



PATIENT

Rocky Binks

SPECIES

Canine

BREED

Boxer

SEX

Neutered Male

AGE

2 years 9 mos

WEIGHT

47 lbs

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Amanda Lacey-Crook
- SDEP Clinical

HOSPITAL NAME

River's Edge Pet
Medical Center

REFERRING VET

Dr. Stern

INVOICE

10535

DATE

3/14/22

PRESENTING CLINICAL SIGNS

History: Icteric, BCS 2/9, firm lobular structure on abdominal palpation. PU/PD, waxing/waning appetite Current Medications: SAME 225 1.5 po sid, denamarin large 1 sid, lixotinic 3ml BID, maropitant 48mg as needed

Abnormal PE/Chem/CBC/UA Results: Labwork from rDVM: 2/8/22 - anemia, neutrophilia, monocytosis, hypoglycemia, elevation of all liver values 3/9/22 repeat labs inc pt/ptt performed - see attached- too abnormal count. Radiographs: Diffuse soft tissue opacity and loss of visceral detail; Glucose 55. ALT 212. ALP 7558. GGT 36. Total Bili 3.8. Globulin 7.4. White count 35,700 with neutrophilia and bands. Hematocrit 29%. Mildly regenerative.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is distended. A small amount of suspended echogenic debris is observed within the lumen. 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 to prominent in size (1.47 cm in width) with a normal shape and smooth curvilinear peripheral contours. The parenchyma is mildly heterogenous in appearance with hyperechoic linear striations. The prostatic urethra is not overtly dilated.

The left kidney presented normal size (8.90 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. The cortex is mildly speckled. Mild to moderate pyelectasia is present (0.35 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney presented normal size (8.81 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. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is small in size (0.36 cm at cranial pole) (0.43 cm at caudal pole) (1.91 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 (0.54 cm at cranial pole) (0.61 cm at caudal pole) (1.87 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 (2.38 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.



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Liver

The liver is subjectively prominent in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogenous in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

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The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of echogenic to mineralized suspended debris/sludge with linear striations at the periphery is observed within the lumen. The cystic and proximal common bile ducts are mildly dilated (up to 0.60 cm). There is a suspected 0.48 cm choledocholith in the proximal common bile duct.

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Gastrointestinal

The gastric lumen is not distended. 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. The colonic lumen contains shadowing fecal material. There is no evidence of an obstructive pattern.

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Pancreas

The pancreas is difficult to discern from the severe mesenteric pathology (see also "Other" category).

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Free Abdomen

A small to moderate amount of echogenic free fluid is observed. A few prominent mid- to caudal abdominal lymph nodes are visualized, the largest measuring 1.97 cm in length.

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Other

A scant amount of what appears to be pericardial effusion is visualized. The mesentery throughout the cranial to mid abdomen is irregular to nodular in appearance and exhibits heterogeneity. Numerous ill-defined coalescing echogenic nodule are observed throughout the mesentery, which create a mass effect.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The mesenteric appearance/mass effect could be consistent with neoplasia (carcinomatosis, lymphoma), severe pancreatitis (i.e., necrotizing), panniculitis, other. Diffuse peritonitis is present, likely secondary to the mesenteric changes.
- The gall bladder changes could be secondary to cholestasis or early mucocele formation. However, mucoceles are rare in young patients. There is a suspected choledocholith in the proximal common bile duct.
- The mild hepatomegaly could be consistent with infiltrative disease (i.e., neoplasia), inflammatory hepatopathy, hepatotoxicosis, or other hepatopathy.
- Suspected trace pericardial effusion

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Secondary Findings



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- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis, lymphoid hyperplasia, or neoplastic infiltration.

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- The mild left pyelectasia may be secondary to IV fluid therapy and/or pyelonephritis.

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- The small left adrenal gland may be a normal variant for this patient or may be secondary to early atrophy (i.e., secondary to hypoadrenocorticism).

- The significance of the prostate changes is unclear. They may represent hyperplastic change, particularly if the patient was neutered recently. Alternatively, emerging neoplasia is possible.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- Given the concern for pericardial effusion, a full echocardiogram should also be considered.
- Regarding the hepatic and mesenteric changes, consider fine-needle aspirates of the liver and mesentery. Given that the PT and PTT are not significantly prolonged and that the platelet count is normal, the risk of hemorrhage aspiration is relatively low. However, if aspiration is pursued, the PT and PTT should be rechecked just prior to the procedure. Also, sonographic monitoring should be performed for at least 10 minutes post-aspiration to assess for evidence of hemorrhage. If cytology results are inconclusive, an abdominal exploratory with hepatic and mesentery biopsies should be considered.
- Given the hyperglobulinemia, a serum protein electrophoresis may be useful in determining whether neoplasia is present.

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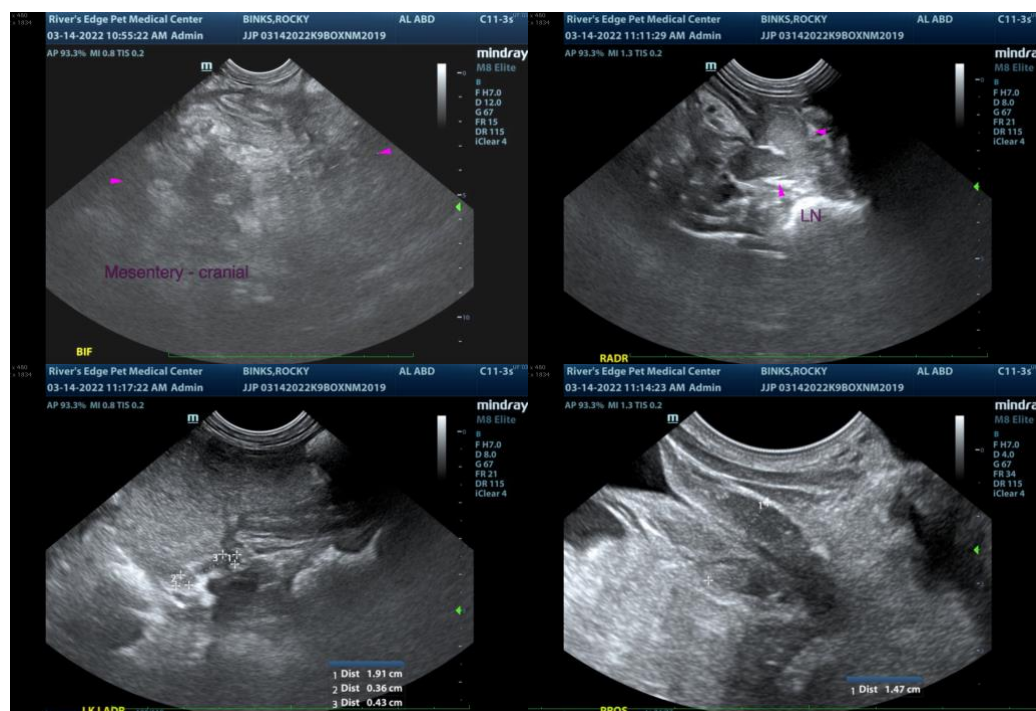
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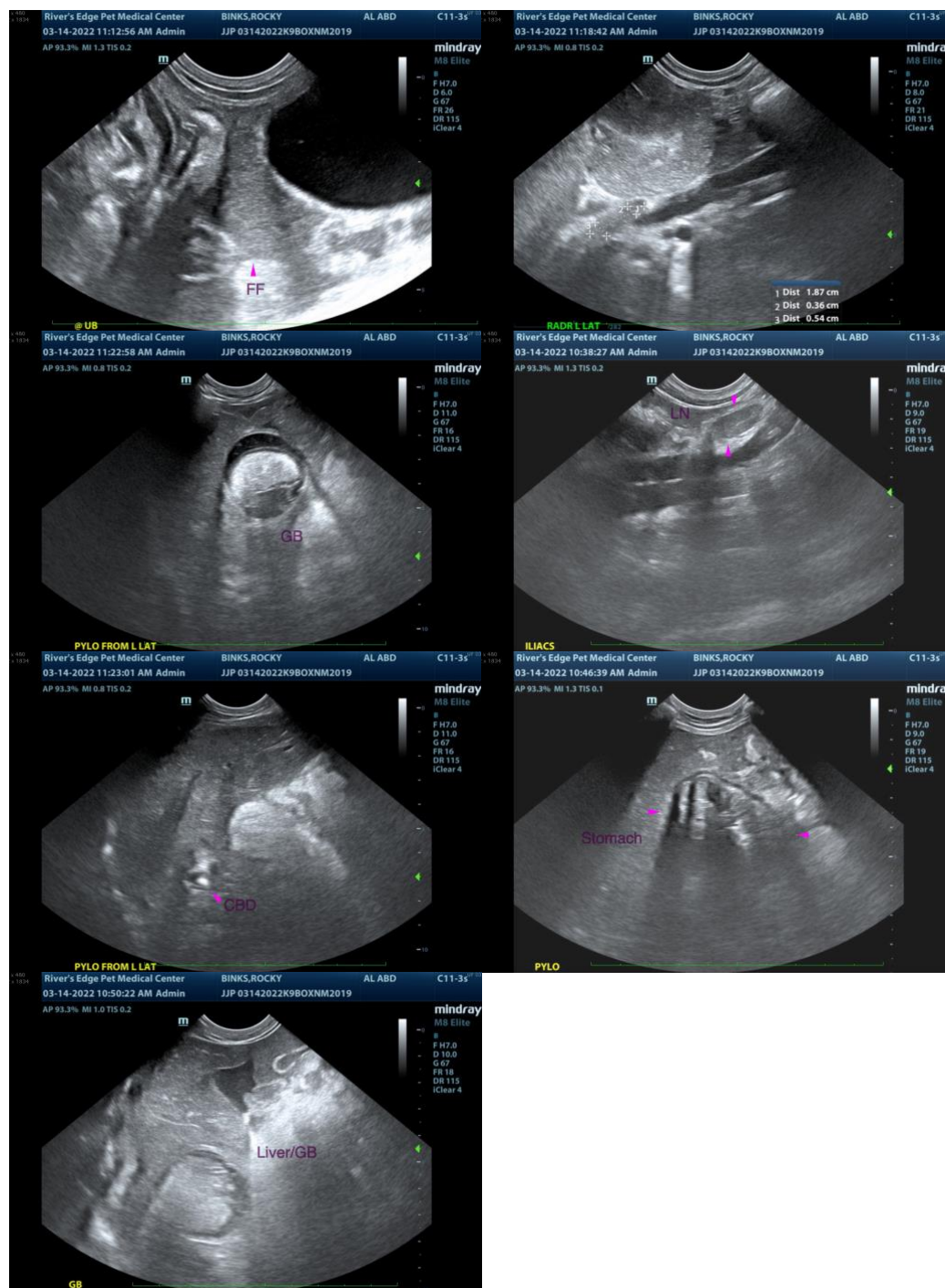
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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



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can be of any further assistance, please contact me.

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