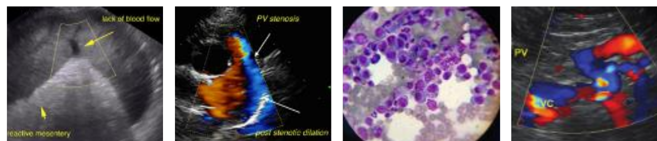


SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Diesel Muhsen

SPECIES

Canine

BREED

Husky

SEX

Neutered Male

AGE

9 Years

WEIGHT

77.5 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Potomac Mobile Veterinary Ultrasound

HOSPITAL NAME

Banfield PH Herndon

REFERRING VET

Dr. Jarrett

INVOICE

13859

DATE

PRESENTING CLINICAL SIGNS

History: Rectal hernia in past, had some blood in urine and stool that seems to have resolved, lethargic, pain when tail is lifted, hind leg weakness, pain when defecating, hx elevated ALKP, and Pu/Pd not resolving. Currently on amoxicillin 500mg BID. Patient will attempt to urinate and only produce small amounts.

Abnormal PE/Chem/CBC/UA Results: (02/09/2022) CBC: WBC 22.01 and Neu 17.61. (02/09/2022) CHEM: ALKP 1721, GLOB 4.6, GLU 164. (10/13/2021) U/A: USG 1.030.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is distended. The majority of the bladder wall is normal in thickness with a smooth mucosal surface. In the region of the trigone/cystourethral junction, the wall is thickened and irregular with foci of mineralization. A 1.17 cm cystic calculus (versus aggregation of mineralized sand) is observed within the lumen along with a small amount of suspended echogenic debris.

The prostate is enlarged in size (5.38 cm in length x 3.74 in width) with a mass effect. The contours are relatively curvilinear. The parenchyma is slightly heterogeneous with foci of mineralization. The mass effect extends cranially into the cystourethral junction/trigone area of the urinary bladder. The prostatic urethra is not overtly dilated.

The left kidney presented normal size (7.28 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.

The right kidney presented normal size (7.57 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. A small nephrolith is visualized. There is no evidence of pyelectasia, infarcts or hydroureter.

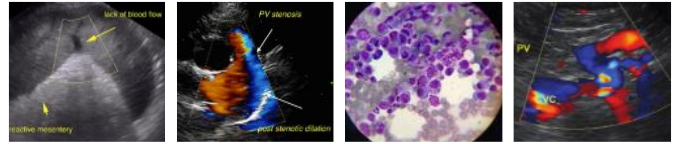
Adrenal Glands

The left adrenal gland is normal size (0.78 cm at cranial pole) (0.60 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 (0.76 cm at caudal pole) (2.51 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 not definitively visualized (it is unknown whether the patient has had a prior splenectomy).



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Liver

The liver is subjectively prominent in size with normal curvilinear peripheral contours. The parenchyma is of appropriate echogenicity and echotexture and is subtly mottled in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of gravity dependent, echogenic to mineralized debris is observed within the lumen. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is mildly distended with ingesta. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally dilated with chyme. 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

There is no evidence of free fluid. 2 enlarged, rounded, hypoechoic to slightly heterogeneous sublumbar lymph nodes are visualized, the left measuring 3.13 cm x 2.89 cm, the right measuring 3.60 cm x 2.99 cm.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

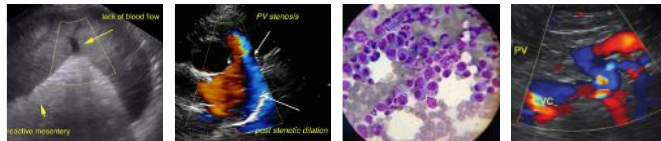
- Prostatic mass with extension into the cystourethral junction. Neoplasia (i.e., prostatic adenocarcinoma, transitional cell carcinoma) is considered likely. A cystic calculus (or aggregated urinary bladder sand) is present.The regional lymphadenopathy likely represents metastatic disease with a lower possibility of reactive change.

Secondary Findings

- Minor age-related renal changes with right non-obstructive nephrolithiasis

- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered unlikely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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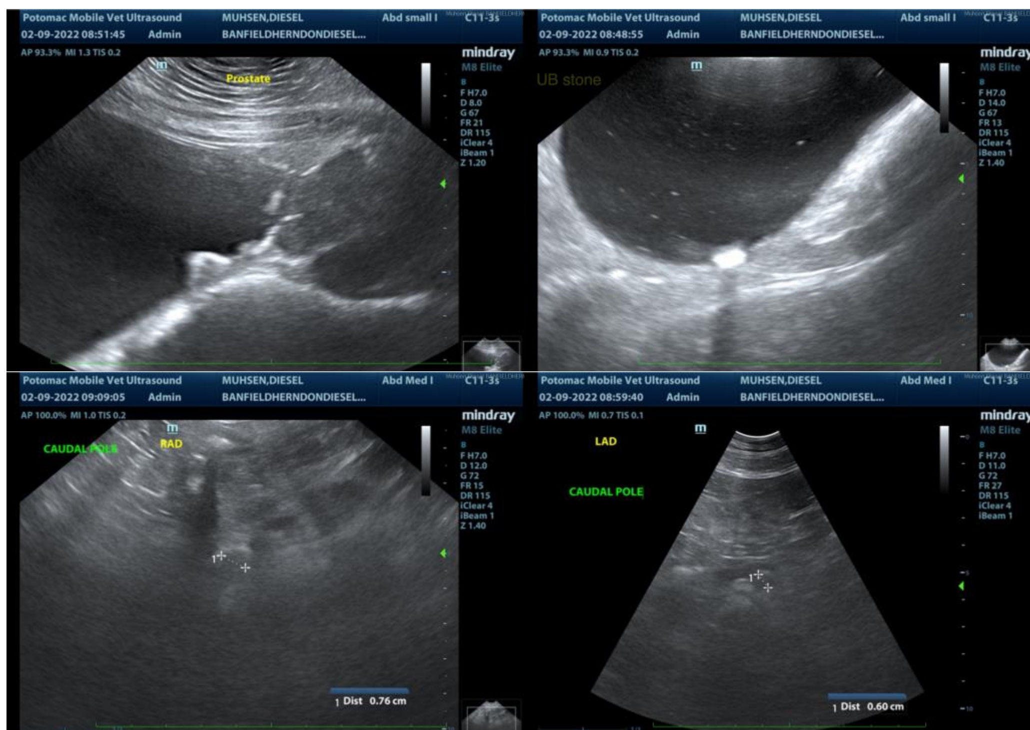
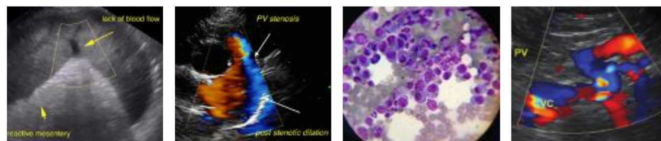
- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- To further confirm prostatic neoplasia, consider a urine BRAF test or traumatic urethral catheterization with collection of prostatic cells for cytologic evaluation.
- If aggressive therapy is desired, consider consultation with a board-certified oncologist. Otherwise, palliative care can be considered, including the following:

1. Piroxicam at 0.3 mg/kg PO every 24 hours (may need to be compounded in smaller patients)
2. Misoprostol (stomach protectant) at 2 mcg/kg PO every 12 hours
3. Baseline renal values should be performed then repeated every 4 weeks to monitor for nephrotoxicity
4. *It should be noted that if prostatic adenocarcinoma is present, the above protocol is unlikely to be effective.

- Given the probable urethral obstruction, a tube cystostomy should be considered to allow bladder emptying while treatment modalities are being considered.





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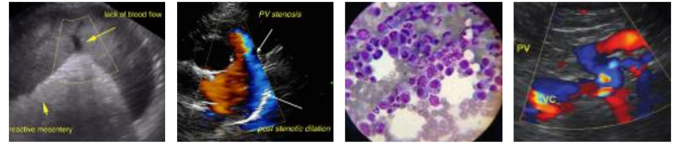
The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I



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can be of any further assistance please contact me.

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andrea_nicastro2@hotmail.com