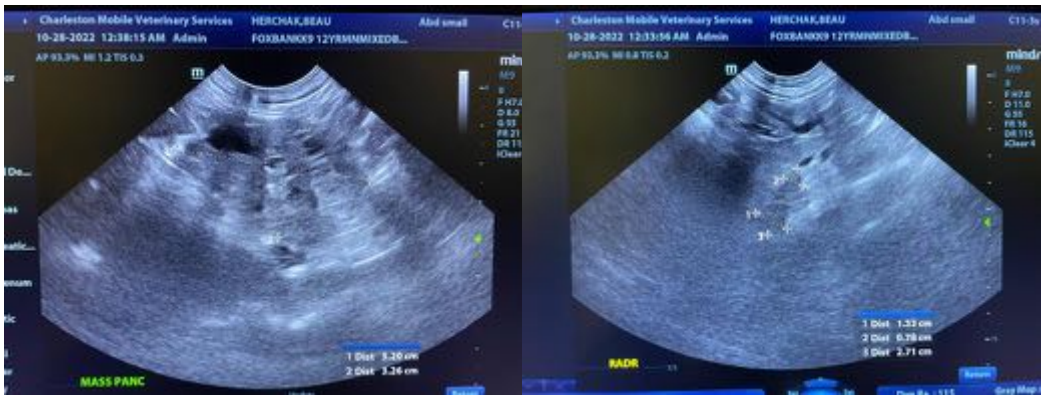

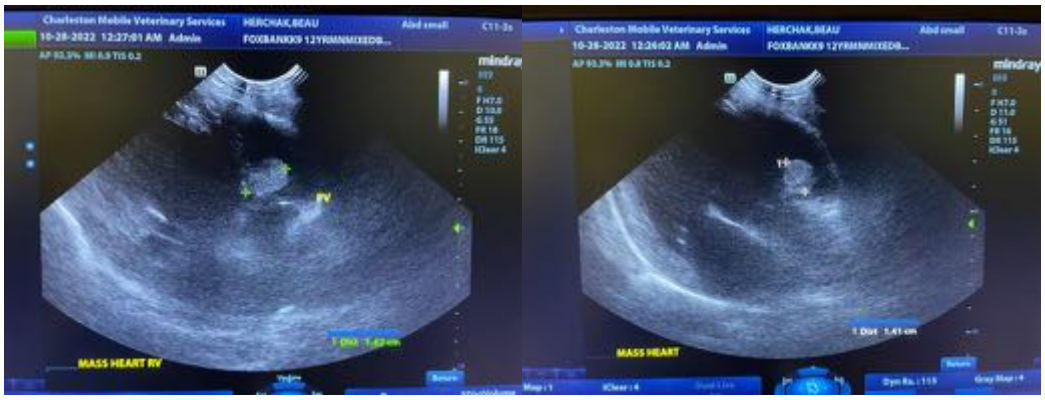

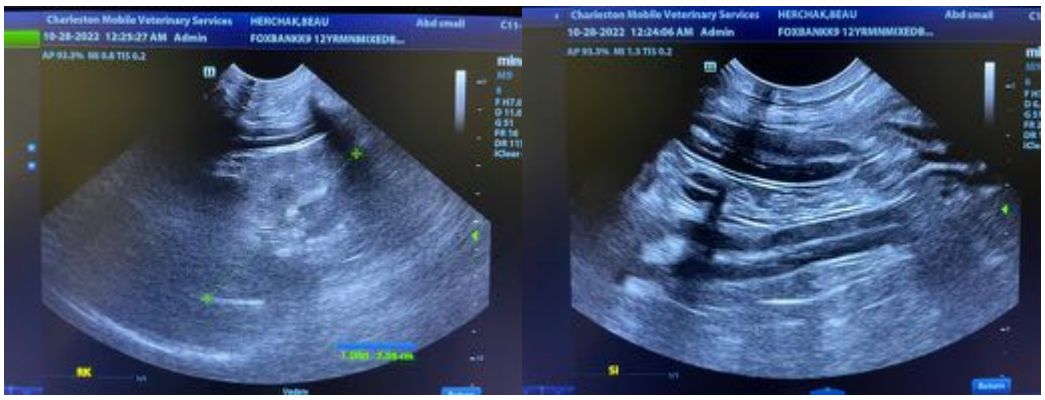

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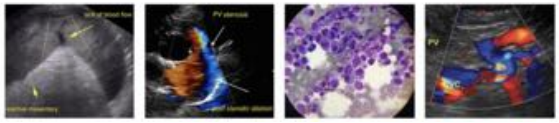

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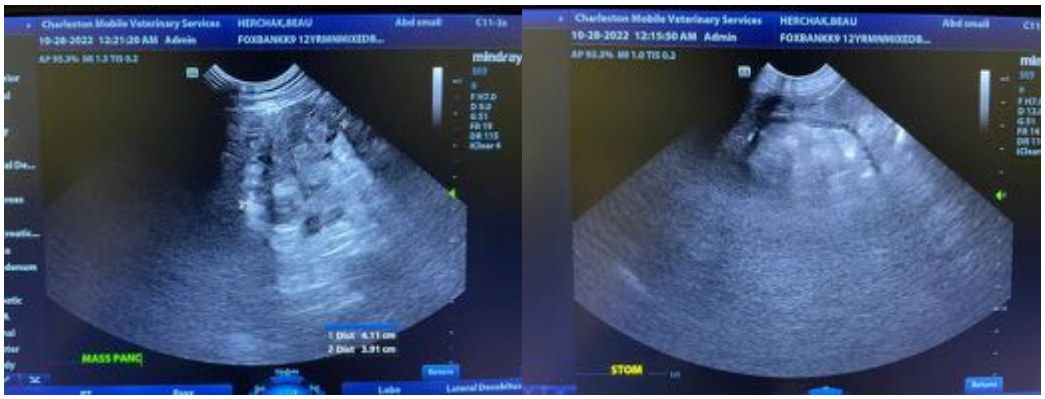

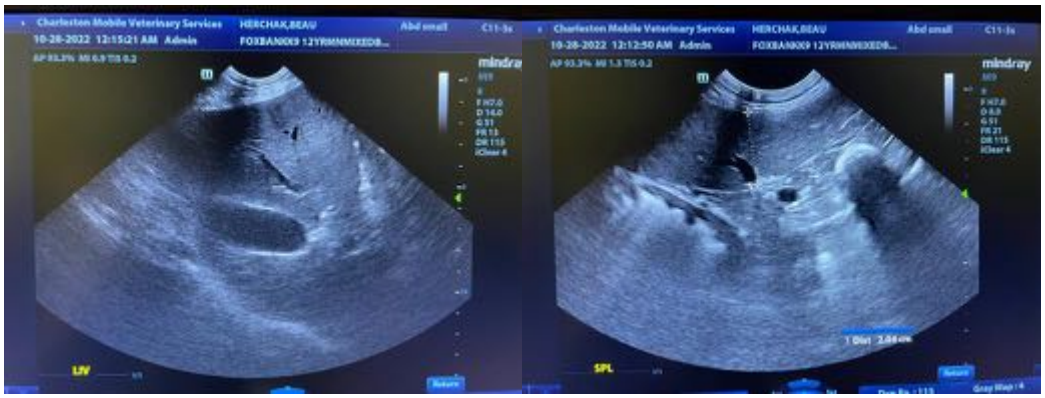

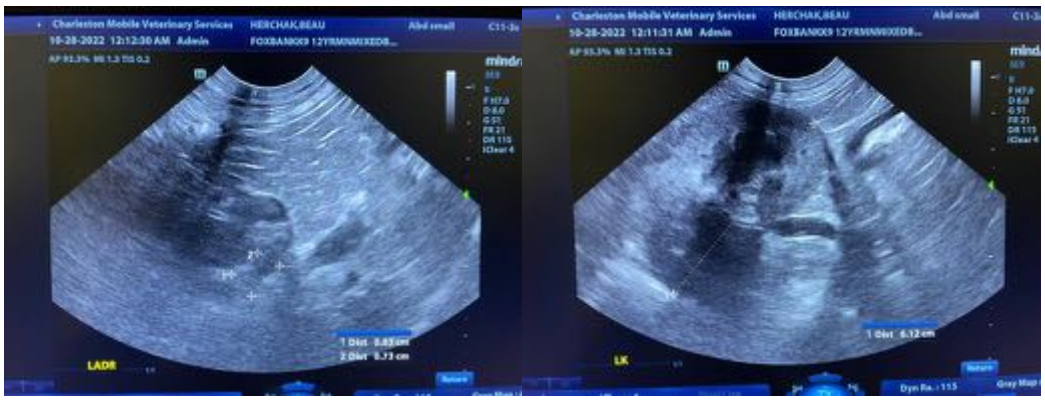

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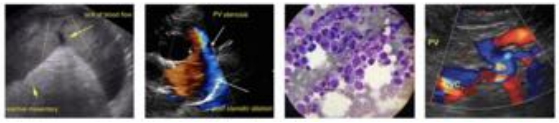

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com