PATIENT

Mojo Kerns

SPECIES

Canine

BREED

Boston Terrier

SEX

Male

AGE

5/20/2016

WEIGHT

26.4 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

Dunes VC

REFERRING VET

Dr. Devin Soileau

INVOICE

13358

DATE

11/19/25

PRESENTING CLINICAL SIGNS

Pt has been having inappropriate urinations for the past couple of months, dribbling urine. The dribbling does improve on antibiotics. Has had 4 courses of antibiotics (Clavamox twice, Marbofloxacin twice), urine culture negative. Pt had foreign body surgery over the summer.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface in the region of the apex is slightly irregular. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 4 cm, are normal. The penile urethra was evaluated. No obvious pathology was seen.

The prostate is enlarged (2.86 cm in width) with relatively smooth peripheral contours. The parenchyma is heterogeneous in appearance. A few small ill-defined cysts are observed within the parenchyma. The prostatic urethra and visible portion of the post-prostatic urethra are not overtly dilated.

The left kidney is normal in size (5.32 cm in length) with a normal shape, architecture and 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 in size (5.23 cm in length) with a normal shape, architecture and 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 in size (0.47 cm at cranial pole) (0.54 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

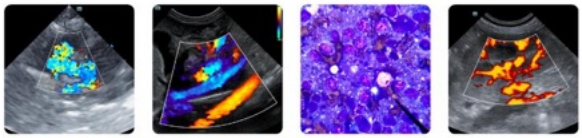
The right adrenal gland is normal in size (0.67 cm at cranial pole) (0.47 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.27 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.58 x 0.32 cm cystic lesion is observed approximately mid-body. 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. The portal vein to caudal vena cava ratio is approximately 1:1.



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The gall bladder lumen is moderately distended. The wall is thin and smooth. A scant amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

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 is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph nodes

A 1.09 x 0.35 cm medial iliac lymph node is visualized.

Free Abdomen

There is no obvious evidence of free fluid.

Other

The testicles are subjectively normal in size and symmetrical with homogeneous parenchyma.

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The prostatic changes are most consistent with cystic benign prostatic hyperplasia. Concurrent bacterial prostatitis is possible. Correlation with the patient's urinalysis findings is recommended. Prostatic neoplasia is possible but considered less likely.

Secondary Findings:

- Minor bilateral age-related renal changes
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The prominent medial iliac lymph node is likely reactive with a lower possibility of emerging neoplasia.
- The small cystic lesion within the splenic parenchyma may represent a benign cyst or an emerging vascular tumor.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. A minimum database including a CBC chemistry panel, urinalysis and T4 is recommended to assess overall metabolic function.
2. Orthopedic and neurologic examinations should also be considered to assess for non-metabolic causes of dysuria and dribbling urine.

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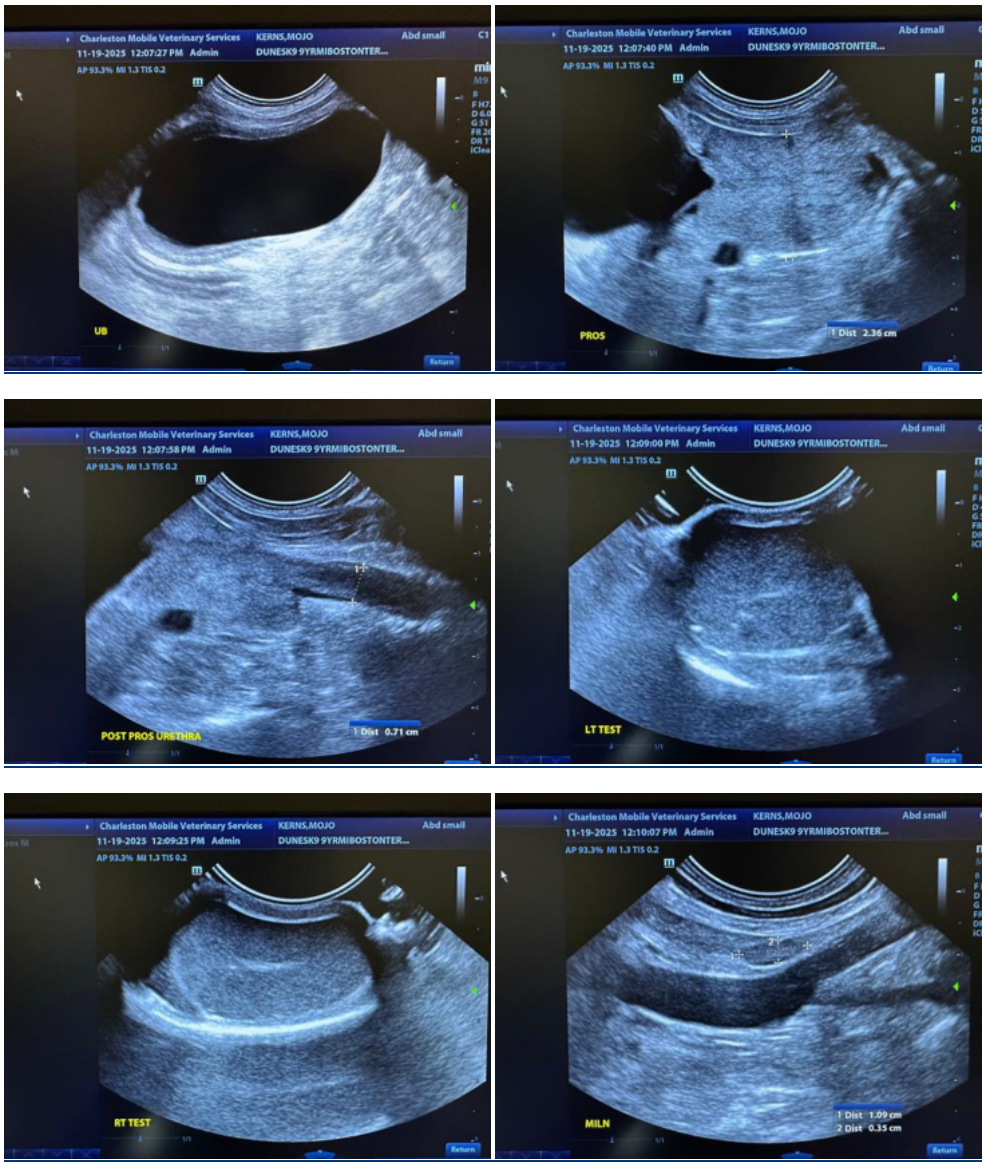
3. Ultimately, castration should be strongly considered as the patient's dysuria may be secondary to prostatitis/benign prostatic hyperplasia.



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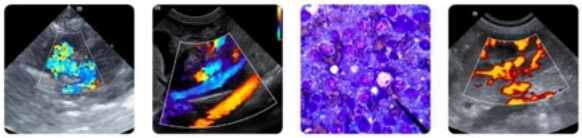

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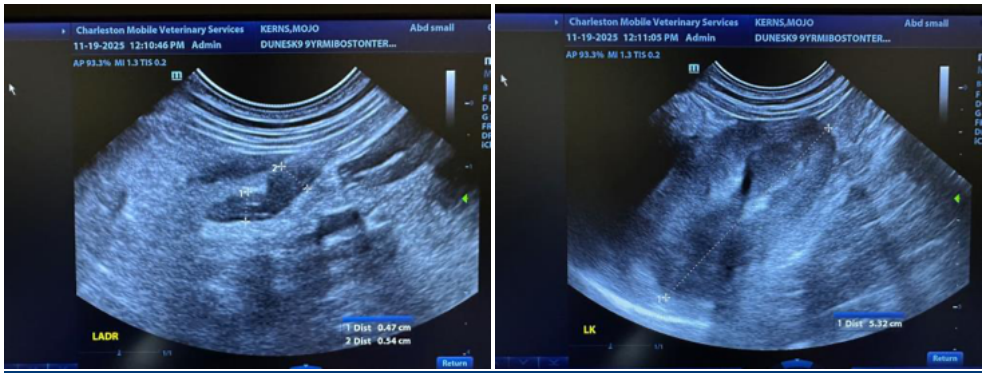

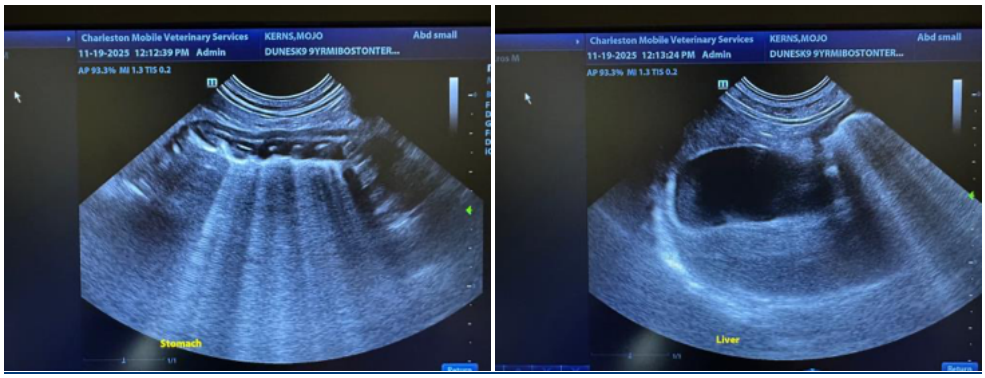

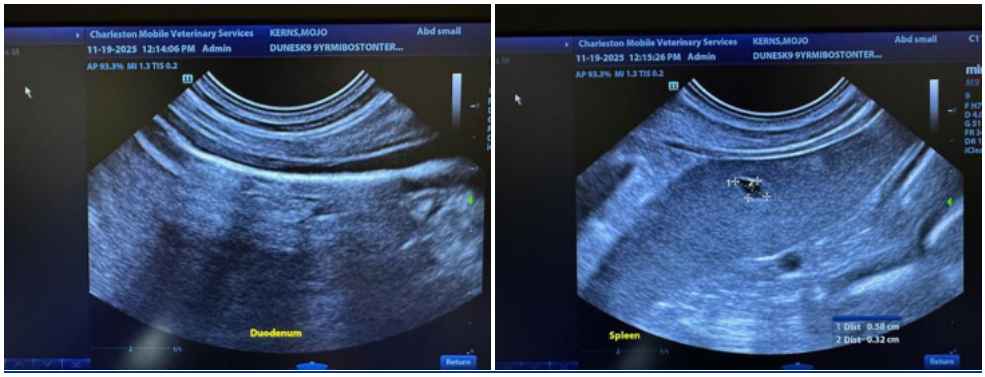

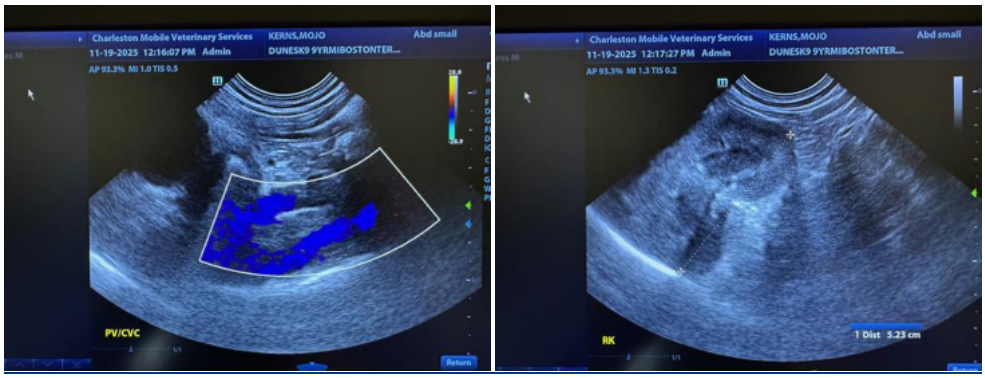

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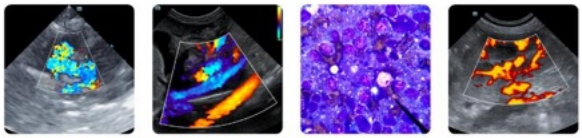

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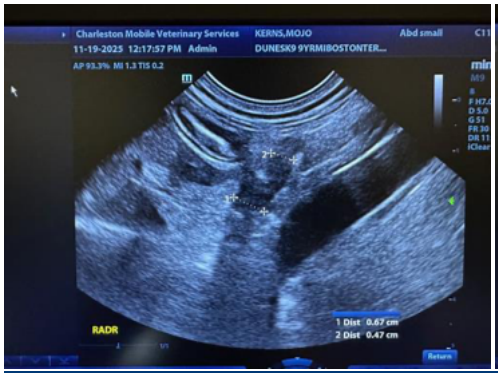

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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