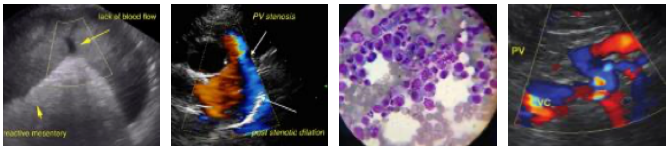
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Odin Naumann

SPECIES
Canine

BREED
Mastiff

SEX
Male, neutered

AGE
4 Yrs.

WEIGHT
162.4 lbs.

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

IMAGING PERFORMED BY
Amy Mayhew LVT

HOSPITAL NAME
SVS Imaging Michigan

REFERRING VET
Mitten AH

INVOICE
13332

DATE
5/9/22

PRESENTING CLINICAL SIGNS

History: Patient originally presented on April 18, 2022 for reluctance to sit down and slow to rise in back end. Owner also noted consistent inappropriate urinations in house and patient seemed to be straining to urinate at times. On April 22, 2022 patient was neutered, radiographs of lumbar spine, hips and stifles were performed along with a CBC / Chem10 / SDMA, HWT 4Dx and urine culture. Patient was started on carprofen 150mg PO BID post-operatively and all of owners concerns markedly improved. Once NSAID was discontinued after 5 days, patient immediately restarted symptoms including apparent straining to urinate. Carprofen was again restarted and immediately symptoms improved.
Abnormal PE/Chem/CBC/UA Results: Exam findings and abnormal lab values: - HWT 4Dx all negative - Mild left shift - r/o inflammation, infection, other - All else WNL on CBC / Chem10 / SDMA - Urine culture revealed no growth - Radiographic Conclusions: 1. Bilateral stifle joint effusion and/or synovial thickening with minimal degenerative changes. Consider ligamentous and/or meniscal injury. Cranial cruciate ligament injury is most common. Immune-mediated polyarthropathy not ruled out. 2. Multifocal sites of spinal degenerative change. 3. Mild prostatomegaly, likely secondary to the intact status of the patient. Prostatitis not ruled out given the history. I was unable to palpate prostate due to patients size even while under anesthesia.

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 the visible portion of the proximal urethra are normal.

The prostate is mildly enlarged (3.63 cm in width) with a relatively normal shape. The parenchyma is subtly heterogeneous in appearance. The prostatic urethra is not overtly dilated.

The left kidney is normal size (8.46 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.

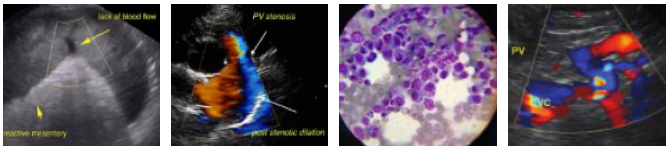
The right kidney is normal size (8.32 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.62 cm at cranial pole) (0.68 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 right adrenal gland is normal size (0.76 cm at cranial pole) (0.56 cm at caudal pole) (3.62 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



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The spleen is normal in size (2.60 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 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 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 thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

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

There is no evidence of free fluid.

Lymph Nodes

See *Other.*

Other

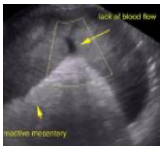
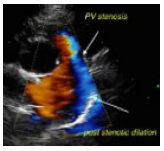
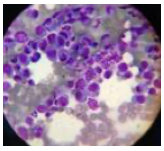
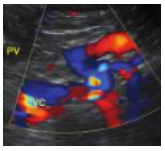
A 4.36 x 2.44 cm irregular cavitated mass/lesion is observed in the right cranial quadrant.

ULTRASONOGRAPHIC FINDINGS

- The prostate changes are consistent with residual benign prostatic hyperplasia.
- The origin of the mass in the right cranial quadrant is unclear. It may be arising from lymph nodes, mesentery, other. It may represent a benign process (i.e., a cystic/reactive lymph node). Other differentials include neoplasia or emerging abscess.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider an orthopedic consultation with a board-certified surgeon to assess for non-metabolic cause for the patient's clinical signs.

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- Despite the negative urine culture, empirical treatment with broad spectrum antibiotics can be considered in case of an occult urinary tract/prostatic infection.
- Regarding the lesion in the right cranial quadrant, consider the following:
  1. Thoracic radiographs to assess for pulmonary metastatic disease.
  2. A repeat abdominal ultrasound in 3-4 weeks to assess for progression.
  3. If an aggressive approach is desired, an abdominal exploratory with removal of the lesion and submission for histopathology can be considered.

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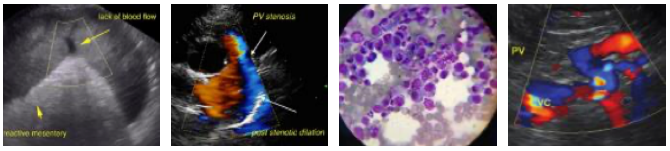

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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*)

Andrea.nicastro@sonopath.com