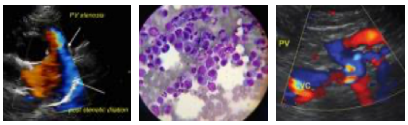
IMAGING PERFORMED BY

IntraPet.com



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DATE

5/16/22

PATIENT

Bart Vancamp

SPECIES

Canine

BREED

Basset Hound

SEX

Male, neutered

AGE

10/30/2010

WEIGHT

59.8 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Eastern AH

REFERRING VET

Dr. Cusack

INVOICE

13377

PRESENTING CLINICAL SIGNS

Presenting Complaint: Tenesmus with mucoid liquid to gelatinous stool; dribbling urine, increased frequency or urinations. PE: Moderate tartar, multiple subcutaneous masses and cyst, remainder wnl, unable to palpate prostate on exam.

Current Medications: Metronidazole 12mg/kg PO BID started 5/11/22
Visbiome started 5/11/22,
Lab Results: UA (5/11/22): SG 1.031 ph 7, nsepi >10/hpf, wbc >50/hpf, rbc >50/hpf, neg glucose, ketones 15, protein 30, suspected cocci
Urine culture (5/12/22): no growth. CBC/Chem (3/25/22): psl 204, remainder wnl.
Radiographs: 5/11/22- Diffuse enteritis non obstructive, subjectively enlarged prostate, no stones seen in urinary tract, body/fundus of stomach consolidated with gas filled body/pylorus (empty stomach vs mass effect) Mass like effect in R caudal lung field on VD and L lateral
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is minimally distended with anechoic urine. An approximately 5.0 x 1.83 cm echogenic mass is arising from the caudodorsal and caudoventral walls/cystourethral junction. It appears to extend into the proximal urethra. No cystic calculi are observed.

The prostate is enlarged (4.07 cm length; 2.86 cm width) with a slightly irregular shape. The parenchyma is hypoechoic relative to surrounding omental fat and mottled in appearance with a foci of mineralization. The prostatic urethra is not overtly dilated. The mass effect appears to extend into the proximal urethra and urinary bladder. The mesentery effacing the serosal surface of the prostate is hyperechoic.

The left kidney is normal size (6.51 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 or infarcts. Renal vasculature is normal. There is concern for possible early distal urethral dilation at the level of the trigone.

The right kidney is normal size (6.85 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 or infarcts. Renal vasculature is normal. There is concern for possible early distal urethral dilation at the level of the trigone.

Adrenal Glands

The left adrenal gland is normal size (0.69 cm at cranial pole) (0.72 cm at caudal pole) (2.59 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 (0.66 cm at cranial pole) (0.70 cm at caudal pole) (3.17 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 (1.53 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is slightly mottled in appearance. 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 slightly mottled in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. 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 not distended. A portion of the gastric wall in the region of the fundus is thickened (up to 1.18 cm). Within this region, there is an area of suspected loss of the normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. The colonic wall is normal. No obstructive disease is noted.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. A few enlarged (up to 3.70 cm) irregular, hypoechoic sublumbar lymph nodes are visualized. Surrounding mesentery is hyperechoic.

Other

Brief visualization of the chest reveals at least 2 small pulmonary nodules. There is no obvious evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Caudal urinary bladder/prostatic mass effect. Neoplasia (i.e., transitional cell carcinoma, prostatic adenocarcinoma) is considered likely with a low possibility of a non-neoplastic process. Regional retroperitonitis is present. There is suspicion for distal ureteral dilation, likely secondary to obstruction at the level of the trigone.
- The sublumbar lymphadenopathy could be consistent with metastatic disease or reactive change.
- The gastric wall thickening could be consistent with a neoplastic process, particularly in the region where there is loss of the normal layering pattern. Alternatively, an inflammatory disease or hypertrophy are other possibilities.
- Pulmonary nodules could be consistent with metastatic disease, granulomas, inflammatory foci, other.

Secondary Findings:

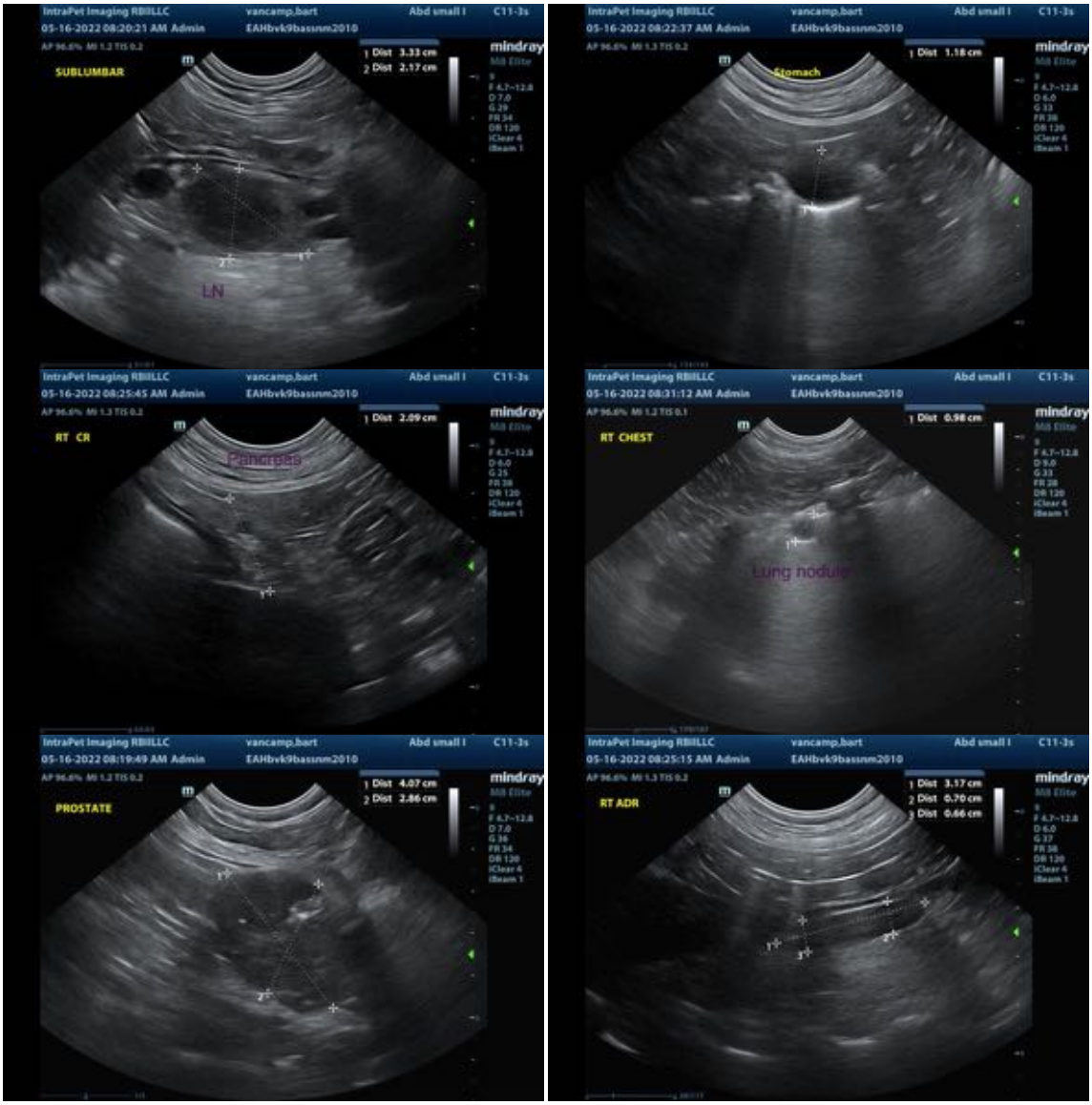
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, antigenic stimulation or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

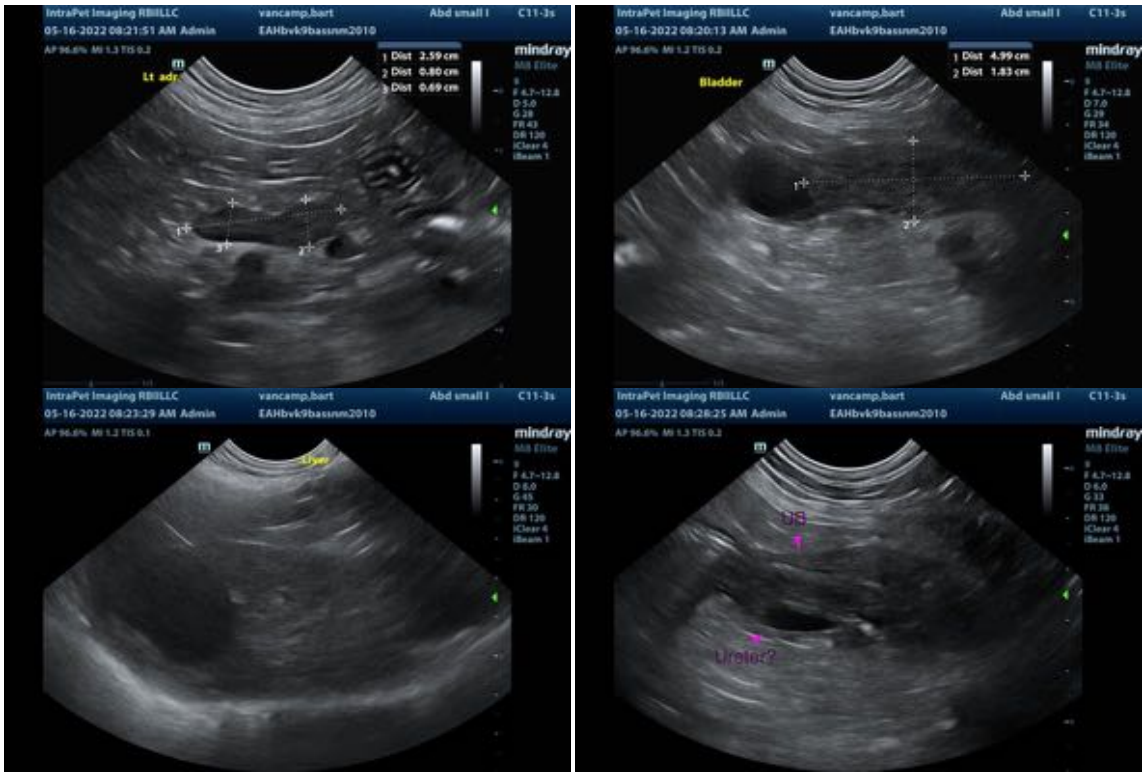
- The hepatic parenchymal changes are non-specific and are most likely secondary to age-related remodeling, regenerative nodular hyperplasia and/or vacuolar hepatopathy. However, metastatic disease cannot be completely excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider a urine BRAF test to further evaluate for lower urinary tract neoplasia. It should be noted, however, that a negative test does not rule out cancer. Therefore, if a negative result is obtained, consider traumatic urethral catheterization to try to obtain a definitive diagnosis.

- Given the plethora of issues, consider consultation with a board-certified oncologist.





The information and recommendations provided are based on the images presented by the referring veterinarian. 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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