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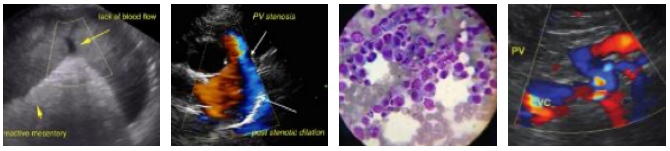


PATIENT
Marley Gaustad

SPECIES
Canine

BREED
Blue Heeler Mix

SEX
Male, intact

AGE
8 Yrs.

WEIGHT
9.7 kg.

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

IMAGING PERFORMED BY
Tom McNeill

HOSPITAL NAME
SVS Imaging CT

REFERRING VET
Dr. Galvis

INVOICE
14158

DATE
10/26/22

PRESENTING CLINICAL SIGNS

History: Marley presented to the MVS Emergency Service on Oct 25, 2022, at 6:08pm, for evaluation of vomiting and straining to urinate/defecate. On Monday Marley became lethargic, wasn't moving around much, and vomited 3 times small yellow bile piles with flecks of blood in it. Marley didn't have a bowel movement yesterday and has had no interest in food or water since last night. Today Marley began straining to defecate and was only producing small drops of dark brown stool. Marley has also been urinating a normal amount but then straining to urinate with no production afterwards. Per owner no chance of getting into anything and no toys are missing in the house. Marley does have a history of seizures since she was 2 years old but they are well controlled on phenobarbital, last seizure was 1.5 months ago. Marley was started on Dasuquin on Saturday this last weekend for her joints. Current medications: Phenobarbital 24.3mg PO q12hr(last dose 6pm 10/24)
Abnormal PE/Chem/CBC/UA Results: T- 103.1°F Persistent pyrexia (103.9 @ 12am) since being on IVF Rectal: Mucoid, yellow diarrhea Patient became hypotensive at 10am today (68 systolic), responded to fluid bolus WBC - 18.72 (5.05-16.76) NEU- 11.77 (2.95-11.64) LYM - 4.18 (1.05-5.10) Mono- 2.72 (0.16-1.12) EOS - 0.05 (0.06-1.23) ALKP- 328 (23-212) Cl- 107 (109-122)

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 moderately 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 (4.1 cm in width) with a slightly irregular shape. The parenchyma is hyperechoic relative to surrounding omental fat and heterogeneous in appearance with ill-defined cystic areas. The cystic areas contain suspended echogenic debris. The prostatic urethra is not overtly dilated.

The left kidney is normal size (4.94 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.

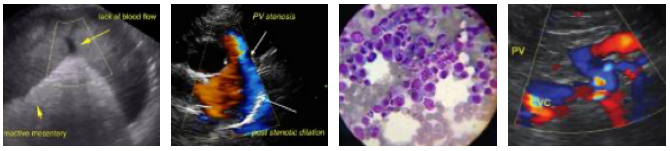
The right kidney is normal size (5.16 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.42 cm at cranial pole) (0.55 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 (0.85 cm at cranial pole) (0.54 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.

Spleen



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The spleen is normal in size (1.38 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. 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 mildly to moderately distended. The wall is normal in thickness. The lumen is filled with hyperechoic to mineralized debris, which appears gravity-dependent. 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

Trace free fluid is observed. The medial iliac lymph nodes are visualized (left 1.62 x 0.53 cm; right 3.16 x 0.52 cm). A few prominent mesenteric lymph nodes are also seen, the largest measuring 3.38 cm in length.

Other

The testicles are subjectively normal in size (left 2.54 x 1.56; right 2.37 x 1.57 cm).

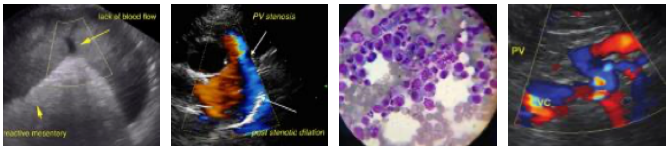
A 2.98 x 0.72 cm ill-defined, echogenic structure is observed in the right caudal quadrant, adjacent to the urinary bladder. The mesentery surrounding this structure is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The prostate changes are consistent with benign prostatic hyperplasia with parenchymal cysts. Concurrent bacterial prostatitis is also a possibility, particularly given the presence of lower urinary tract signs.
- Trace ascites.
- The echogenic structure adjacent to the urinary bladder may represent an adhered blood clot (i.e., secondary to recent cystocentesis, if applicable), granuloma, inflammatory focus, other.

Secondary Findings:



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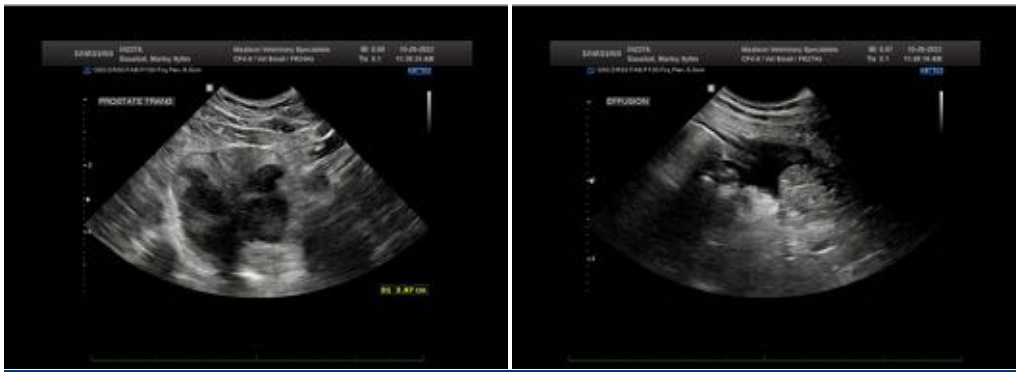
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

*An obvious cause for the patient's gastrointestinal signs is not identified in this study. Considerations include primary GI disease (i.e., dietary indiscretion, food allergy/intolerance, infectious/parasitic disease, other), underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the prostate changes, a urine culture and sensitivity is recommended to further evaluate for bacterial prostatitis. If results are inconclusive, a fine needle aspirate of the prostate may be warranted.
- Regarding the GI signs, consider the following:
  1. A fecal evaluation for ova/Giardia.
  2. Prophylactic deworming with Fenbendazole when the patient is no longer vomiting.
  3. Fecal PCR panel for infectious diseases.
  4. Three-view thoracic radiographs to assess for occult aspiration pneumonia.
  5. Supportive care for acute gastroenteritis is recommended while awaiting test results. Treatment could include IV fluid therapy, gastric protectants, antiemetics and a probiotic Broad-spectrum antibiotics (as empirical treatment for bacterial prostatitis) should also be considered.
  6. If bacterial prostatitis is ultimately diagnosed, castration would be recommended.



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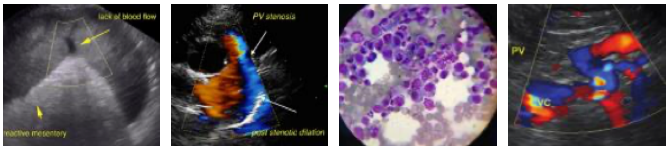

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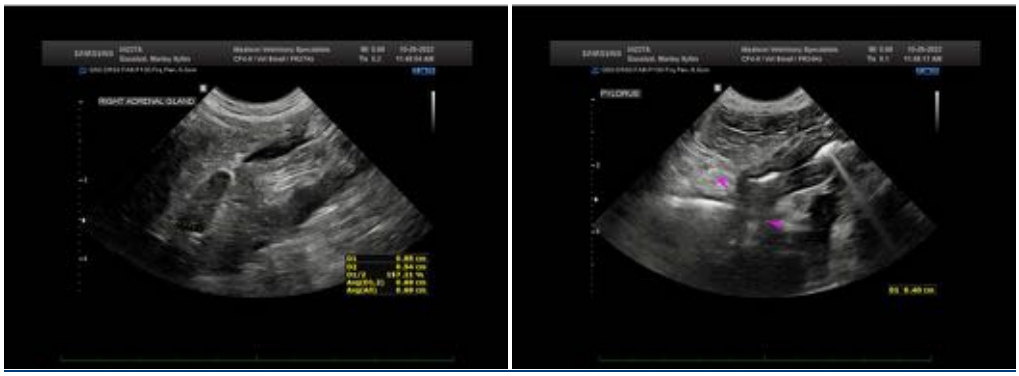

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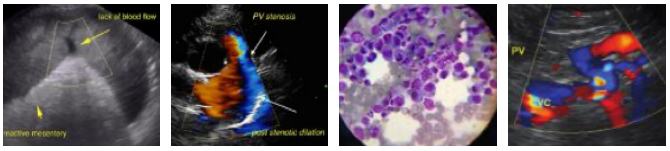

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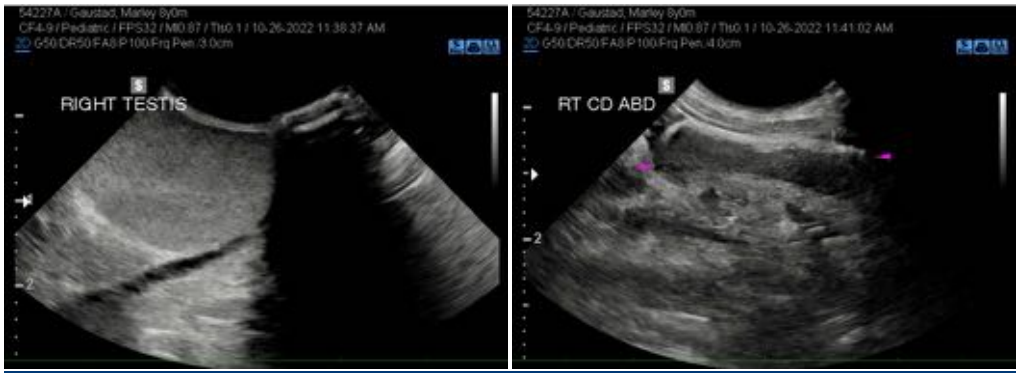

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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