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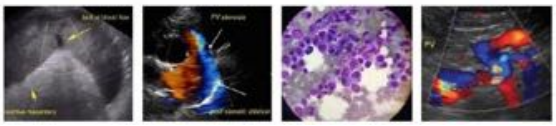


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Paczek Krol-Wawrzynczyk

SPECIES

Canine

BREED

Dacshund

SEX

Intact Male

AGE

6 years

WEIGHT

7.2 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Sixteen Mile VC

REFERRING VET

Dr. Gibbs

INVOICE

11237

DATE

7.20.22

PRESENTING CLINICAL SIGNS

History: Abdominal distension, slowly progressive anorexia and lethargy starting about 3 weeks ago. Abdominal pain noted on exam. Gabapentin and Hydromorphone given.
Abnormal PE/Chem/CBC/UA Results: CBC normal, Urea and Creatinine decreased, and ALT mildly increased at 222(10-125u/L)

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 mostly 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 (2.27 cm in width) with a normal shape and smooth peripheral contours. Parenchyma is slightly hypoechoic relative to surrounding omental fat and relatively homogenous in appearance. No distinct focal lesions are observed. The prostatic urethra is moderately dilated (0.58 cm in diameter). There is no obvious evidence of an intraluminal obstruction in the available images.

The **left kidney** is normal size (4.42 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (5.10 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is normal size (0.46 cm at cranial pole) (0.53 cm at caudal pole) (0.55 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 region of the **right adrenal gland** is evaluated. No obvious pathology is observed.

Spleen

The **spleen** is normal in size (1.27 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.

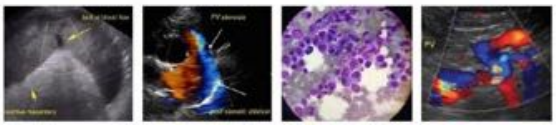
Liver

The **liver** is normal to slightly prominent in size with normal curvilinear peripheral contours. 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 scant amount of gravity dependent, echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The **gastric lumen** is mildly distended with ingesta. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall thickness is



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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.

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.

Other

The **testicles** are subjectively normal in size and symmetrical, with homogenous parenchyma. No focal lesions are observed.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- An obvious cause for the patient's clinical signs is not identified in this study.

Secondary Findings

- The cause for the prostatic urethral dilation is unclear. This may be a normal variant for this patient or may represent a distal urethral obstruction (i.e., stone, structure, or less likely, tumor). Correlation with the patient's clinical signs is recommended.
- Minor bilateral, chronic 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Regarding the prostatic urethral dilation, consider caudal abdominal/pelvic radiographs to assess for distal urethrolith, particularly if the patient is exhibiting stranguria. A passive urinary catheter may also help to determine if a distal urethral obstruction is present.

Regarding the patient's clinical signs, further work-up is warranted, and could include the following:

1. Whole body radiographs to assess for thoracic and bony lesions
2. Orthopedic and neurologic examinations to evaluate for nonmetabolic causes for the patient's clinical signs.
3. T4/free T4 by equilibrium dialysis
4. Malabsorption panel, including serum cobalamin and folate, TLI and PLI
5. Comprehensive tick panel
6. Given the history of abdominal pain, consider a urine culture and sensitivity to assess for occult pyelonephritis.
7. Given the elevated ALT, consider pre-and postprandial serum bile acids to assess hepatic function.

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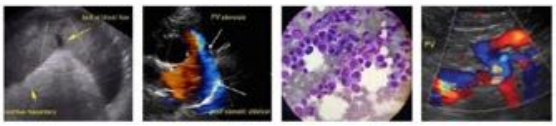

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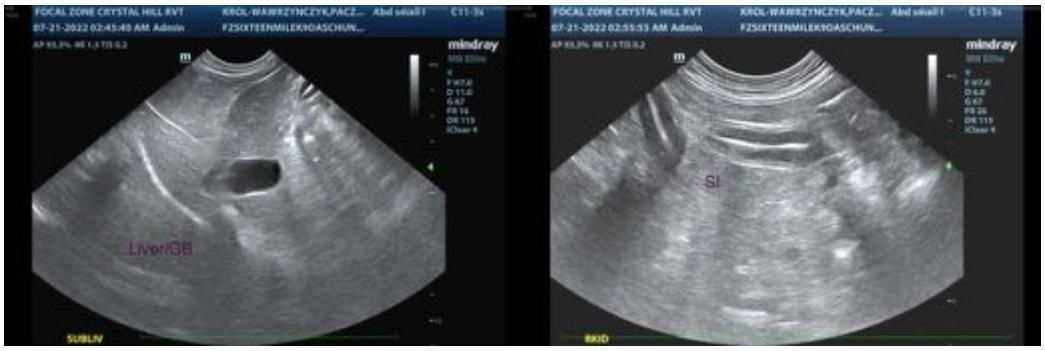

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 DACVIM (Small Animal Internal Medicine)
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