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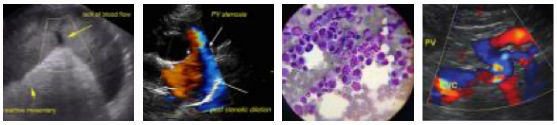


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Benny Washburn

SPECIES

Canine

BREED

Staffordshire ix

SEX

Neutered Male

AGE

10 years

WEIGHT

62.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

Eugene AH

REFERRING VET

Dr. Polk

DATE

7.27.22

INVOICE

11277

PRESENTING CLINICAL SIGNS

History: Persistent weight loss (mild but continual), inappetence. Inflammatory airway disease with potential secondary infection - managed with abx CHF - managed with below medication Current Medications Cerenia, minocycline, prednisone, pimobendan, furosemide.

Abnormal PE/Chem/CBC/UA Results: NSF but attached. ALP 896. ALT 217. Albumen borderline low, 2.7. Borderline nonregenerative anemia. Hematocrit 38%. USG 1.021. No proteinuria. Inactive sediment. Normal T4. 4dx negative. Fecal negative.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. 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 prominent in size (1.67 cm in width) with a normal shape and smooth peripheral contours. Parenchyma is homogenous. No focal lesions are observed. The prostatic urethra is not overtly dilated.

The **left kidney** is normal size (7.14 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. A few cortical cysts are seen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right 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 moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is normal size (0.75 cm at cranial pole) (0.65 cm at caudal pole) (3.68 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.

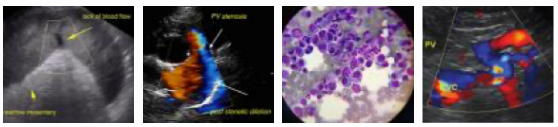
The **right adrenal gland** is normal size (0.71 cm at cranial pole) (0.62 cm at caudal pole) (2.74 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is normal in size (1.77 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



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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** is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No cholelithsare observed. 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. There is no evidence of an obstructive pattern.

Pancreas

The right limb of the **pancreas** is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic 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

The **peritoneal cavity** is normal. There is no evidence of inflammation or effusion. The abdominal **lymph nodes** are normal/not visible.

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- An obvious cause for the patient's weight loss and inappetence is not identified in this study. Considerations include microscopic gastrointestinal disease (i.e., inflammatory bowel disease, food allergy/intolerance, infectious/parasitic disease), underlying metabolic issue, orthopedic/neurologic disease, mild pancreatitis, other.

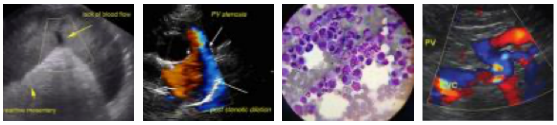
Secondary Findings

- Bilateral chronic age-related renal changes
- Minor age-related pancreatic remodeling. Concurrent mild chronic, pancreatitis cannot be completely excluded, particularly if the patient exhibits pain on cranial abdominal palpation.
- The mild prostatomegaly may be a normal variant for this patient or may represent late-in-life neutering (if applicable) or emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Regarding the patient's clinical signs, consider the following:

1. Thorough orthopedic and neurologic examinations to assess for nonmetabolic causes for inappetence and weight loss



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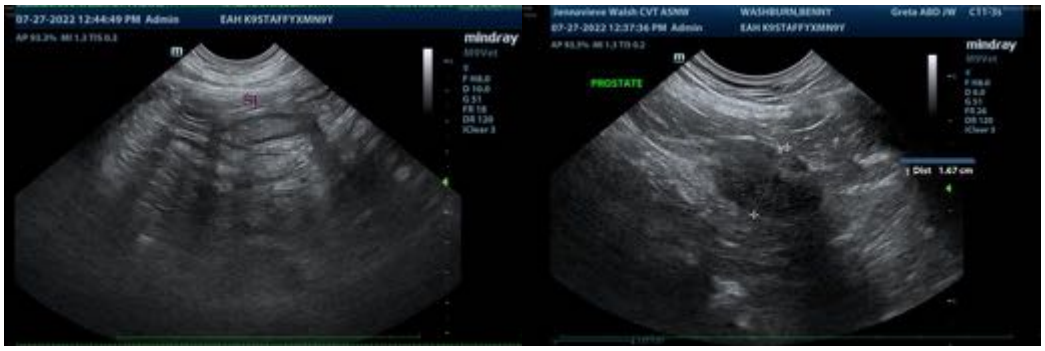
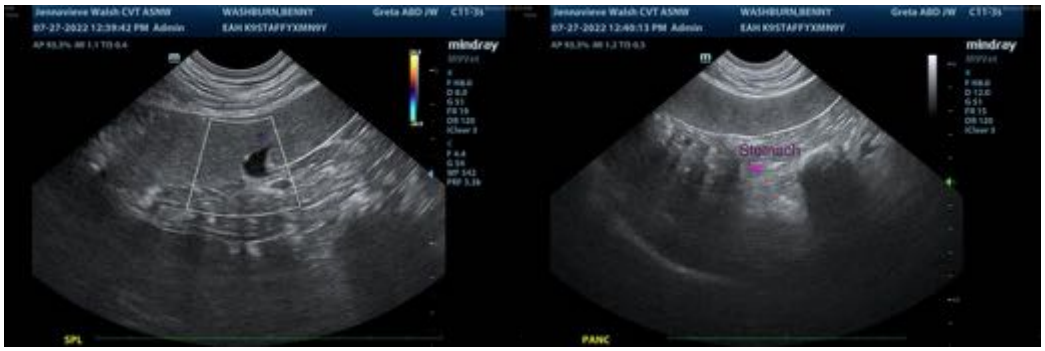
2. Malabsorption panel, including serum cobalamin and folate, TLI and PLI, is recommended.
3. Consider a resting cortisol level to screen for hypoadrenocorticism.
4. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.

Regarding the mild prostatomegaly, consider a urine BRAF test to further evaluate for lower urinary tract neoplasia, particularly if the clinical suspicion for disease is high. It should be noted that a negative BRAF test does not completely rule out the possibility of cancer, and further testing (traumatic urethral catheterization or surgical biopsy) may be warranted.





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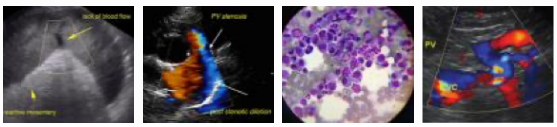

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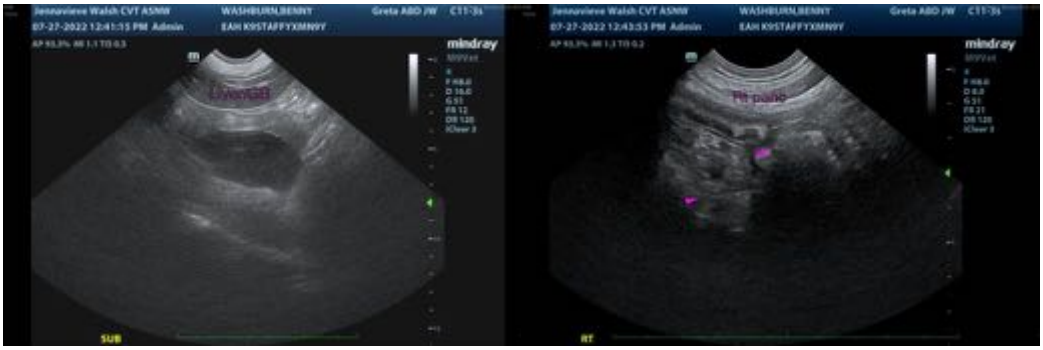

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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