



PATIENT

Watson Miller

SPECIES

Canine

BREED

Cardigan Corgi

SEX

Neutered Male

AGE

13 Years

WEIGHT

40 Lbs.

INTERPRETED BY

Andrea Nicastro, DMV,
Diplomate DACVIM
(Small Animal
Internal Medicine)

IMAGING PERFORMED BY

Amanda Crook- SDEP
Certified Clinical
Sonographer

HOSPITAL NAME

Rivers Edge PMC

REFERRING VET

Dr. Jason Christensen
/ Dr. Cora Hollomon

INVOICE

13086

DATE

12/17/21

PRESENTING CLINICAL SIGNS

History: Has had sporadic urinary incontinence. Painful on caudal abdomen. C/s is pending, rods are present. Clumped, abnormal epithelial cells are present based on Path review of most recent u/a. O reports P not eating over last few days, only ate rice in last 24 hours, O reports P straining to both defecate and urinate. Last night, P straining significantly and now 3rd eyelid is elevated and covering the majority of the globe and P is locally painful @ eye. O reports P was neutered @ 8 months of age. Current Medications: Entyce SID, Enrofloxacin 5 mg/kg SID, Sucralfate PRN - Previous Cerenia inj on 12/14, Previous short course of Rimadyl.

Abnormal PE/Chem/CBC/UA Results: per rDVM, normal Chem/CBC Abnormal UA: Rods +++ growing, not identified yet Abnormal epithelial cells present

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. Luminal contents are mostly anechoic. No cystic calculi are observed. The region of the trigone is normal. The proximal urethra is questionably slightly thickened with a smooth mucosal surface.

The prostate is severely enlarged (5.07 cm x 2.83 cm in width) with a slightly irregular shape. The parenchyma is diffusely heterogeneous with ill-defined hypoechoic to anechoic areas. Foci of mineralization are observed. The prostatic urethra is not overtly dilated. The mesentery effacing the serosal surface is hyperechoic.

The left kidney presented normal size (637 cm in length); normal shape and architecture with 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 presented normal size (7.13 cm in length); normal shape and architecture with 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 normal size (0.53 cm at cranial pole) (0.53 cm at caudal pole) (2.18 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.

The right adrenal gland is normal size (0.69 cm at cranial pole) (0.52 cm at caudal pole) (2.37 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 (1.61 cm in width at the level of the hilus) with a normal capsular contour. The echotexture is coarse. No focal lesions are observed. Splenic vasculature is normal.



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Liver

The liver is subjectively normal in size with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to the spleen and mottled in appearance. A 1.10 cm hypoechoic nodule is observed on the left side, at the caudal aspect. The lesion causes capsular expansion. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is of normal contours and contains some gravity dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. 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 or overt infiltrative disease is noted.

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.

Free Abdomen

Trace free fluid is observed in the cranial abdomen. 2-3 prominent medial iliac lymph nodes are visualized, the largest measuring 2.46 cm in length. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The prostate changes are most concerning for infiltrative neoplasia (i.e., prostatic adenocarcinoma, transitional cell carcinoma) with a low possibility of benign pathology.
- The prominent medial iliac lymph nodes could be consistent with metastatic disease, reactive lymphadenitis or lymphoid hyperplasia.
- Caudal retroperitonitis is present, likely secondary to prostatic pathology
- The hepatic parenchymal changes are nonspecific and could be associated with benign age-related remodeling. However, metastatic disease cannot be completely excluded, particularly with regard to the left nodule.

Secondary Findings

- Minor age-related renal changes
- The significance of the trace ascites in the cranial abdomen is unclear. It may be secondary to increased vascular permeability, low oncotic pressure or increased hydrostatic pressure. Correlation with clinical findings is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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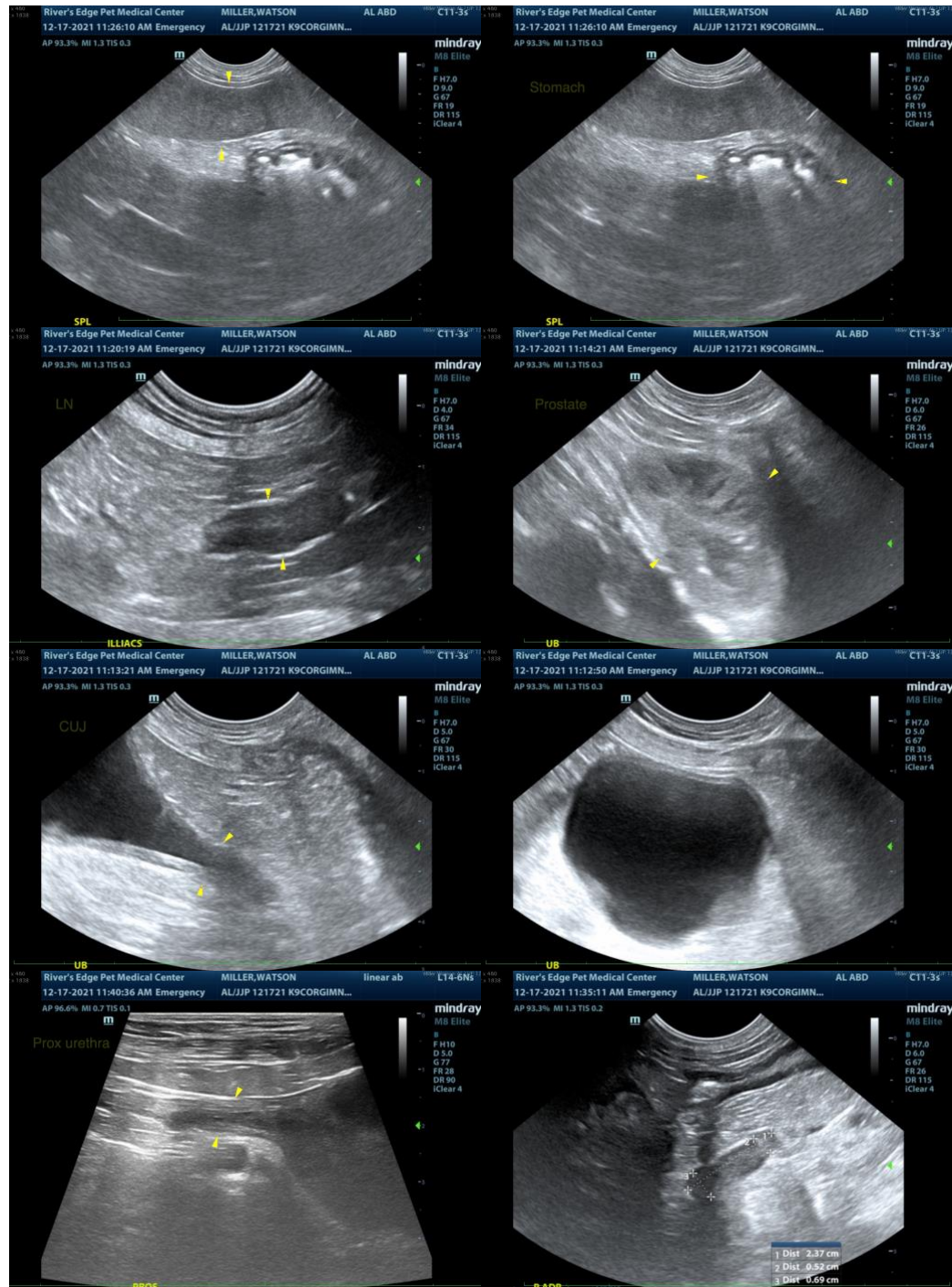
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- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- A urine BRAF test is recommended to further assess for prostatic neoplasia. If results are inconclusive, consider traumatic urethral catheterization with cytologic evaluation. If neoplasia is confirmed, consider consultation with a board-certified oncologist for further recommendations.





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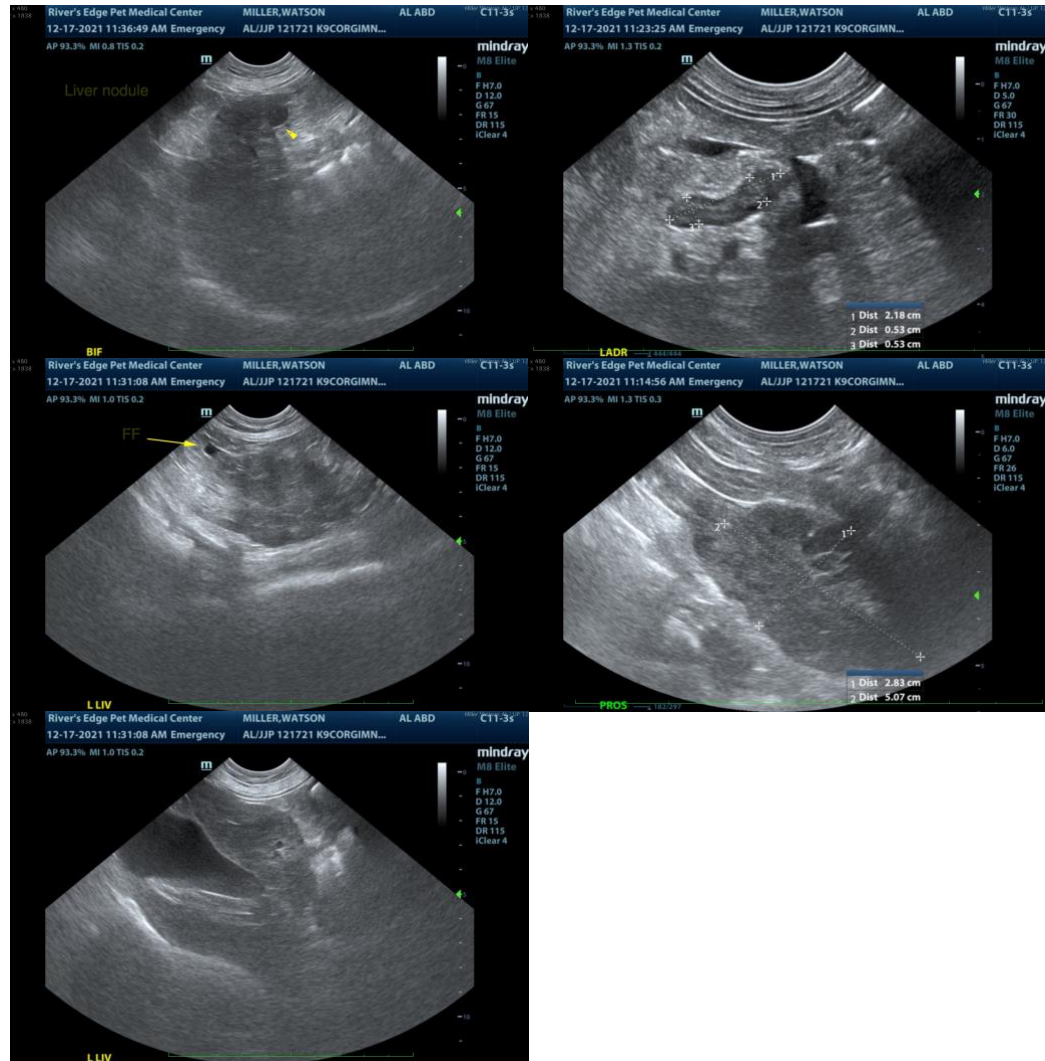
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 DACVIM (Small Animal Internal Medicine)
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