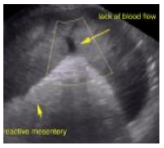
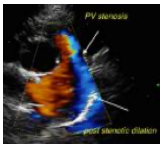
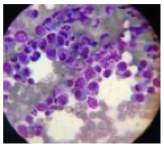
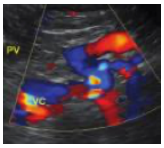
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

SonoPath.com
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PATIENT
Diesel Nelle

SPECIES
Canine

BREED
Labrador Retr

SEX
Neutered Male

AGE
12 years

WEIGHT
80 lbs

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

IMAGING PERFORMED BY
Dr. Sheldon

HOSPITAL NAME
Advanced PC Oakland

REFERRING VET
Dr. Sheldon

INVOICE
12195

DATE
2.9.23

PRESENTING CLINICAL SIGNS

History: In the past month O feels like his abdomen seems larger than normal. On physical exam a distended abdomen was not noted. He does have multiple large soft sub Q masses on his abdomen previously aspirated as lipomas. He does hold his tail down, stiff gait in both rear legs. hyper flexing the stifle on the right side when walking He does pant excessively at home and just seems restless like he can't get comfortable. Owner can't afford an MRI right now.

Abnormal PE/Chem/CBC/UA Results: Bloodwork: mild non- regenerative anemia 38% Radiographs of the chest/abdomen/rear legs: Radiographic impressions: 1. Unremarkable geriatric thorax. 2. Unremarkable lumbosacral and sacral-caudal spine. 3. Unremarkable pelvis and right stifle. 4. Mild left stifle effusion and / or synovial proliferation. Preferential consideration is given to a cruciate ligament injury (partial or complete). Other forms of stifle trauma, intermittent left patellar luxation, or synovitis are less likely differential diagnoses. 5. Predominantly fat opacity subcutaneous nodular lesion along the caudal aspect of the left thigh region.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (1.38 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is mildly enlarged (8.60 cm in length) with a slightly irregular shape. A 3.34 cm cortical cyst is observed at the caudal pole. The lesion causes capsular expansion. In the remainder of the kidney, there is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is mildly enlarged (7.24 cm in length) with a normal shape, architecture and 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 in size (0.54 cm at cranial pole) (0.56 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.

The right adrenal gland is in normal size (1.49 cm at cranial pole) (0.80 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 (1.63 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 normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen with minor changes consistent with age-related remodeling. No focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion.

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

Gastrointestinal
The lumen is mildly distended with ingesta. The gastric wall is 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. There is no evidence of an obstructive pattern.

Pancreas
The pancreas is normal in size with normal peripheral contours. The pancreatic duct is normal. The base and limbs of the pancreas are isoechoic to surrounding omental fat. No focal lesions are observed. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen
The peritoneal cavity is normal. There is no evidence of inflammation or effusion. A 2.21 cm left medial iliac lymph nodes is visualized. The node is normal in shape and echogenicity.

ULTRASONOGRAPHIC FINDINGS

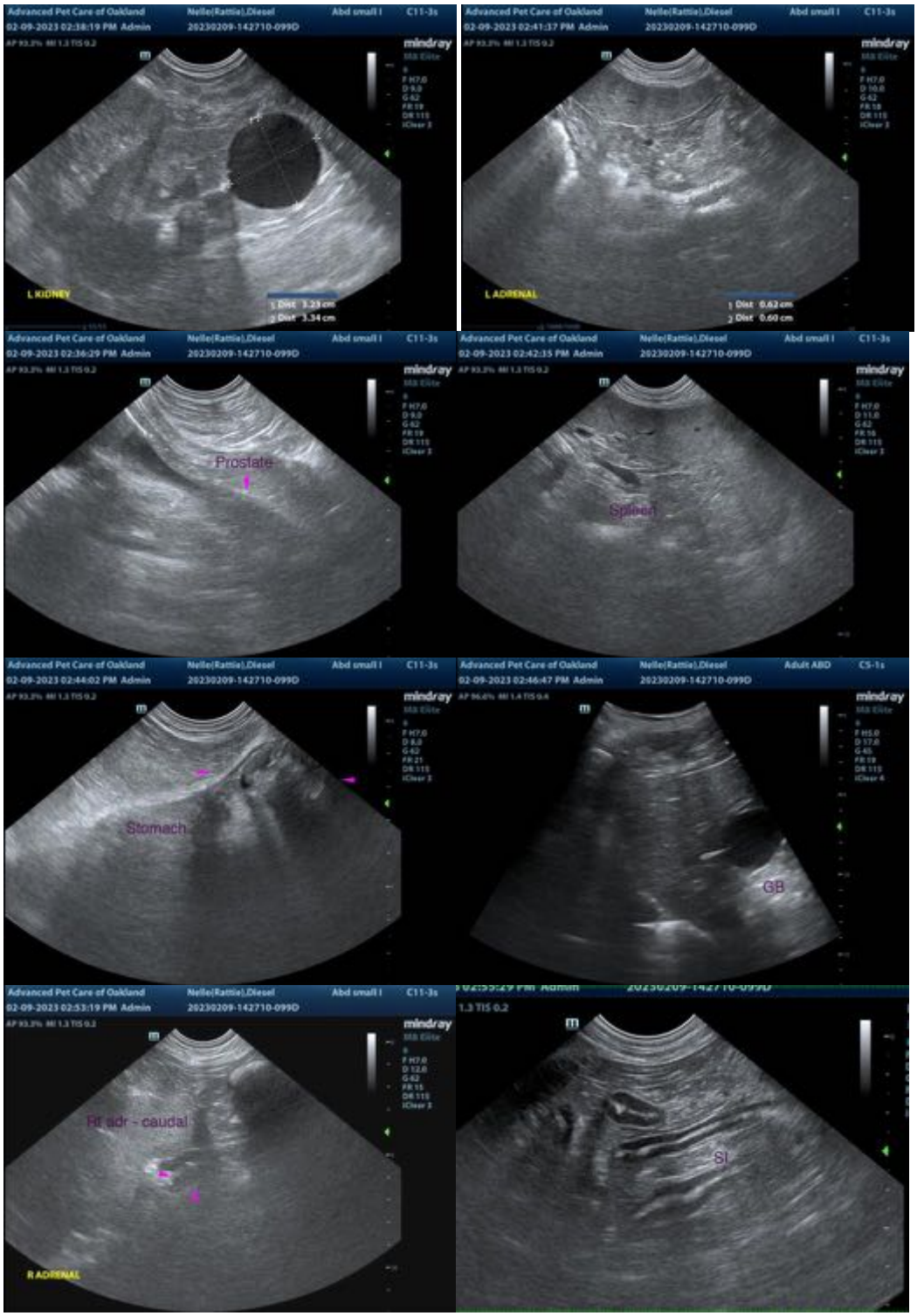
Primary Findings

Minor age-related hepatic and renal changes. The remainder of the abdomen is unremarkable.

*An obvious cause for the patient's clinical signs and mild regenerative anemia is not definitively identified in this study. Differentials for regenerative anemia include hemolysis and blood loss (i.e., GI, other).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for occult disease (i.e., neoplasia in the chest).
- A fecal evaluation for ova and Giardia is also recommended to assess for internal parasitism.
- Also consider a slide agglutination test to evaluate for auto-agglutination.
- Consider a comprehensive tick panel (Send to MC State Vector-borne Disease Lab).
- If the regenerative anemia persists, and the above diagnostics are inconclusive, an upper GI endoscopy may be warranted to evaluate for a low-grade bleeding ulcer.
- Regarding the hind-end issues, consultation with a board-certified surgeon or neurologist should also be considered, if possible.



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.

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