**DATE PRESENTING CLINICAL SIGNS**

9.8.2022

9/6/2022 Trouble defecating. For last 4-6 weeks straining to defecate, o now seeing mucous with blood; overall eating and drinking normally but now eating less. vomited once on 9/6. o thinks weight loss and slightly "off". Rectal- thickening, rough, irregular surfaces. Dorsal aspect of colorectal area about 3"- friable and bleeds. Cannot feel prostate.

PATIENT

RocknRoll Moran

Current Medications: None listed.

Lab Results: CBC vetscreen pending

SPECIES

Radiographs: 3 view chest rads- no mets, heart WNL. abdominal- slight gas filled intestines in one view, cranial quadrant. not overly distended.

Canine

BREED

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Pitbull

Imaging Performed By: Rachel Brillhart, RDMS.

SEX**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

Neutered Male

Urinary System

The **urinary bladder** is mildly distended with anechoic urine. The wall in the region of the apex is thickened (up to 0.50 cm) with an irregular mucosal surface. The wall tapers to a normal thickness as it extends toward the cystourethral junction. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

AGE

6/1/2012

WEIGHT

75lbs

The **prostate** is mildly enlarged (3.39 cm in length) (1.83 cm in width) with a relatively normal shape. The parenchyma is hypoechoic relative to surrounding omental fat and subtly mottled in appearance. No distinct focal lesions are observed. The prostatic urethra is not overtly dilated.

INTERPRETED BY

The **left kidney** is normal size (6.47 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.

Andrea Nicastro, DMV,
Diplomate DACVIM
(Small Animal
Internal Medicine)

The **right kidney** is normal size (7.57 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.

HOSPITAL NAME

Jacksonville VH

Adrenal Glands

The **left adrenal gland** is normal size (0.73 cm at cranial pole) (0.69 cm at caudal pole) (2.98 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.

REFERRING VET

Dr Larsson

The **right adrenal gland** is normal size (0.88 cm at cranial pole) (0.68 cm at caudal pole) (3.74 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.

INVOICE

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Spleen

The **spleen** is subjectively normal in size (1.89 cm in width at the level of the hilus) with normal curvilinear peripheral contours. The parenchyma is diffusely mottled with at least two ill-defined hypoechoic nodules. Splenic vasculature is normal with no 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 **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 **gastric lumen** is not distended. The gastric wall is 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. The rectal tissue is evaluated and is thickened (up to 0.95 cm) and irregular with apparent retention of the normal layering 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 obvious evidence of free fluid. A 2.44 x 0.61 cm sublumbar **lymph node** is visualized. The node is normal in size and echogenicity.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The prostate changes could be consistent with emerging neoplasia (i.e., prostatic adenocarcinoma, transitional cell carcinoma). Alternatively, hyperplastic change may be present, particularly if the patient was neutered later in life. Correlation with the patient's clinical history is recommended.
- The rectal thickening is most consistent with proctitis with a lower possibility of emerging neoplasia.
- The splenic changes could be consistent with a benign process (i.e., splenitis, lymphoid hyperplasia, antigenic stimulation, extramedullary hematopoiesis) or infiltrative neoplasia.
- The urinary bladder wall thickening could be consistent with cystitis or may be artifactual due to lack of full repletion. Correlation with the patient's urinalysis findings and clinical history is recommended.

Secondary Findings

- The sublumbar lymphadenopathy is most consistent with reactive change. However, infiltrative neoplasia cannot be completely excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

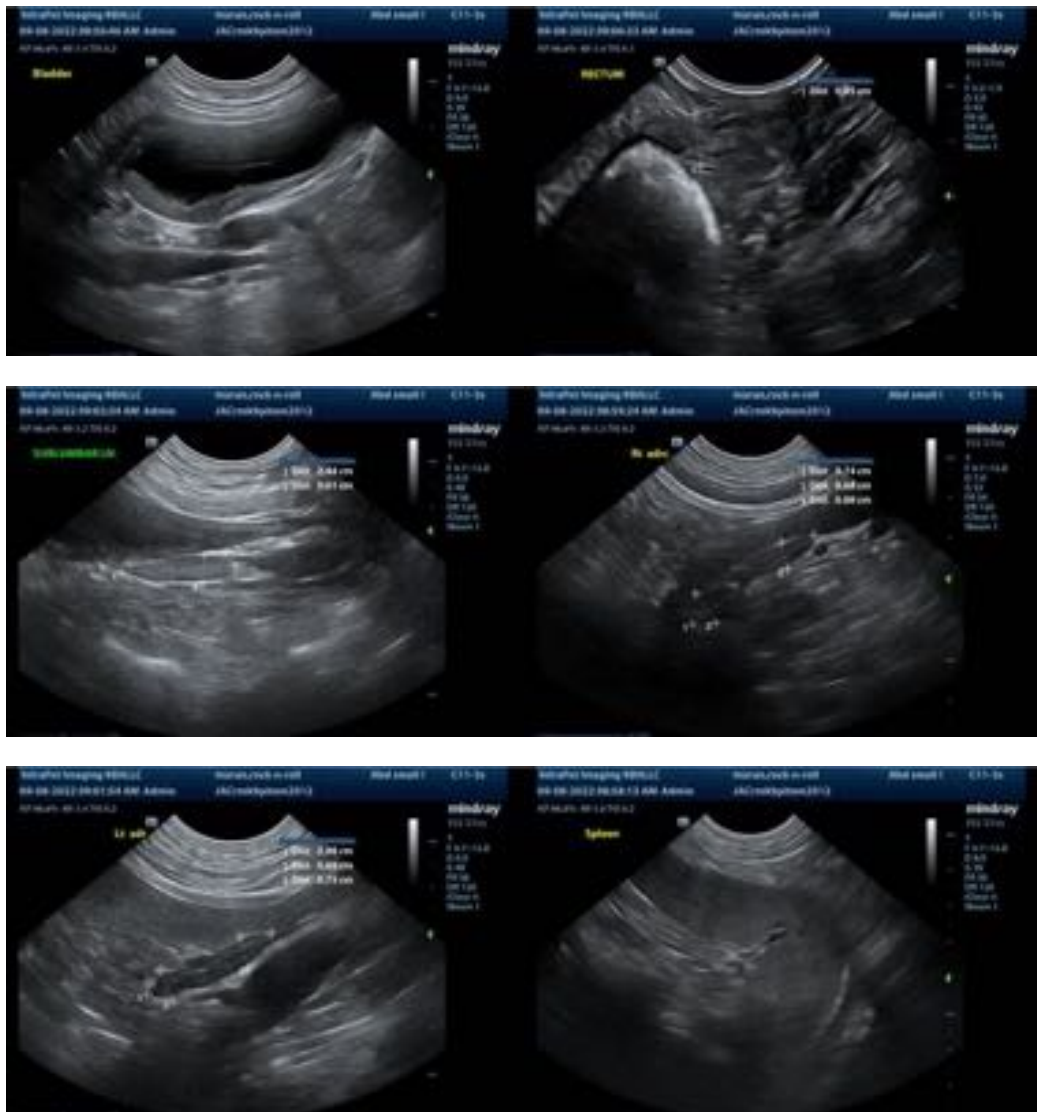
Given the prostate changes, consider a urine BRAF test to further assess for lower urinary tract neoplasia. It should be noted however that a negative BRAF test does not completely rule out the possibility of cancer

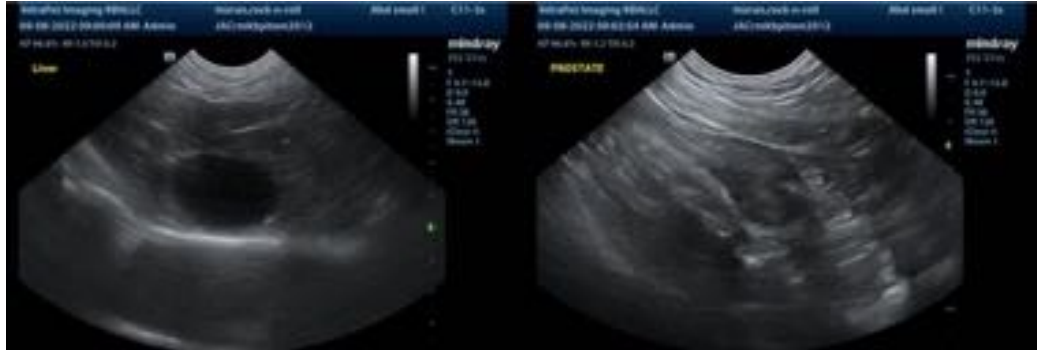
and further testing (i.e., biopsies) may be necessary to get a definitive diagnosis. If prostatic neoplasia is not present, consider a colonoscopy with biopsies.

Other diagnostic considerations include the following:

1. Fecal evaluation for ova and Giardia
2. Fecal PCR infectious disease panel

Regarding the splenic parenchymal changes, a fine-needle aspirate can be considered if clotting status is appropriate.





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