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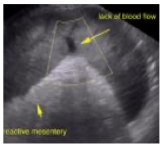
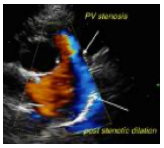
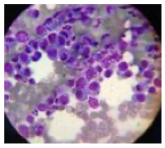
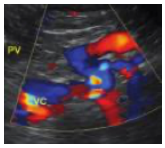
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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PATIENT

Kingston Bully Crew

SPECIES

Canine

BREED

Pitbull Terrier

SEX

Intact Male

AGE

10 years

WEIGHT

64.2 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Ferrer DVM

HOSPITAL NAME

Paseos VC

REFERRING VET

Dr. Maria Martes

INVOICE

12572

DATE

3.29.23

PRESENTING CLINICAL SIGNS

History: The patient presented today for an abdominal sonogram to evaluate the Bladder and abdominal mass noticed on radiographs. Pt has history of hematuria after taking a sample through a urinary catheter recommended abdominal ultrasound due to abdominal mass effect and changes in prostate treating as suspected UTI/prostatitis with Rimadyl and enrofloxacin.

Abnormal PE/Chem/CBC/UA Results: CBC - mild anemia with Hct 35.3% and Hgb 12.1, neutrophilia, leukocytosis Chem - hyperglobulinemia 4.8, decreased amylase 332 Radiographs - spondylosis; mass effect on cranial abdomen; prostatomegaly fecal - negative.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone and visible portion of the proximal urethra are normal.

The prostate is enlarged (3.71 cm in width) with a relatively normal shape and smooth peripheral contours. The parenchyma is heterogenous with ill-defined cystic areas and foci of mineralization. The prostatic urethra is not overtly dilated.

The left kidney is normal in size (7.50 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal in size (7.80 cm in length) with a normal shape, architecture and 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 normal in size (0.73 cm at cranial pole) (0.58 cm at caudal pole) (3.12 cm in length) with a normal shape. A 0.66 x 0.47 cm hyperechoic nodule is observed at the cranial pole. The remaining echogenicity and detail. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is in normal size (0.55 cm at cranial pole) (0.72 cm at caudal pole) (2.72 cm in length) 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 enlarged with irregular peripheral contours. An approximately 10.00 cm heterogenous mass is arising from the parenchyma. In the remainder of thickened spleen, the parenchyma is subtly mottled in appearance. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

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. A moderate amount of echogenic, partially dependent to suspended sludge is observed within the lumen. The sludge is in a partially stellate pattern. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness 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 diffusely visible with minimal deviation from the normal peripheral contours. The parenchyma is isoechoic-to-slightly-hyperechoic relative to surrounding omental fat and subtly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen
Trace free fluid is observed. The medial iliac lymph nodes are visible/prominent (the largest measuring 2.50 cm in length). Ill-defined cystic areas are observed within the nodes. In addition, a few prominent mesenteric lymph nodes are seen (the largest measuring 1.79 cm in length).

Other
A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Large splenic mass. Neoplasia (i.e., sarcoma, round cell tumor) is suspected with a lower possibility of a non-malignant process.
- The prostate changes could be consistent with benign prostatic hyperplasia with foci of mineralization. However, neoplasia (i.e., prostatic adenocarcinoma, transitional cell carcinoma) cannot be completely excluded, particularly given the presence of mineralized foci within the gland.
- The trace ascites is likely secondary to splenic pathology.

Secondary Findings

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Bilateral nonspecific chronic age-related renal changes
- The left adrenal nodule could be consistent with benign nodular hyperplasia or an emerging tumor. A benign process is favored.
- The gall bladder changes are suggestive of and emerging mucocele. However, cholestasis is also possible.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

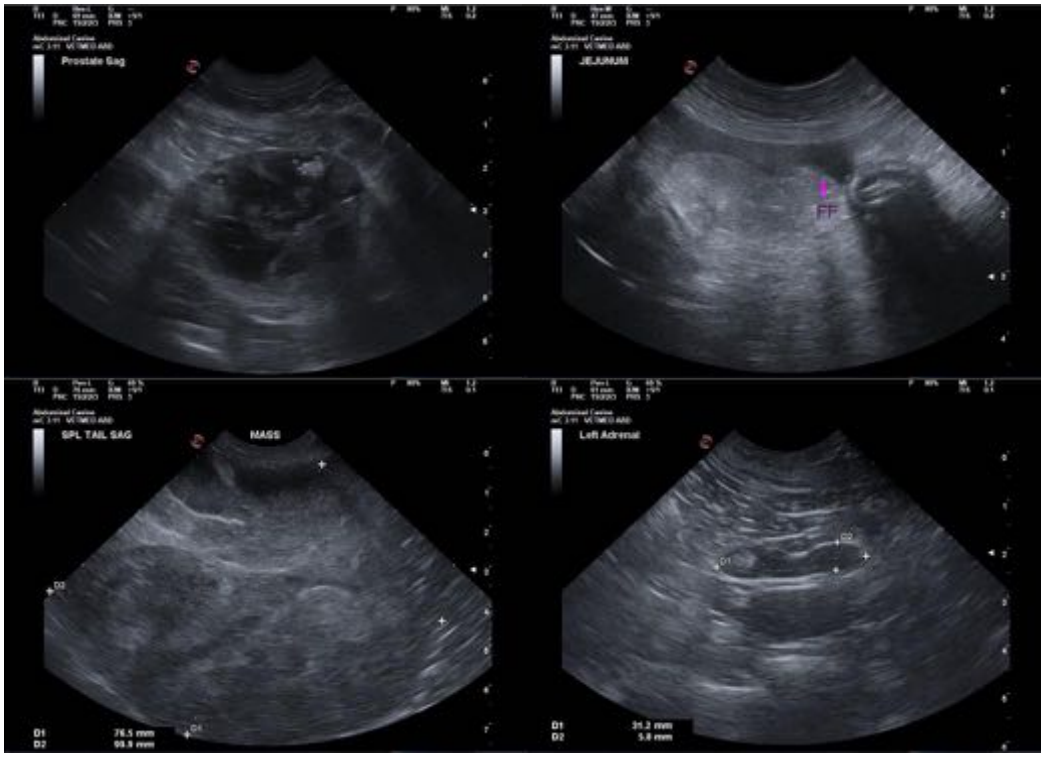
- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.

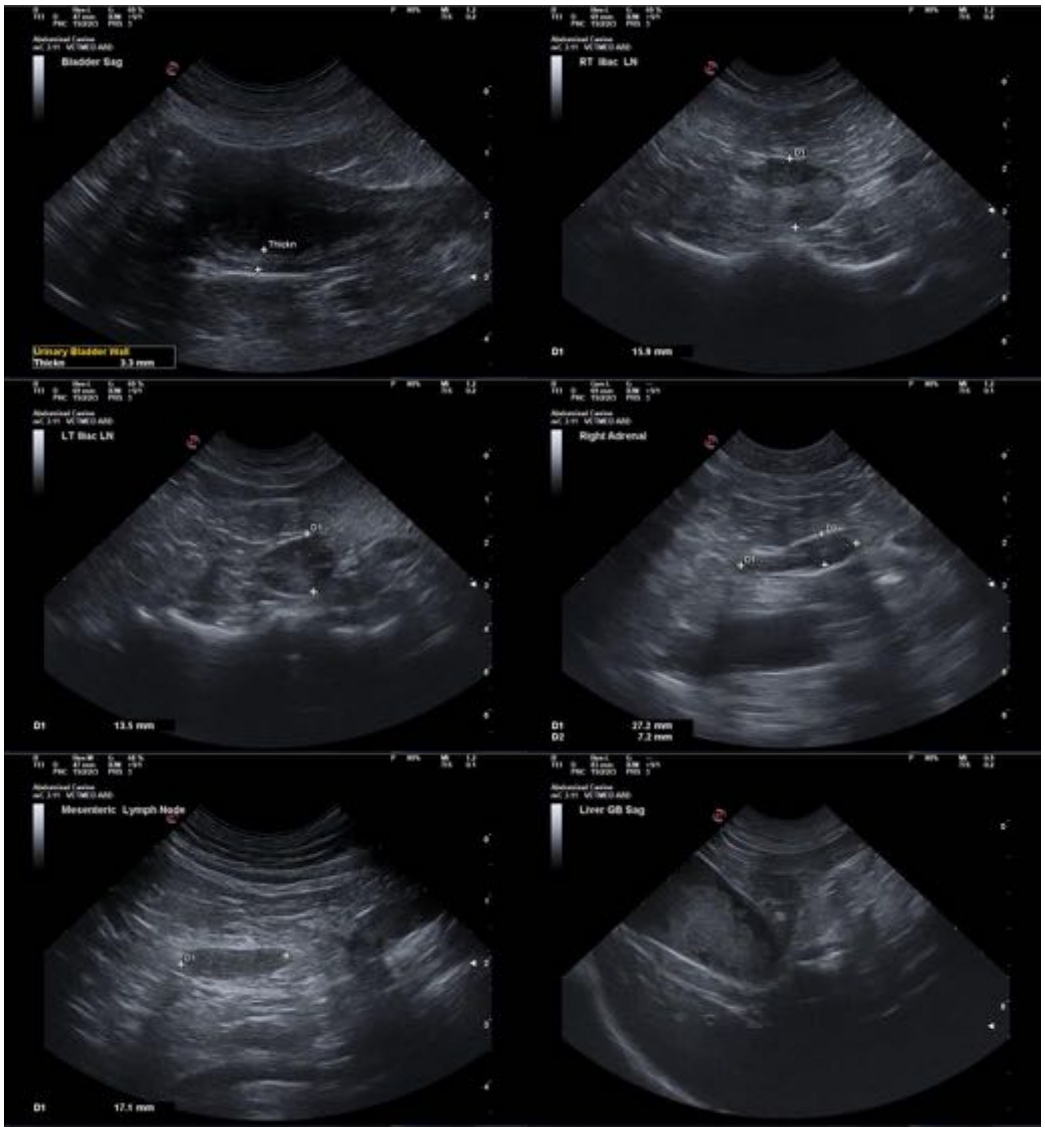
- Consider a fine-needle aspirate of the splenic mass (if clotting status is appropriate). A 25-gauge needle should be used. If the cytology results are inconclusive or if cytology is not pursued, a splenectomy with submission of the spleen for histopathology can be considered. If surgery is performed, a liver biopsy should also be obtained and castration performed.

- Regarding the prostatic cytology, if results are inconclusive, consider the following:

    1. Urine culture and sensitivity (preferably on an antibiotics-free sample)
    2. Urine BRAF test to further assess for lower urinary tract neoplasia.

- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) is recommended. Serial sonographic monitoring (e.g., every 6-8 weeks) of the gall bladder is recommended to assess for progression to a fully formed mucocele. If progression occurs, a cholecystectomy may be warranted.





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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