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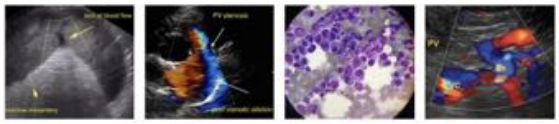


Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

PATIENT

Prince Szostak

SPECIES

Canine

BREED

Golden Retriever

SEX

Male, intact

AGE

6/12/12

WEIGHT

58 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Flowerton AH

REFERRING VET

Dr. Kline

INVOICE

13792

DATE

8/2/22

PRESENTING CLINICAL SIGNS

- History of IBD
- Acute onset vomiting with nasal discharge
- Tense abdomen
- Moderate tachycardia with moderate tachypnea

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is enlarged (3.72 cm in width) with a slightly irregular shape. The parenchyma is hyperechoic relative to surrounding omental fat and slightly mottled in appearance. Distinct focal lesions are observed. The prostatic urethra is not overtly dilated.

The left kidney is normal size (6.39 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. Mild pyelectasia is present (0.35 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (6.88 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 hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.67 cm at cranial pole) (0.74 cm at caudal pole); 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.

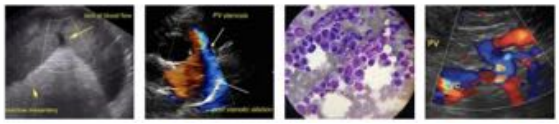
The right adrenal gland is normal size (1.25 cm at cranial pole) (0.69 cm at caudal pole) (2.89 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is subjectively enlarged with rounded, swollen peripheral contours. The parenchyma is homogeneous. No distinct focal lesions are observed. 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 portal vein: caudal vena cava ratio is approximately 1:1.



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The gall bladder lumen is moderately distended. The wall is slightly thickened (up to 0.30 cm) and hyperechoic. A small amount of suspended echogenic debris is observed within the lumen. 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 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 segmentally dilated with chyme. 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

Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

Other

An approximately 4 x 3.5 cm irregular, fluid-filled structure with a thick (up to 0.85 cm) irregular wall is observed in the right mid to caudal abdomen. The fluid contains suspended echogenic debris. The mesentery surrounding the lesion is hyperechoic.

The testicles are subjectively normal in size (left testicle 3.50 x 1.78 cm; right testicle 3.58 x 2.84) with relatively normal shapes and echogenicity. No obvious pathology is observed in either gland.

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

ULTRASONOGRAPHIC FINDINGS

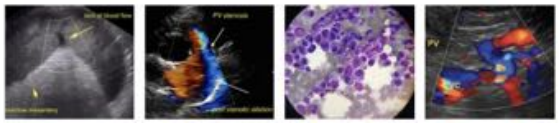
Primary Findings:

- Right mid-to-caudal abdominal mass effect, the origin of which is unclear. It may be arising from mesentery, lymph node, bowel, other. Differentials include abscess vs. necrotic tumor vs. other. Adjacent peritonitis is present.

Secondary Findings:

- Bilateral, chronic age-related renal changes.
- The prostate changes are most consistent with benign prostatic hyperplasia. Bacterial prostatitis is also a differential but considered unlikely in the absence of lower urinary tract signs.
- The mildly thickened gallbladder wall could be consistent with benign age-related hyperplasia and/or cholecystitis. Correlation with the patient's clinical history is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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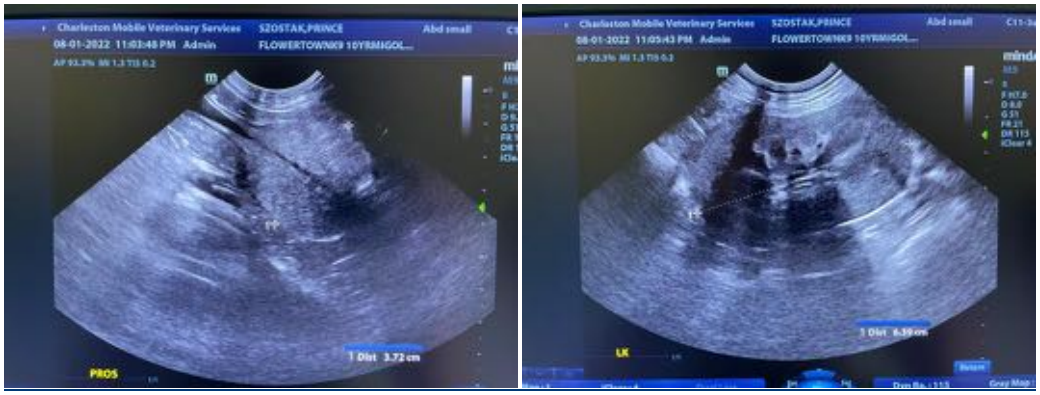
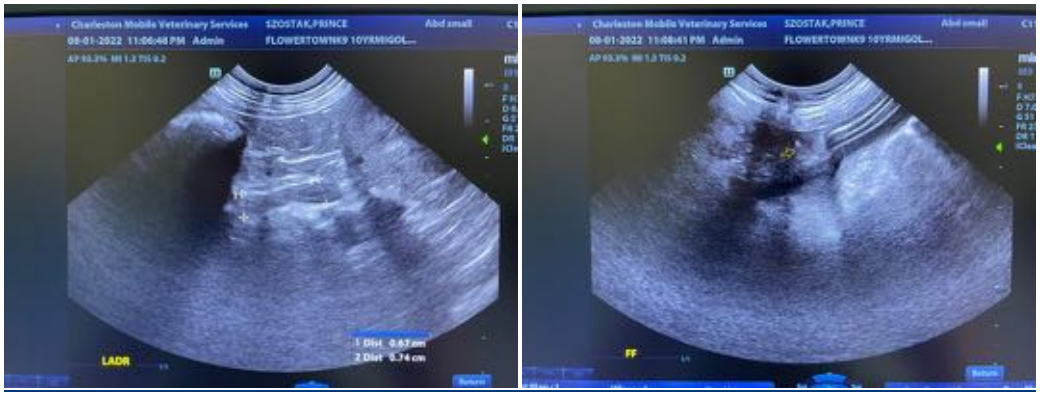
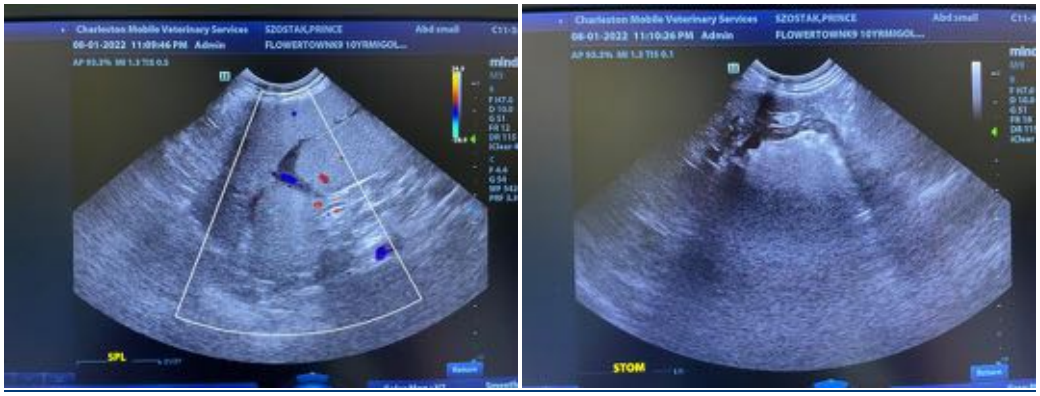
- If an aggressive approach is desired, consider an exploratory surgery with removal of the mass and submission for histopathology +/- aerobic and anaerobic cultures. If surgery is pursued, splenic biopsy should be considered (Alternatively, a splenic aspirate of the spleen can be considered if clotting status is appropriate.) Given the history of suspected inflammatory bowel disease, GI biopsies can also be considered at the time of surgery along with castration, if the patient is stable. Referral to a board-certified surgeon is recommended due to potential for perioperative complications.
- In the meantime, supportive care for possible aspiration pneumonia is recommended including broad-spectrum antibiotic therapy, symptomatic care and fluid therapy as needed.







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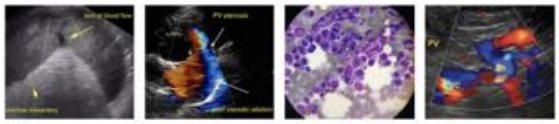

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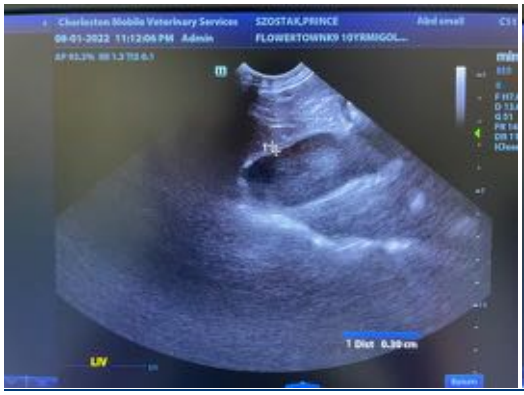

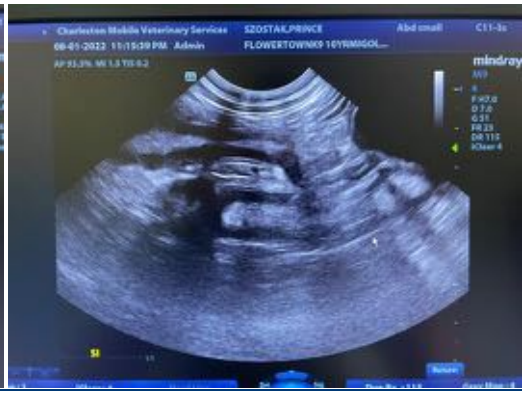

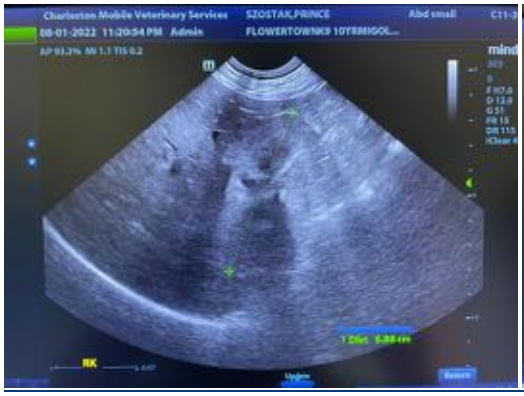

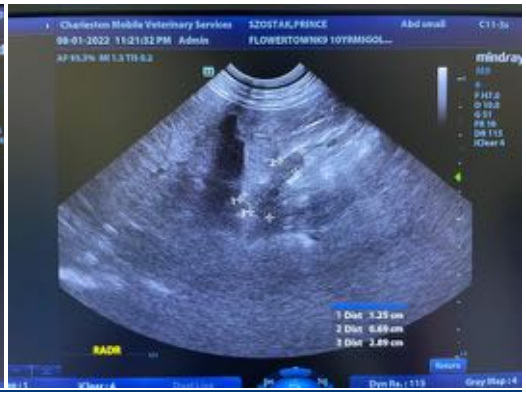

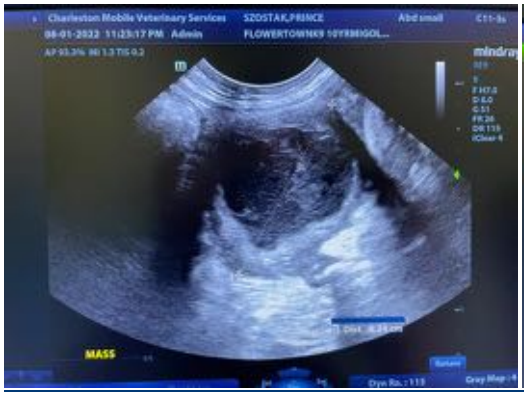

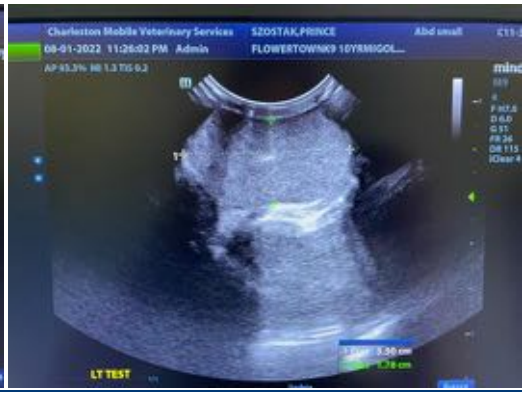

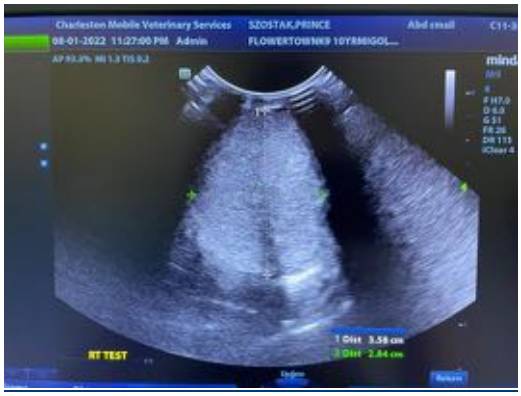

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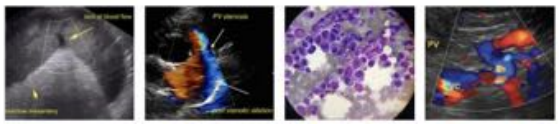

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com