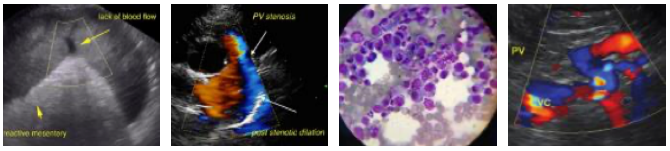
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Alastair Tait

SPECIES
Canine

BREED
Bassett Hound

SEX
Male, neutered

AGE
8 Yrs.

WEIGHT
53 lbs.

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

IMAGING PERFORMED BY
Dr. Lincoski

HOSPITAL NAME
University Drive VH

REFERRING VET
Dr Lincoski

INVOICE
13819

DATE
8/11/22

PRESENTING CLINICAL SIGNS

History: Alistair has been suddenly losing weight, 11.2# since neutered 6/29. Bloodwork and exam at that time was unremarkable. He is a breeding dog who is retired and just got neutered. He had a suspected large sebaceous cyst on tail at time of procedure and was treated with clavamox bid x 14 and rimadyl. Today, t=102.7 Cyst on tail is ruptured and not regressing, despite clavamox. He has lost 11.2# since end of june, when he was here for neuter. John does not note any known gi issue, but he is kennel dog so can't be certain. He is eating canned food very well. EX: Lethargy, though some is his disposition (he is usually a lazy guy). Epaxial muscle wasting. Severe periodontal disease, mm's pink and crt< 2 sec. Chest ausculs wnl, as does abdomen, however very deep chested. No pain on forelimb palpation, some discomfort both stifles but no lameness at all. Prostate not palpable and no obvious anal gland masses noted. The cyst dorsal tailbase if inflamed, cavitated, approximately 6cm diameter. Bloodwork is WNL, though lack of inflammatory leukogram prompts a resting cortisol, which is 6.5. Radiographs of abdomen and thorax obtained and sent to synergyare unremarkable. John is going to do a course of panacur, in case parasitism. though would be odd only dog affected and sudden symptoms. FNA of cyst from unruptured area sent for cytology. 4DX negative. Abnormal PE/Chem/CBC/UA Results: Only muscle wasting and weight loss noted.

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. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is enlarged with relatively smooth peripheral contours. The parenchyma is mildly heterogeneous in appearance. No distinct focal lesions are observed. The prostatic urethra is not overtly dilated .

The left kidney is normal size (6.37 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, infarcts or hydroureter. Renal vasculature is normal.

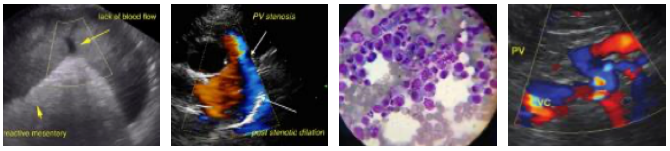
The right kidney is normal size (5.41 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.57 cm at cranial pole) (0.56 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 (0.58 cm at cranial pole) (0.58 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.

Spleen



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The spleen is normal in size (1.77 cm in width at the level of the hilus) with normal linear peripheral contours. The parenchyma is homogeneous. No distinct focal lesions are observed. Splenic vasculature appears normal with no obvious 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 gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly distended with ingesta. 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

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

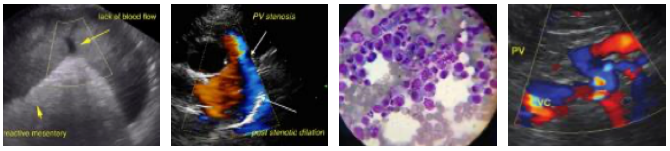
ULTRASONOGRAPHIC FINDINGS

- The prostatomegaly may be secondary to resolving benign prostatic hyperplasia although infiltrative neoplasia (i.e., prostatic adenocarcinoma, transitional cell carcinoma) cannot be completely excluded.

*Regarding the severe weight loss, an obvious cause is not identified in this study. Considerations include inadequate caloric intake, maldigestion/malabsorption, occult neoplasia (i.e., brain tumor), other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider a urine BRAF test to assess for prostatic neoplasia if there is strong clinical suspicion for this issue. A negative result does not rule out the possibility of cancer and additional testing may be warranted if neoplasia is suspected. Alternatively, consider a repeat abdominal ultrasound in 4-6 weeks to reassess prostate size/appearance.
- Regarding the weight loss, consider the following:
  1. GI panel including serum cobalamin, folate, TLI and PLI to assess for maldigestion/malabsorption and occult pancreatic disease.



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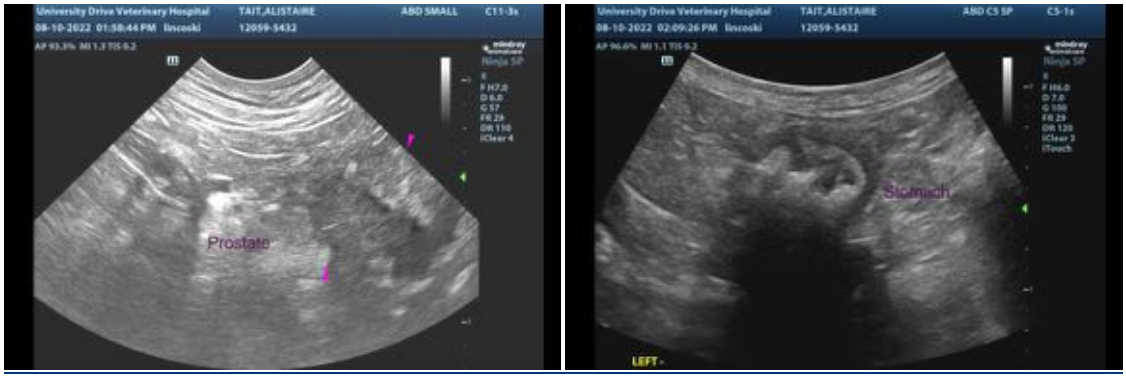
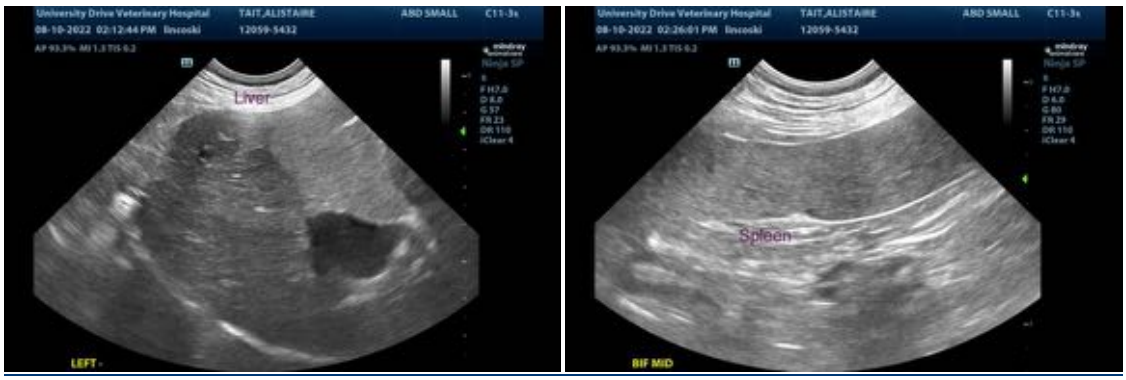
2. Thorough neurologic examination to assess for subtle deficits, as brain tumors can sometimes present with weight loss as the sole clinical sign.
3. Measurement of the patient's daily caloric intake is also recommended to assess for any inadequacies, particularly given that the patient lives in a kennel.

- If all diagnostics are inconclusive, a brain MRI can be considered to assess for the presence of neoplasia.





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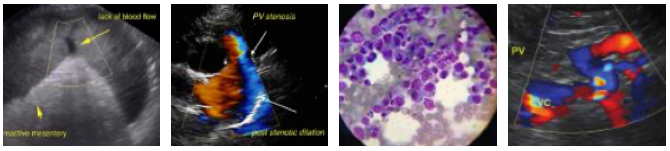

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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