

PATIENT

Dexter Fulcher

SPECIES

Canine

BREED

Mix

SEX

Neutered Male

AGE

7/24/2010

WEIGHT

22 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Trinity Island VC

REFERRING VET

Kristi Oldham, DVM

INVOICE

11484

DATE

8.25.22

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Appears to have abdominal pain, spine is quiet. Down dog posturing, yelping when defecating (is defecating but thinner and longer than normal in shape), cannot get comfortable and history of excessive gas in the abdomen.

Hx of UTI - today's u/a: inflammatory cells, red blood cells and cocci

Hx of enlarged prostate - recent radiographs and reviewed by Dr. Simone (radiographs from emergency in Beaufort, SC)

Hx of bloody diarrhea with pancreatitis

Abnormal lab-work values: Will try to attach records :)

Current Medications: Metacam and CBD

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** is mildly distended with anechoic contents. The wall is of appropriate thickness for the level or repletion. The mucosal surface is slightly irregular. The region of the trigone is normal. The proximal urethra is slightly thickened (up to 0.26 cm) and mildly irregular.

The prostate is enlarged (3.18 x 2.48 cm) with an irregular shape. Parenchyma is heterogenous with a few, small, ill-defined cavitated lesions and pinpoint focus of mineralization. The prostatic urethra is not overtly dilated. Surrounding mesentery is hyperechoic.

The **left kidney** is normal size (5.11 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

The **right kidney** is normal size (5.43 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is normal size (0.66 cm at cranial pole) (0.60 cm at caudal pole) (2.15 cm in length); with a normal shape. A 0.26 x 0.42 cm hyperechoic nodule is observed at the caudal pole. The remaining glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

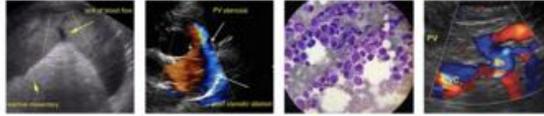
The **right adrenal gland** is normal size (1.40 cm at cranial pole) (0.46 cm at caudal pole) (2.20 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is normal in size (1.04 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.



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The **gall bladder** 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/not seen.

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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.

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Pancreas

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

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Free Abdomen

There is no evidence of free fluid. A 0.82 cm left medial iliac **lymph node** is visualized. Surrounding mesentery is mildly hyperechoic.

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Other

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

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Andrea Nicastro,
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Medicine)

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Prostatic mass effect. Neoplasia (i.e., prostatic adenocarcinoma, transitional cell carcinoma) is considered likely with a lower possibility of an inflammatory process. Regional peritonitis is present. There is questionable extension of the mass effect into the proximal urethra.

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Secondary Findings

- Bilateral degenerative renal changes.
- The left adrenal nodule trends toward the benign (i.e., nodular hyperplasia) with a lower possibility of an emerging tumor.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

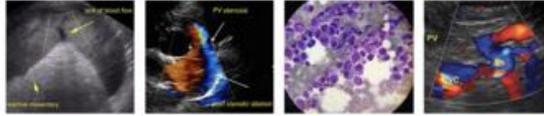
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To further confirm prostatic neoplasia, consider a urine BRAF test. It should be noted that a negative BRAF test does not completely rule out the possibility of cancer. Therefore, if a negative result is obtained, further diagnostics (i.e., traumatic urethra catheterization or biopsy) may be necessary to get a definitive diagnosis. If further testing is not pursued, consider transitioning from Meloxicam to Piroxicam after a 3-5-day washout period, along with a gastric protectant (i.e., misoprostol) as empirical treatment for transitional cell carcinoma (This treatment is unlikely to be effective in reducing clinical



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signs if prostatic adenocarcinoma is present). Also consider initiation of other pain medication (i.e., gabapentin) particularly during the washout period.

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Three-view thoracic radiographs can also be considered to assess for pulmonary metastatic disease.

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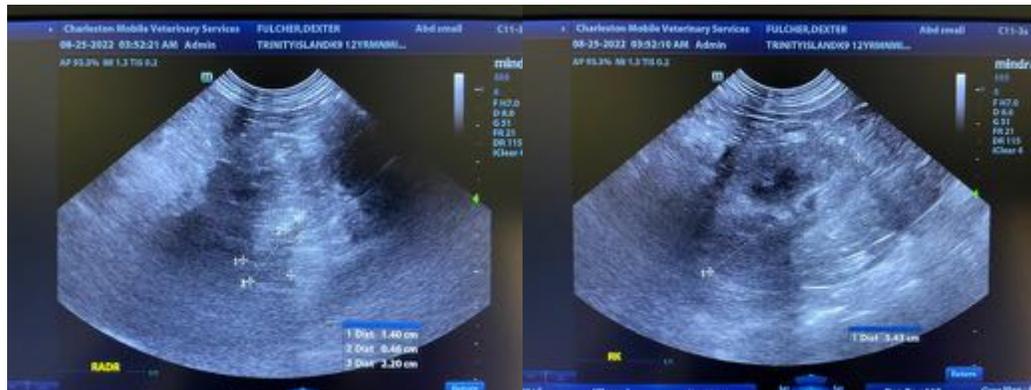
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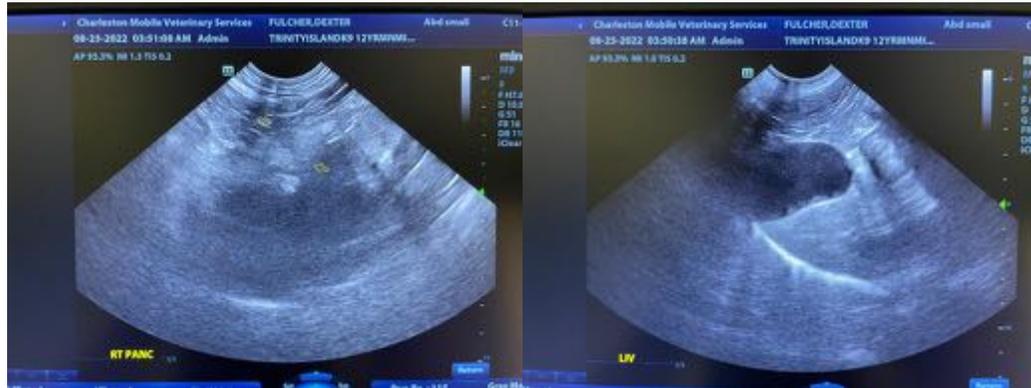
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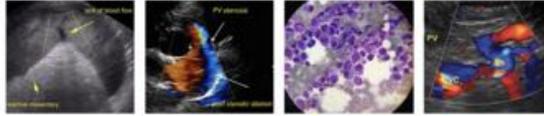
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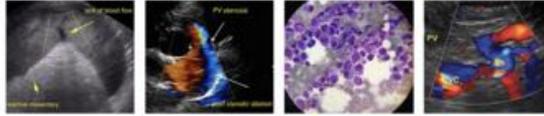
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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