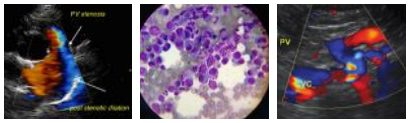
IMAGING PERFORMED BY

IntraPet.com



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**DATE**

3/31/2022

**PATIENT**

Deke Lawler

**SPECIES**

Canine

**BREED**

Golden Retriever

**SEX**

Neutered Male

**AGE**

3/16/2009

**WEIGHT**

70.6 lbs

**INTERPRETED BY**

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

**HOSPITAL NAME**

Lake Shore PH

**REFERRING VET**

Dr. Prestia

**INVOICE**

10641

## PRESENTING CLINICAL SIGNS

Swelling at base of penis, straining to urinate and only producing dribbles just started 3/23. Was neutered February 2022 for enlarged prostate. Now dog is dribbling urine

Current Medications: Enrofloxacin flavor tabs 136mg- 3 SID for 14 days with food, Novox 75mg 1 BID for 5 days then as. Needed thereafter.
Lab Results: See attached.
Urine Specific Gravity 1.022. No proteinuria. Trace hematuria. CBC shows a persistent lymphocytosis.
Radiographs: See attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

Imaging Performed By: Andi Parkinson, RDMS.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is over-distended. The wall is normal in thickness with a smooth mucosal surface. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone is normal. The proximal urethra, visible to a depth of >10 cm, is mildly dilated, up to 0.99 cm in diameter. There is no obvious evidence of an intraluminal obstruction in the visible portion of the urethra. The urethral wall is mildly thickened (0.33 cm).

The prostate is enlarged (4.45 cm in width) with a mostly normal shape and smooth peripheral contours. The parenchyma is heterogenous with numerous, varying-sized cysts observed throughout the gland, the largest measuring 2.83 cm in diameter. The prostatic and post-prostatic urethra are moderately dilated.

The left kidney is normal size (8.15 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Mild pyelectasia is present (0.41 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter.

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 mild to moderate loss of corticomedullary distinction. Mild pyelectasia is present (0.45 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter.

### *Adrenal Glands*

The left adrenal gland is normal size (0.68 cm at cranial pole) (0.80 cm at caudal pole) (2.08 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 (0.70 cm at cranial pole) (0.73 cm at caudal pole) (2.94 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 (1.30 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. A small to moderate amount of echogenic-to-mineralized, mostly gravity dependent debris is observed within the lumen. The cystic and common bile ducts are normal.

***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 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 or overt infiltrative 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***
The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

- Urinary bladder overdistention with urethral dilation. Differentials include bladder atony, distal urethral obstruction, reflex dyssynergia, other. Urethritis is present.
- Bilateral chronic nonspecific age-related renal changes. The mild pyelectasia may be secondary to age-related remodeling, pyelonephritis, backup of urine, other.
- The prostate changes are consistent with benign prostatic hyperplasia with parenchymal cysts. Concurrent bacterial prostatitis is also a consideration.

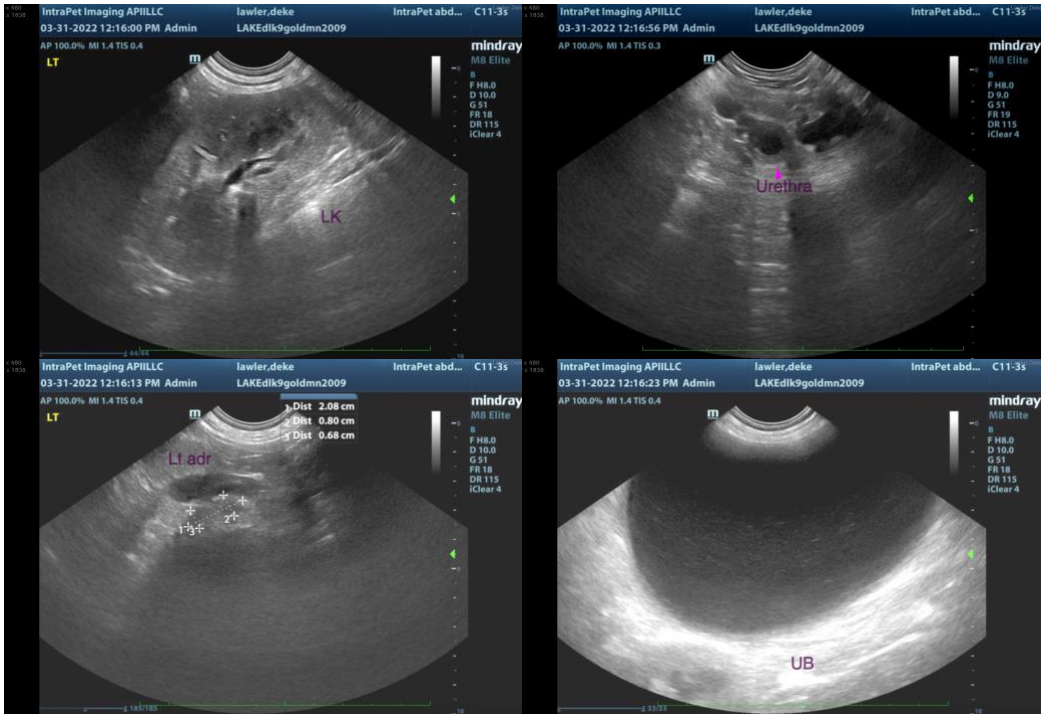
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

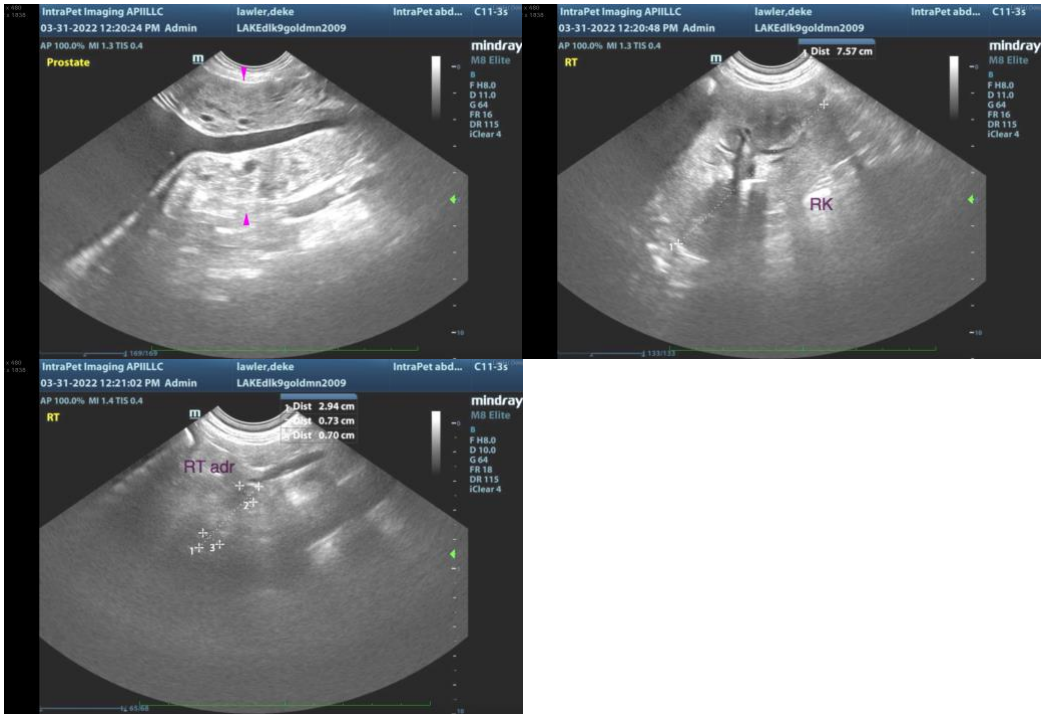
A urine culture and sensitivity, preferably on a pre-antibiotic sample, is recommended. Alternatively, a urine sample can be obtained 5-7 days after the last dose of antibiotics and submitted for culture.

Radiographs of the caudal abdomen, including the distal urethra, are recommended to further evaluate for

urethroliths.  Also consider passing a urinary catheter to better assess for possible obstruction in the distal urethra. If a distal urethral obstruction has been ruled out, consider initiation of bethanechol for bladder atony.

Given the persistent lymphocytosis, three-view thoracic radiographs as well as a CBC with clinical pathology review are recommended to assess for emerging lymphoid neoplasia. A bone marrow aspirate may also be warranted.






**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 DACVIM (Small Animal Internal Medicine)
info@SonoPath.com