



PATIENT PRESENTING CLINICAL SIGNS

Stryder Cockerham
Pt presented for limping and intermittent vomiting and eating grass. Pt has a history of an elevated ALT which has increased from 249 in Feb 2021 to 400 on bloodwork on 4/8/22. Abdominal rads had decreased serosal detail in mid abdomen and rounded liver margins. Left CCL tear diagnosed.

SPECIES

Canine

ALT 400
Remainder of cbc/chem wnl

BREED

Bluetick Coonehound

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

SEX

Urinary System

Male neutered

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. A moderate amount of echogenic debris is observed within the lumen, some of which is gravity-dependent and some of which is suspended. No cystic calculi are observed. The region of the trigone is normal. The proximal urethral wall is normal in thickness. The post-prostatic urethral wall appears mildly thickened and irregular.

AGE

3/5/2011

What is thought to be prostate is enlarged (4.93 x 2.90 cm) with an irregular shape and a mass effect, predominantly on the left side. The parenchyma is heterogeneous with foci of mineralization. The prostatic urethra is not overtly dilated.

WEIGHT

53.5 lbs.

The left kidney is normal size (6.51 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

INTERPRETED BY

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

The right kidney is normal size (7.29 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

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Adrenal Glands

The left adrenal gland is normal size (0.64 cm at cranial pole) (0.69 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.

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The right adrenal gland is normal size (1.18 cm at cranial pole) (0.57 cm at caudal pole) (2.01 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. Andrea Winney

Spleen

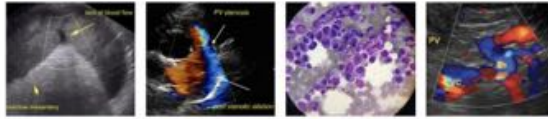
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The spleen is normal in size (2.46 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. 1-2 small hyperechoic nodules are

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visualized. In addition, a 0.72 cm ill-defined hypoechoic nodule is observed near the lateral aspect. Splenic vasculature is normal.

Liver

The liver is normal to slightly prominent in size with normal curvilinear peripheral contours. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein: caudal vena cava ratio is approximately 1:1. The gall bladder lumen is moderately distended. The wall is thin and smooth. A scant amount of echogenic debris is adhered to the luminal surface. 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. 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

There is no evidence of free fluid. Two caudal abdominal lymph nodes are prominent and cystic.

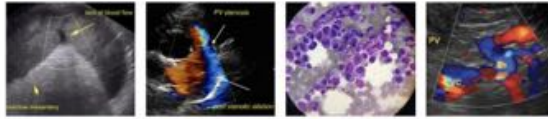
Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Suspected prostatic mass effect with thickening of the post-prostatic urethra. Neoplasia (i.e., prostatic adenocarcinoma, transitional cell carcinoma) are the top differentials. However, abscessation cannot be completely excluded. The post-prostatic urethral changes could be consistent with inflammation or infiltrative neoplasia.
- The caudal abdominal lymphadenopathy could be consistent with reactive change or infiltrative neoplasia.
- Non-specific diffuse hepatopathy. Top differentials include inflammatory hepatopathy (i.e., bacterial cholangiohepatitis, chronic active hepatitis), copper hepatotoxicosis, Leptospirosis, infiltrative neoplasia (less likely), other hepatopathy.
- Minimal gallbladder debris- incidental.



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- The urinary bladder debris could be consistent with cells, crystals and/or exfoliated material.

Secondary Findings:

- Minor bilateral age-related renal changes.
- The hypoechoic splenic nodule could be consistent with a benign process (i.e., focus of lymphoid hyperplasia or extramedullary hematopoiesis). Alternatively, there is a possibility for emerging neoplasia, although this is considered less likely.

*It is unclear if the patient's vomiting is secondary to liver disease, microscopic gastrointestinal disease or other underlying disorder.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the prostate changes, consider the following:
 1. Thoracic radiographs (three-view) to assess for pulmonary metastatic disease.
 2. Urine BRAF test. If results are negative, this does not rule out prostatic neoplasia and further testing (i.e., traumatic urethral catheterization or biopsy) may be necessary to get a definitive diagnosis.
 3. Also consider a urine culture and sensitivity. Urine should be obtained either via free catch or catheterization.
- Regarding the liver changes and elevated ALT, consider the following:
 1. Pre- and post-prandial serum bile acids.
 2. Leptospirosis testing (i.e., blood and urine PCR).
 3. Hepatic tissue sampling (i.e., fine needle aspirate or biopsy). Surgical biopsies would be ideal in that they are more likely to be representative of global organ pathology. If biopsies are pursued, aerobic and anaerobic bile cultures and acquisition of additional hepatic tissue samples for potential copper quantitation are recommended.
- Regarding the vomiting, consider a malabsorption panel including serum cobalamin, folate, TLI and PLI +/- gastrointestinal biopsies.



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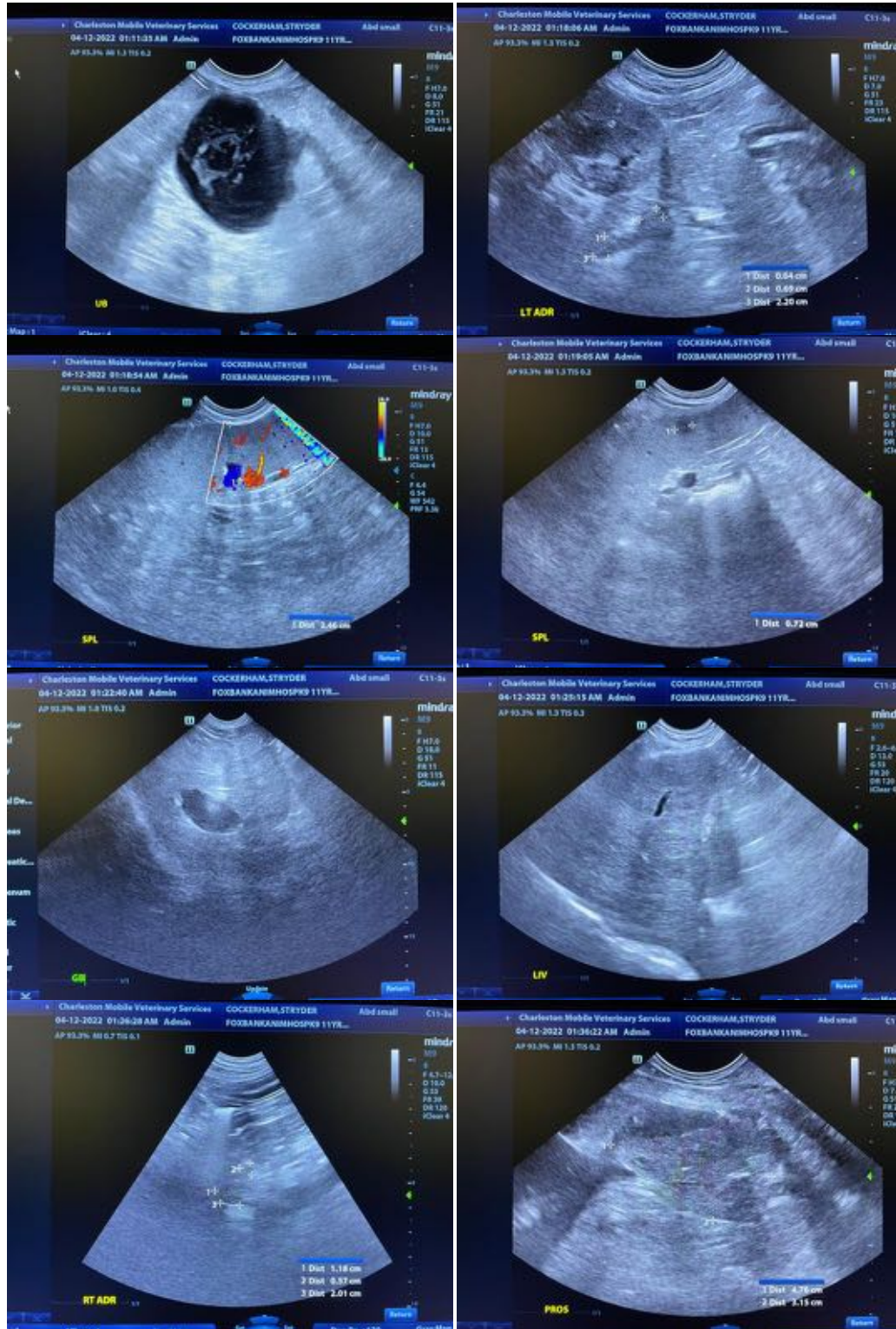
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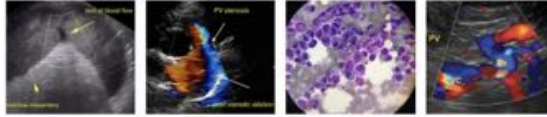
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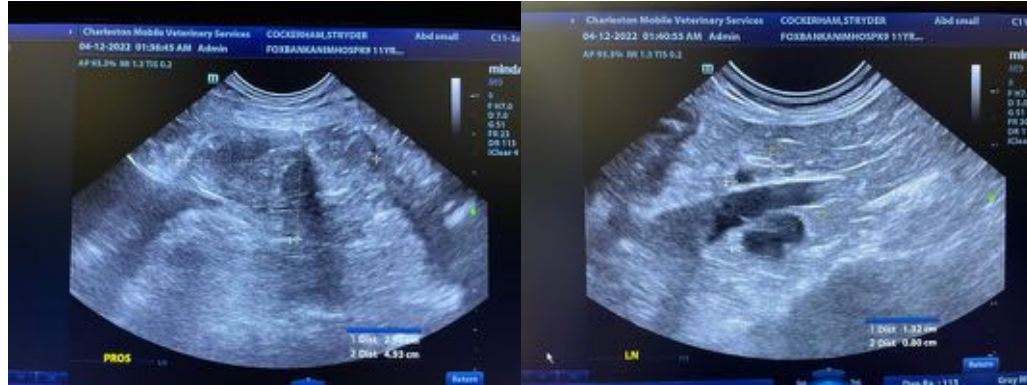
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

Andrea.Nicastro@CharlestonMobile.net