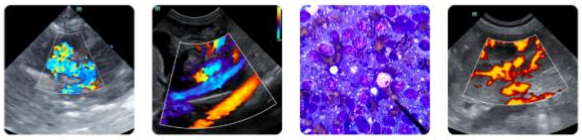

DATE

11-24-25

PATIENT

Bronson Thomas

SPECIES

Canine

BREED

Golden Retriever

SEX

Neutered Male

AGE

11/19/2016

WEIGHT

37.9kg

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Mason Dixon AEC

REFERRING VET

Dr. Moser

INVOICE

22311

PRESENTING CLINICAL SIGNS

Patient History: Acute onset of abdominal breathing, cough, gagging starting about a week ago, dx w/ pleural effusion. 11/19; PE - dry, "honking" cough, inc RR, decreased lung sounds ventrally. Patient was HBC April 2024, dented car and walked away and patient was put on Denamarin per owner.

Current Medications: Thyroxine 0.8 mg q 12, Cefpodoxime 200 mg q 24 (recently started by rDVM), Lasix 20 mg 1.5 q 12 (recently started by rDVM) - received all meds this morning
Labwork Results: Diagnostics not attached, reported as: Radiographs- mod pleural effusion, unable to visualize cardiac silhouette, increased soft tissue density mid-abd above spleen and caudal to stomach. Fluid analysis - protein 4.2, low cellularity (occ abnormal lymphocyte noted), straw colored fluid
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Approved.
Imaging Performed by: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is mildly 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 mildly enlarged (1.70 cm in width) with smooth peripheral contours. Parenchyma is homogenous. No focal lesions are observed. The prostatic urethra is not overtly dilated.

The left kidney is normal in size (6.44 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 (6.94 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 (0.68 cm at cranial pole) (LaAN cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity 0.69 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 (0.80 cm at cranial pole) (0.63 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 (1.36 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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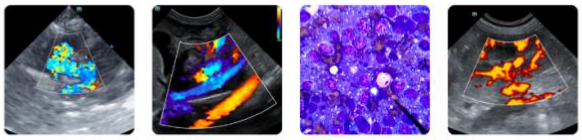

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Liver

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.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A scant amount of suspended echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly 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 with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic 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.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

Trace free fluid is observed.

Other

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass. In one-to-two video clips, there is a questionable breach in the diaphragm.

Thorax

A moderate amount of echogenic pleural effusion is visualized. Within the left hemithorax, a tissue opacity is observed between the heart and the body wall. The tissue has the appearance of hepatic parenchyma. The heart is visualized. The cardiac chambers are subjectively normal. No obvious intracardiac masses are visualized. There is questionable scant pericardial effusion (vs pericardial fat).

ULTRASONOGRAPHIC FINDINGS

- Pleural effusion with hepatic-like tissue in the left hemithorax. The tissue may represent herniation of liver tissue through a possible diaphragmatic hernia or consolidation of lung resulting in hepatization of pulmonary parenchyma.
- Possible breach in the diaphragm/diaphragmatic hernia vs imaging artifact
- Questionable scant pericardial effusion vs pericardial fat
- Trace ascites
- Minor bilateral age-related renal changes

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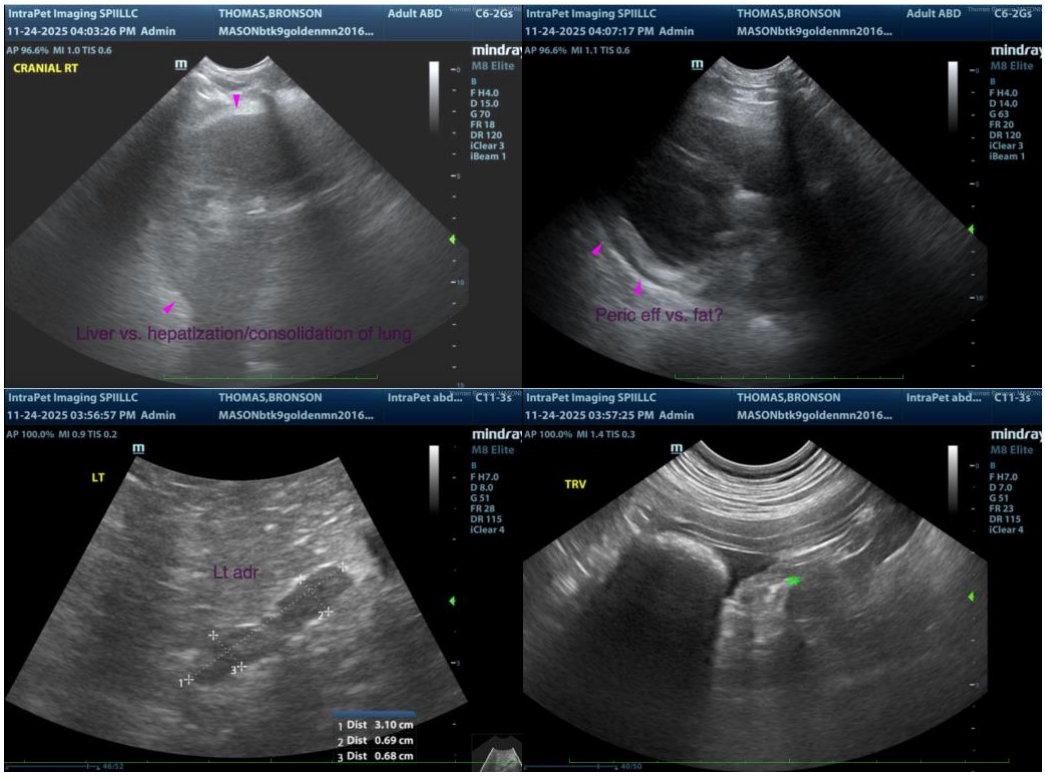
- The mild prostatomegaly may be a normal variant for this larger-breed patient. Other considerations include emerging neoplasia, late-in-life neutering (if applicable), prostatitis, other. Correlation with the patient's clinical history is recommended.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- To further evaluate thoracic pathology and to assess for a diaphragmatic hernia, a thoracic CT scan is recommended. Submission of the pleural effusion for cytologic evaluation is also recommended.
- Regarding the mild prostatomegaly, consider a urine BRAF test to further evaluate for neoplasia. A positive test confirms neoplasia. However, a negative test does not rule out the possibility of cancer, and further testing (i.e., biopsies) may be necessary to get a definitive diagnosis. A urinalysis should also be performed to screen for a lower urinary tract infection.



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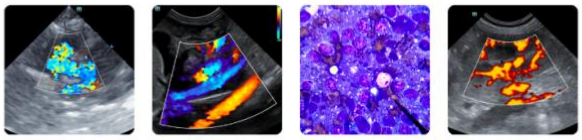

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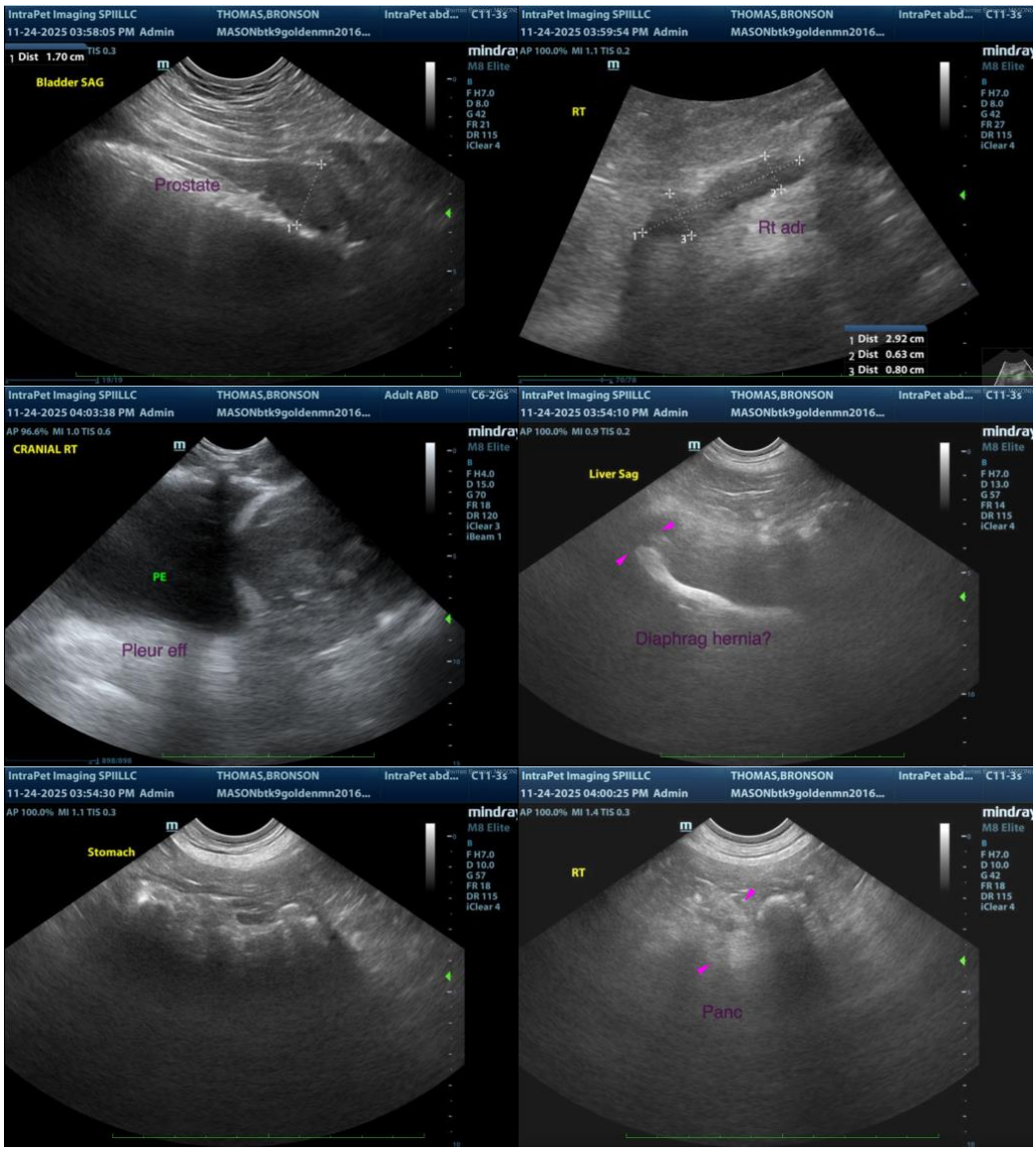

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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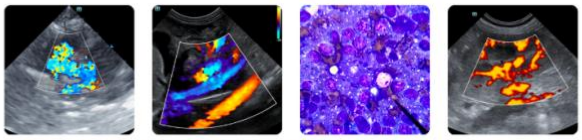

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