

**DATE PRESENTING CLINICAL SIGNS**

3/10/2022

PATIENT

Henry Howley

History: Protein losing enteropathy- diagnosed late Jan 2022. Moderate improvement on medication and diet (albumin 1.8 on 1/28/22 then 3.5 on 3/2/22). However- recent ALT 661. Previous normal 18 on 1/28/22. Ongoing weight loss. Stool has been close to normal on meds but very recent (past 2 days)- liquid stool and poor appetite.

SPECIES

Canine

Current Medications: Prednisone 20mg SID currently (50mg daily 1/31-2/21, then 20mg daily), Chlorambucil 3.5mg SID since 2/13- just stopped 3/8 (concerns with thrombocytopenia and poor appetite), Cobalequin SID, Omeprazole 20mg BID, Tylan ¼ BID, recent trial with metro 375mg BID.

Lab Results: New ALT elevation 667. Mild thrombocytopenia 120K on blood smear.

Date of Previous IntraPet Ultrasound: 1/28/22 & 11/19/21.

BREED

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Golden Retriever Mix

SEX

Neutered Male

Imaging Performed By: Andi Parkinson, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**AGE**

2/3/2010

Urinary System

The urinary bladder is mildly to moderately distended. An irregular mineralized mass effect is observed at the dorsoapical aspect. The wall in this region is severely thickened (up to 1.74 cm), and irregular. No cystic calculi are observed. The visible portion of the proximal urethra is normal.

WEIGHT

52.4 lbs

The prostate is normal in size (1.26 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

INTERPRETED BY

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The left kidney presented normal size (6.93 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney presented normal size (5.87 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

HOSPITAL NAME

Timonium Animal
Hospital

Adrenal Glands

The left adrenal gland is normal size (0.48 cm at cranial pole) (0.67 cm at caudal pole) (2.2 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.

REFERRING VET

Dr. Kauder

The right adrenal gland is mildly enlarged (0.70 cm at cranial pole) (0.78 cm at caudal pole) (2.57 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.

INVOICE

10528

Spleen

The spleen is normal in size (1.34 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 prominent size with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen. An ill-defined hypoechoic area measuring 2.53 cm in its longest dimension is observed on the right side. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

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

Gastrointestinal

The gastric lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal mildly thickened (up to 0.53 cm), with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The colonic wall is normal. There is no obvious evidence of an obstructive pattern.

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. The mesentery in the midabdominal region is mildly hyperechoic. The abdominal lymph nodes are normal/not visible.

Other

A large amount of pleural effusion is visualized in the thorax. A brief echocardiogram reveals no obvious evidence of chamber enlargement or pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Large volume of pleural effusion, the cause of which is unclear. It is unlikely to be due to congestive heart failure due to the subjectively normal cardiac chamber sizes. Given the normal albumin, low oncotic pressure is unlikely to be causing the effusion. Neoplasia or other causes of increased vascular permeability are considerations.
- Urinary bladder mass. Sonographic changes are similar to the previous scan. Transitional cell carcinoma is the top differential. However, severe cystitis cannot be completely excluded.
- Mild peritonitis is present, likely secondary to bowel pathology.

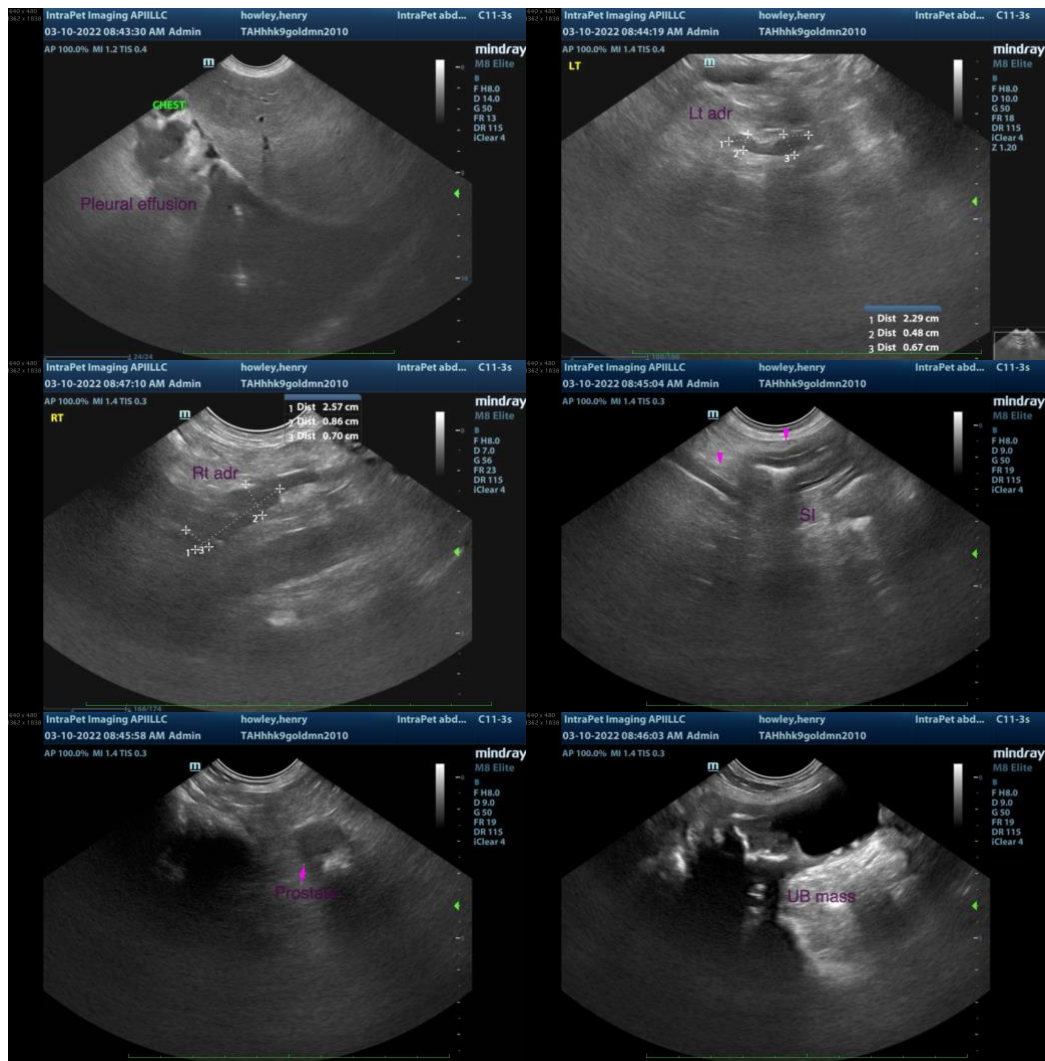
Secondary Findings

- Mild right adrenomegaly.
- The small intestinal wall changes could be consistent with severe inflammatory bowel disease or emerging neoplasia. Findings are similar to the previous scan.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A therapeutic thoracocentesis is recommended. Given the patient's history of dyspnea, a fluid sample should be submitted for cytologic evaluation. Once drained, three-view thoracic radiographs are recommended to assess for neoplasia.

A urine BRAF test should also be considered, if not already performed, to further evaluate for lower urinary tract neoplasia.



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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