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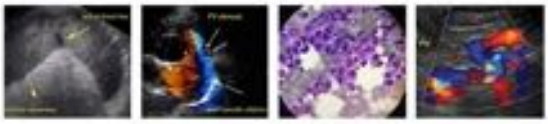

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Oakley Dunleavy

SPECIES

Canine

BREED

Golden Retriever

SEX

Neutered Male

AGE

8 Years

WEIGHT

61.3 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Donner Truckee VH

REFERRING VET

Dr. Greg H

INVOICE

13768

DATE

7/25/22

PRESENTING CLINICAL SIGNS

History: weight loss- Vomiting and Diarrhea after surgery 3 weeks ago- then another episode of Vomiting and Diarrhea 3 days ago- Went to ER and they suspected the NSAIDs and recommended an AUS- Surgery was to remove a mass on the neck- nerve sheath tumor- Checking for neoplasia being a Golden Ret and reason for V/D

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 prominent in size (1.66 cm in width) with normal curvilinear peripheral contours. The parenchyma is homogeneous. No focal lesions are observed. The prostatic urethra is not overtly dilated.

The left kidney is normal size (7.12 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 (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.

Adrenal Glands

The left adrenal gland is normal size (0.68 cm at cranial pole) (0.72 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 normal in length (0.53 cm at the cranial pole)(0.54 cm at the caudal pole)(2.49 cm in length) with a slightly flattened contour. 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 (2.16 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few small hypoechoic nodules are visualized, the largest measuring 0.78 cm in length. 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. A small amount of suspended echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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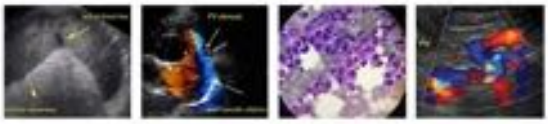

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Gastrointestinal

The gastric lumen is mildly distended with ingesta and appears mildly hypomotile. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract appears patent. The proximal duodenum is slightly corrugated. 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 upper limits of normal thickness (0.30 cm) with retention of the normal layering pattern. 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. A few prominent mid to caudal abdominal lymph nodes are visualized, the largest measuring 3.48 cm in length. The nodes are normal in shape and echogenicity.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

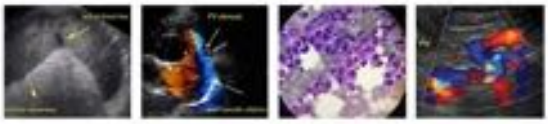
- An obvious cause for the patient's gastrointestinal signs is not identified in this study. Considerations include microscopic GI disease (i.e., dietary indiscretion, food allergy/intolerance, drug reaction, infectious/parasitic disease), underlying metabolic issue (i.e., hypoadrenocorticism), mild pancreatitis, other.
- The prominent prostate may be a normal variant for this patient or may be secondary to emerging neoplasia (i.e., transitional cell carcinoma, prostatic adenocarcinoma). Correlation with the patient's clinical history is recommended.

Secondary Findings:

- The flattened left adrenal gland may be a normal variant for this patient or may be secondary to early atrophy (i.e., due to hypoadrenocorticism).
- The splenic nodules trend toward the benign (i.e., foci of lymphoid hyperplasia or extramedullary hematopoiesis) with a lower possibility of emerging neoplasia.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Baseline labwork including a CBC chemistry panel, urinalysis and T4 is recommended, if not already performed.
- Further GI workup could include the following:
    1. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended



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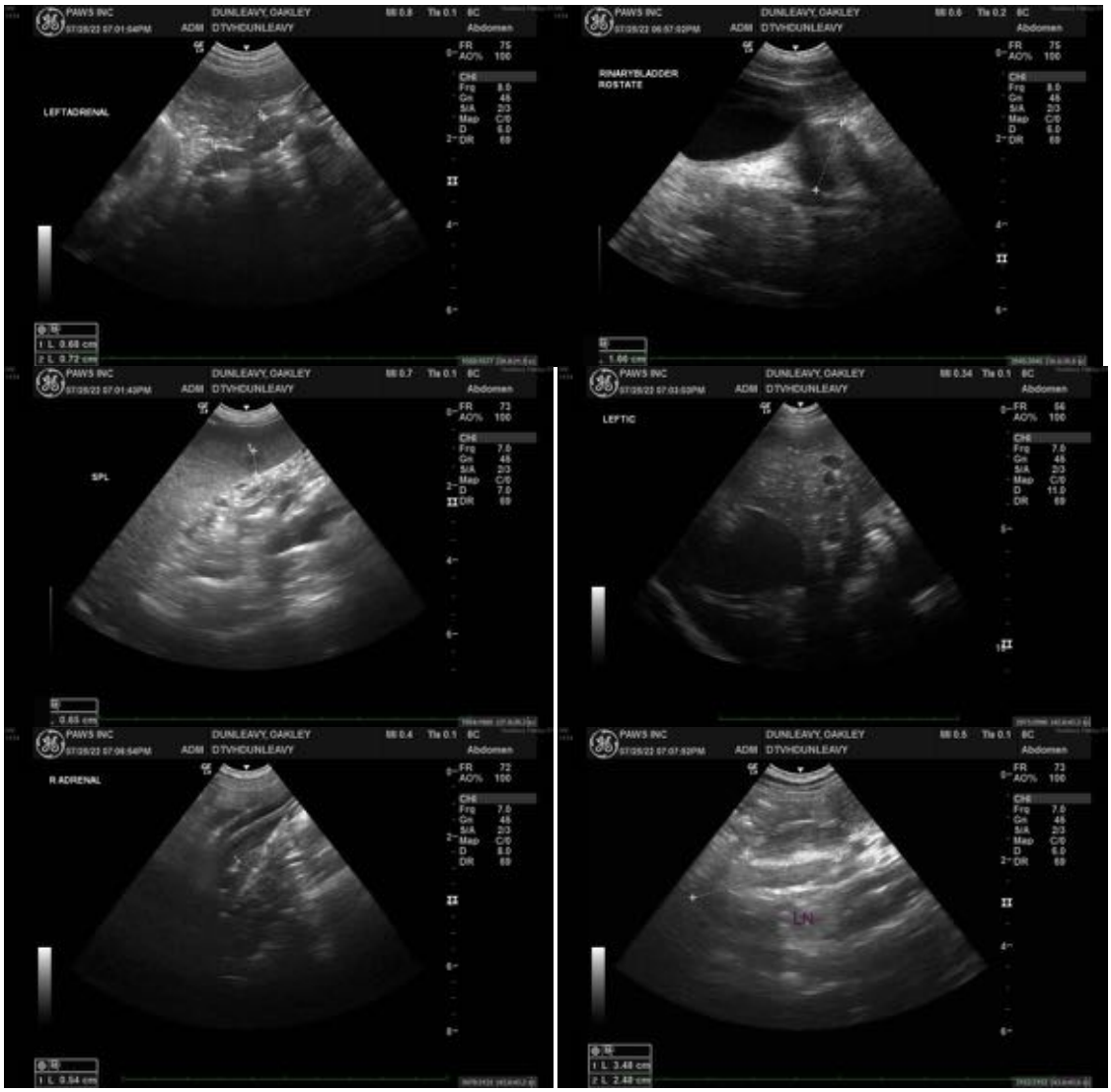
2. GI panel (send to Texas A&M
3. A fecal evaluation for ova/Giardia
4. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
5. Limited antigen diet trial
6. +/- GI biopsies (i.e., endoscopic or surgical). If biopsies are pursued, three-view thoracic radiographs should be performed prior to anesthesia to assess cardiopulmonary status.

- Regarding the prominent prostate, consider a urine BRAF test to further assess for lower urinary tract neoplasia. It should be noted that a negative BRAF test does not completely rule out the possibility of cancer. Therefore, if the clinical suspicion is high and a negative test is obtained, further testing (i.e., traumatic urethral catheterization or surgical biopsy) may be necessary to get a definitive diagnosis.



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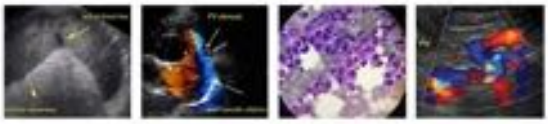

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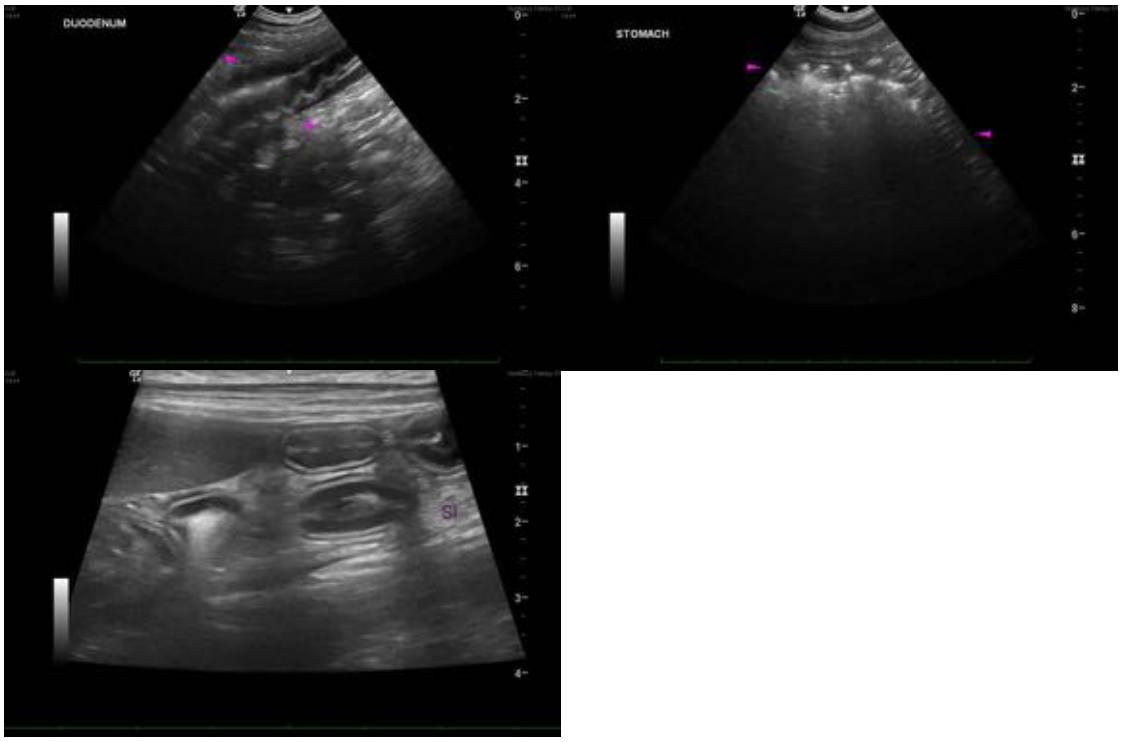

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com