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Clinical Sonography & Telecytology
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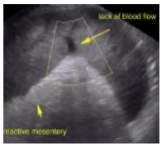
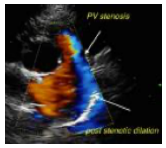
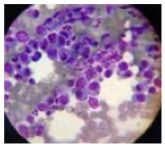
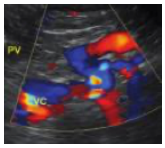

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PATIENT

Sanson Torrellas

SPECIES

Canine

BREED

German Shepherd

SEX

Neutered Male

AGE

8 years

WEIGHT

86.5 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. G. Ferrer, DVM

HOSPITAL NAME

Paseos VC

REFERRING VET

Dr. F. Ortiz Vidal, DVM

INVOICE

11547

DATE

8.31.22

PRESENTING CLINICAL SIGNS

History: Presented for an abdominal ultrasound. Patient originally presented in respiratory distress on 8-26-22 as owner saw patient panting and ADR in the morning. Pt had slightly elevated temperature. The radiologist recommended an abdominal ultrasound based on the radiographs.
Abnormal PE/Chem/CBC/UA Results: cbc - wnl chem - wnl radiographs - Report below:

RADIOGRAPHIC DIAGNOSIS Bronchial calcification, mild. Possible sternal lymphadenomegaly • Sternal new bone (incidental finding)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS
Bronchial calcification is an age-related change and does not normally cause the described clinical signs. The cranial thorax is superimposed by the muscle mass of one foreleg, thus the increased opacity in the region of the sternal lymph node may represent an artefact. Ultrasound of this region will help clarify the matter. I can see no changes that would explain the clinical signs, but bronchitis can be present without radiographic evidence and thus bronchoscopy with broncho-alveolar lavage is necessary to rule out infection and inflammation. The larynx should be checked for paralysis and the tonsils for inflammation and mass lesions. Considering age and breed, splenic hemangiosarcoma should be ruled out, thus abdominal ultrasound is recommended.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** is mildly distended with mostly anechoic urine. The wall in the region of the apex is slightly thickened (up to 0.58 cm) with a slightly irregular mucosal surface. The wall tapers to a normal thickness as it extends towards the cut. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2cm, are normal.

The **prostate** is normal to slightly prominent in size (1.78 cm in width) with a normal shape and homogenous parenchyma. No focal lesions are observed. The prostatic urethra is not overtly dilated.

The **left kidney** is normal size (8.04 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.

The **right kidney** is normal size (7.52 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. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is normal size (0.73 cm at cranial pole) (0.80 cm at caudal pole) (3.03 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 (0.60 cm at cranial pole) (0.74 cm at caudal pole) (3.34 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 (1.57 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.

The **gall bladder** lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. 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 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. At the aortic trifurcation, a 3.09 x 2.37 cm, rounded, hypoechoic to heterogenous **lymph node** is observed on the left side. In addition, a 5.15 x 2.53 cm rounded, heterogenous lymph node is observed on the right side. The mesentery surrounding the nodes is mildly hyperechoic. In addition, a 1.31 cm mesenteric lymph node is seen.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Caudal abdominal lymphadenopathy. Neoplasia (i.e., round cell tumor) is suspected. However, severe lymphadenitis (i.e., pyogranulomatous) cannot be completely excluded.

Secondary Findings

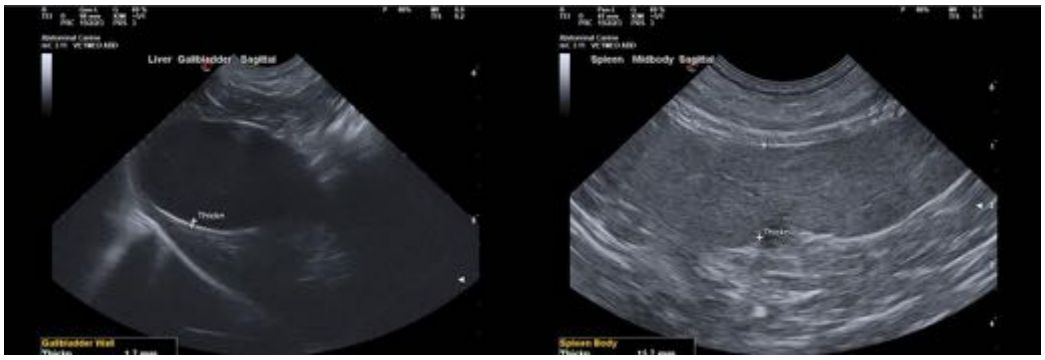
- The mild urinary bladder wall thickening at the apex may be artifactual due to lack of luminal distention. Alternatively, mild cystitis may be present. Correlation with the patient's clinical history and urinalysis findings is recommended.

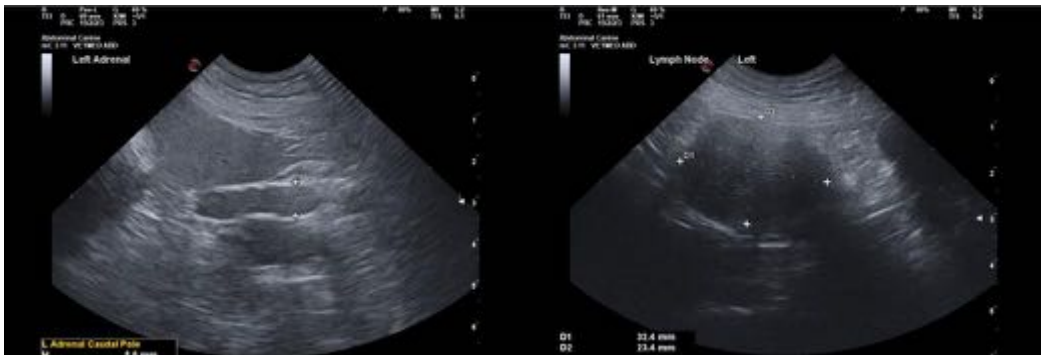
- The slightly prominent prostate may be a normal variant for this large breed dog. However, emerging neoplasia cannot be completely excluded.

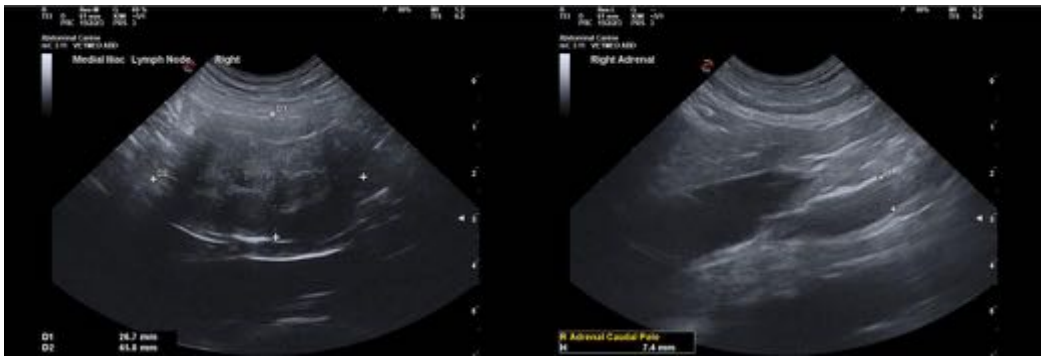
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

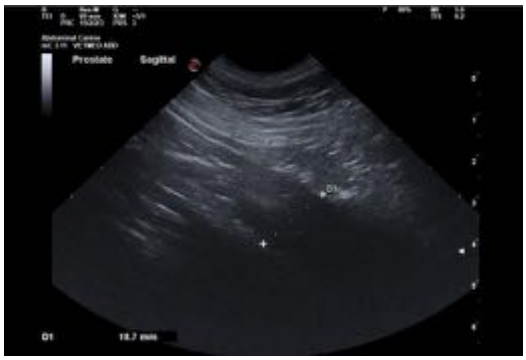
If lymph node cytology results are inconclusive, surgical biopsies may be necessary to get a definitive diagnosis.

If there is strong suspicion of prostatic neoplasia, consider a urine BRAF test for further evaluation. It should be noted that a negative BRAF result does not completely rule out the possibility of cancer.









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