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Clinical Sonography & Telecytology
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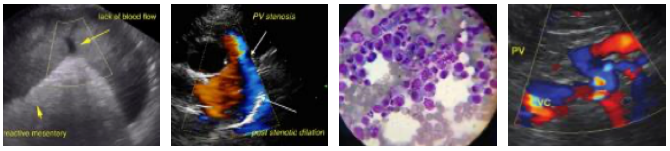


PATIENT
Odie Jones

SPECIES
Canine

BREED
Lab Mix

SEX
Male

AGE
9 Yrs.

WEIGHT
70 lbs.

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

IMAGING PERFORMED BY
Tasha

HOSPITAL NAME
Dillsburg

REFERRING VET
Dr. Crow

INVOICE
13065

DATE
3/1/22

PRESENTING CLINICAL SIGNS

History: Possible foreign body
Abnormal PE/Chem/CBC/UA Results: Prostatomegaly; Started vomiting at 2am, has been vomiting since, unable to keep water down. Not eating. O unsure of p's defecation, did go this morning but unsure of consistency. P is known for eating diaper wipes, other objects. Abdominal radiographs performed showed gas distended stomach, one area of increased radiopacity in the caudal left abdomen. Discussed with owners possibly foreign material, along with foreign material in pylorus causing stomach distension. Cerenia injection and will feed bland diet tonight see if p eats. Recheck radiographs in the morning, if it looks like still not moving through, sx may be indicated. CBC: Neu 13.83, Lymphs 0.45; Chem: Ca+ 12.9, TP 7.8, Alb

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. Several small cystic calculi are visualized within the lumen. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is enlarged with a slightly irregular shape and smooth peripheral contours. The parenchyma is hyperechoic relative to surrounding omental fat and slightly heterogeneous in appearance. Several small ill-defined cystic areas are observed within the gland. The prostatic urethra is not overtly dilated. A small amount of subcapsular fluid is present.

The left kidney is normal size (6.10 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 is normal in size (6.37 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is minimal loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

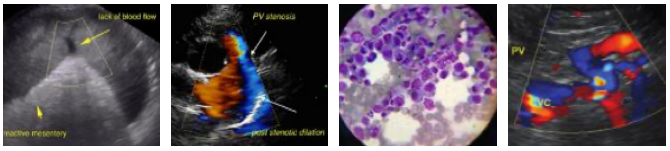
The left adrenal gland is normal size (0.58 cm at cranial pole) (0.55 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The caudal pole of the right adrenal gland is visualized and is normal size (0.53 cm in width) with a normal shape, glandular echogenicity and detail. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is not visualized in its entirety. In the visualized portions, the spleen is subjectively normal in size with normal curvilinear peripheral contours. A 2.30 cm irregular hypoechoic nodule/mass is observed. The remaining parenchyma is slightly mottled in appearance. Splenic vasculature appears normal with no obvious evidence of thrombosis.

Liver



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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. No pathological hepatic lymphadenopathy observed. The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is moderately to severely fluid distended and hypomotile. Irregular hyperechoic material (possible chyme) is observed within the lumen. The gastric wall is normal in thickness with a normal layering pattern. Several bowel segments are moderately to severely fluid distended (up to 1.93 cm in diameter) and hypomotile. The bowel wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal.

Pancreas

A portion of the pancreas is obscured by the gastric distention. In the visualized portions no obvious pathology is seen.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

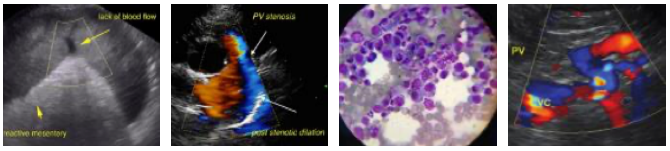
- Bowel pattern suggestive of obstruction. However, diffuse ileus cannot be excluded. An obvious foreign body is not identified.
- Splenic nodule/mass. Differentials include neoplasia (i.e., round cell tumor, sarcoma) versus a focal benign process (i.e., lymphoid hyperplasia, inflammatory focus, extramedullary hematopoiesis).

Secondary Findings:

- Minor, age-related renal changes with right dystrophic mineralization.
- Cystic calculi.
- Benign prostatic hypertrophy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If an aggressive approach is desired, consider an abdominal exploratory to evaluate for a small intestinal obstruction. If there is no evidence of obstruction, gastrointestinal biopsies should be obtained. Also consider a splenectomy, castration and cystotomy with stone removal, analysis and culture if the patient is stable under anesthesia.
- If a more conservative approach is desired, consider aggressive supportive care with a recheck ultrasound in 12-24 hours. If sonographic changes are similar to today's scan, an exploratory should be considered at that time. If surgery is not pursued, a fine needle aspirate of the splenic



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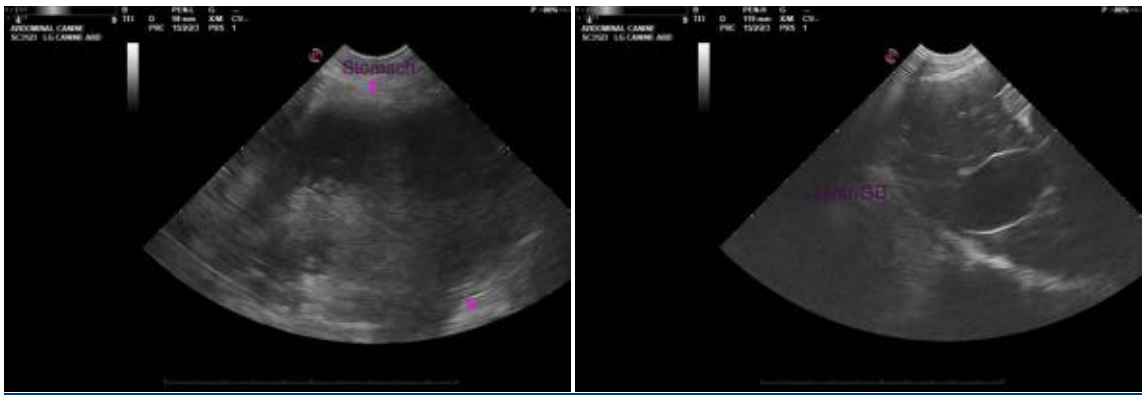
nodule is recommended to assess for neoplasia (along with an attempt at medical dissolution of the bladder stones).

- Three-view thoracic radiographs are also recommended to assess for pulmonary metastatic disease and aspiration pneumonia.
- Given the patient's hypercalcemia, a recheck calcium is recommended when well-hydrated. If hypercalcemia persists, consider an ionized calcium +/- PTH/PTHrP as well as a rectal exam to assess for anal gland tumors.



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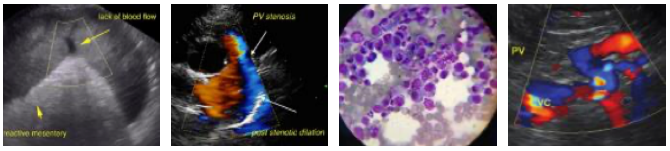

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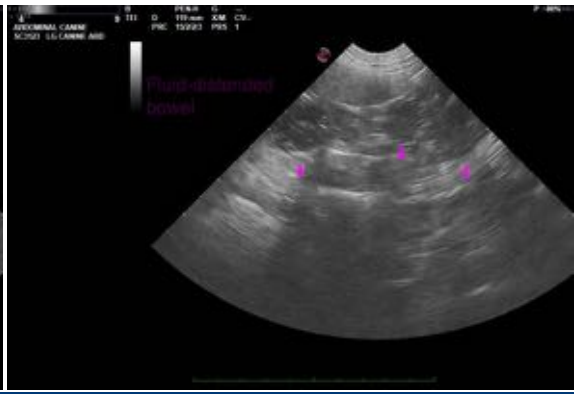

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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