



**PATIENT**

Remo Yordan

**SPECIES**

Canine

**BREED**

Dachshund longhair  
mix

**SEX**

Male, neutered

**AGE**

12 Yrs.

**WEIGHT**

17.4 lbs.

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Dr. G. Ferrer

**HOSPITAL NAME**

Paseos VC

**REFERRING VET**

Dr. Cajigas

**INVOICE**

13810

**DATE**

8/10/22

**PRESENTING CLINICAL SIGNS**

History: Presented as a referral for an abdominal ultrasound to evaluate hematuria. Chronic history of hematuria. Radiographs revealed uroliths and enlarged prostate with mineralization. Rectal exam revealed enlarged and irregular prostate. Want to evaluate possible neoplasia versus hyperplasia of the prostate.

Abnormal PE/Chem/CBC/UA Results: PE: Rectal: Enlarged prostate and irregular prostate.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

*Urinary System*

The urinary bladder is mildly distended. The ventral wall is thickened (up to 0.46 cm) and irregular. The remaining bladder wall is normal in thickness with a slightly irregular mucosal surface. A small to moderate amount of echogenic debris is observed within the lumen. Several cystic calculi are observed. The region of the trigone appears normal. The visible portion of the proximal urethra appears mildly thickened (up to 0.28 cm).

The prostate is enlarged (2.29 cm in width) with a slightly irregular shape. The parenchyma is heterogeneous with ill-defined foci of mineralization and an ill-defined cavitated area. The prostatic urethra is not overtly dilated. The mesentery effacing the serosal surface of the prostate is hyperechoic. There is questionable infiltration into the proximal urethra. Adjacent peritonitis is present.

The left kidney is normal size (4.52 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 hydronephrosis.

The right kidney is normal size (4.86 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 hydronephrosis.

*Adrenal Glands*

The left adrenal gland is enlarged (1.44 cm at cranial pole) (1.19 cm at caudal pole) (2.66 cm in length) with an irregular shape. A 1.43 x 1.24 cm hyperechoic to mildly heterogeneous nodule is observed at the cranial pole. At the caudal aspect, a 1.31 x 0.96 cm hyperechoic to mildly heterogeneous nodule is observed. There is loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is enlarged (1.09 cm at cranial pole) (0.56 cm at caudal pole) (2.14 cm in length) with a slightly irregular shape. At the cranial pole, a 1.13 x 0.88 cm hyperechoic to mildly heterogeneous nodule is observed. Glandular echogenicity and detail at the caudal aspect are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

*Spleen*

The spleen is normal in size (1.41 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

*Liver*



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The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature 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. A small to moderate amount of aggregated echogenic partially dependent to suspended debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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**Gastrointestinal**

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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 ileocecolic junction and colonic wall are normal. No obstructive disease is noted.

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**Pancreas**

**AGE**

12 Yrs.

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**

**WEIGHT**

17.4 lbs.

There is no evidence of free fluid. The medial iliac lymph nodes are severely enlarged (left 3.86 x 2.16 and right 3.76 x 1.82 cm) with irregular shape and slightly heterogeneous parenchyma. Surrounding mesentery is hyperechoic.

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**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings:**

- The prostate changes are concerning for infiltrative neoplasia (i.e., adenocarcinoma, transitional cell carcinoma) with a lower possibility of prostatic hyperplasia. Hyperplasia would be more likely in a patient that underwent late-in-life neutering.
- Cystic calculi are present. The ventral urinary bladder wall changes could be consistent with cystitis or infiltrative neoplasia.
- The severe medial iliac lymphadenopathy is concerning for metastatic disease with a lower possibility of lymphadenitis.

**Secondary Findings:**

- Bilateral, age-related degenerative renal changes.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely. Correlation with the patient's liver values is recommended.
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

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- Age-related pancreatic remodeling.
- Bilateral adrenal nodules. These may represent nodular hyperplasia or emerging tumors.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- Consider a urine BRAF test to further assess for lower urinary tract neoplasia. It should be noted that a negative BRAF test does not rule out the possibility of cancer. Therefore, if a negative test is obtained, additional testing (i.e., traumatic urethral catheterization or surgical prostatic biopsy) may be necessary to get a definitive diagnosis. If cancer is confirmed, consultation with a board-certified oncologist is recommended for treatment recommendations.

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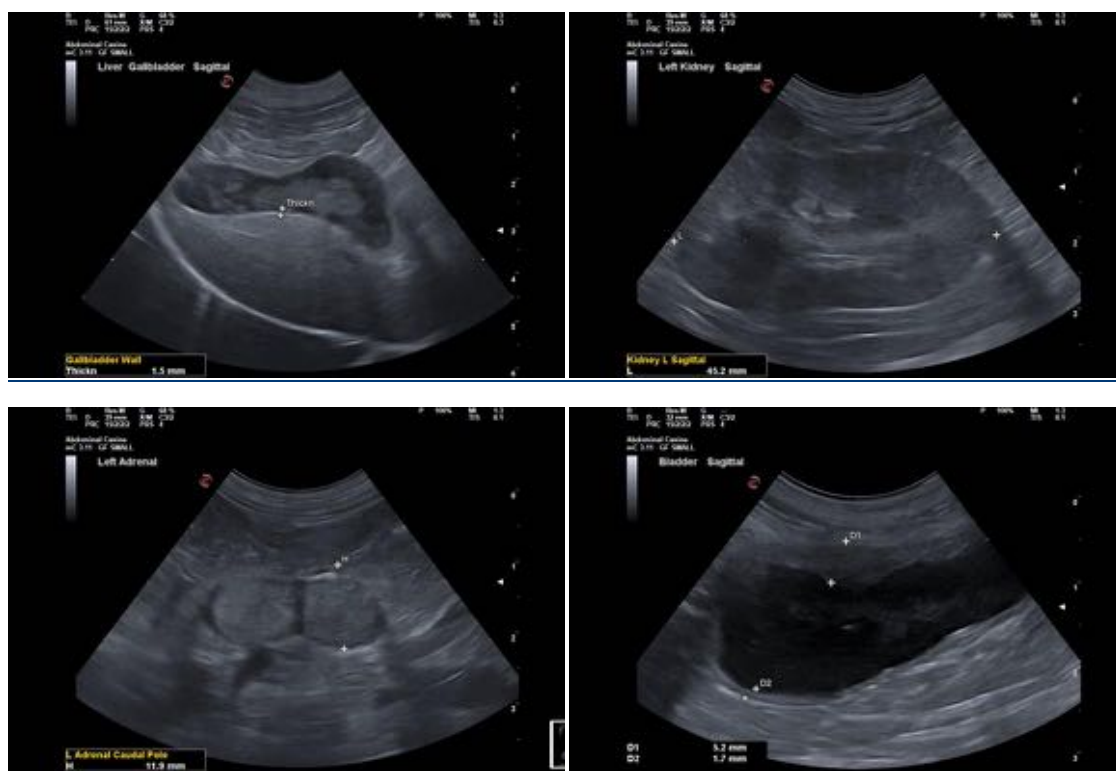
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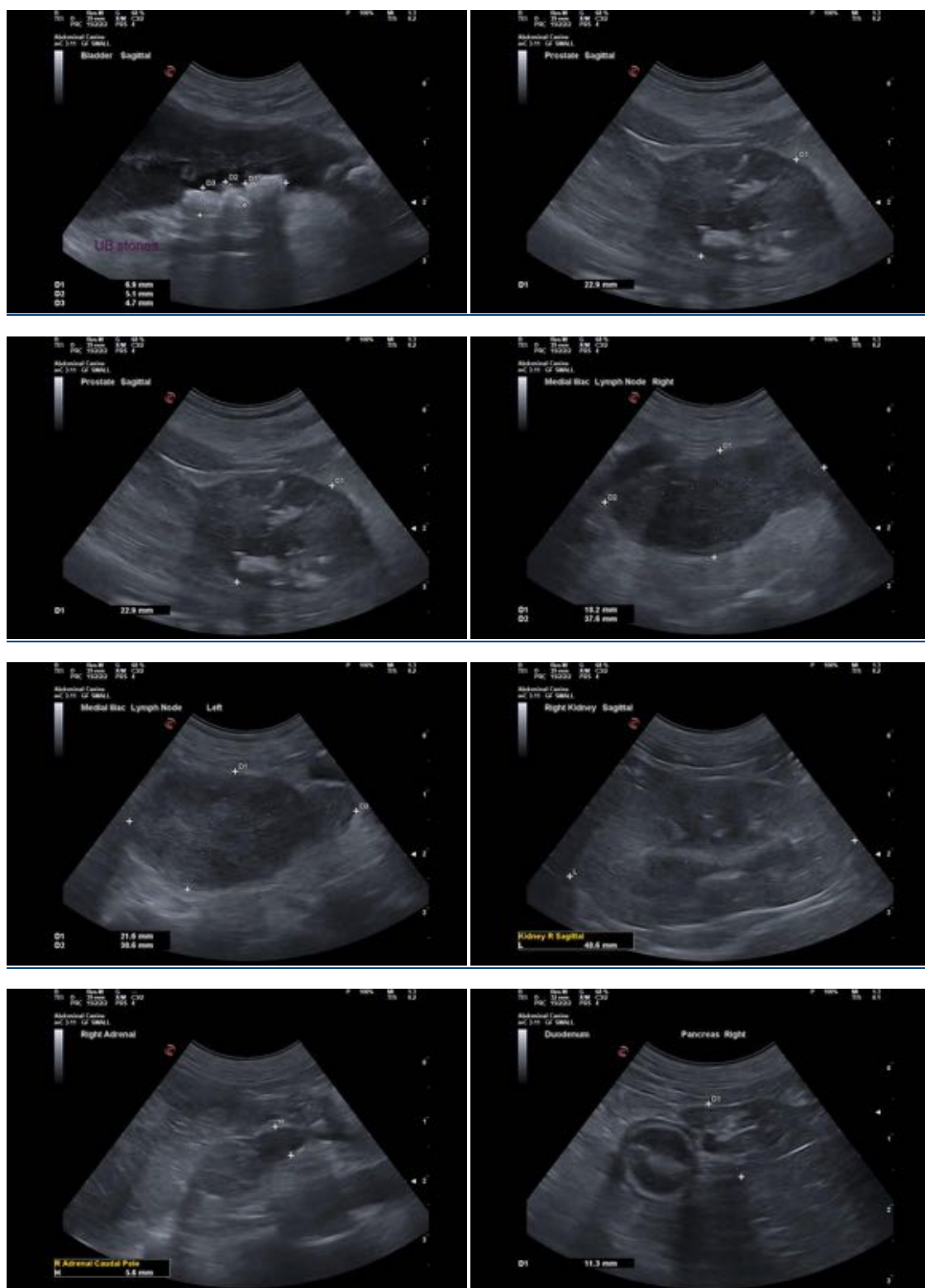
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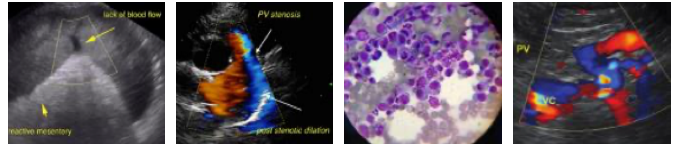
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.



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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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info@SonoPath.com

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