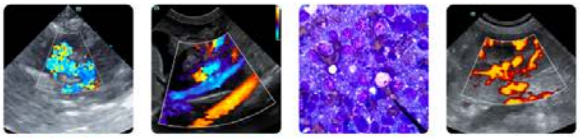


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Cooper Lavoie

SPECIES

Canine

BREED

Aussie

SEX

Neutered Male

AGE

8 Years

WEIGHT

32.7 kg

INTERPRETED BY

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Hamilton Region Vet Emergency Clinic

REFERRING VET

Dr. Ho

INVOICE

73940

DATE

3/23/26

PRESENTING CLINICAL SIGNS

History of stranguria, dribbling urine, hyporexia and vomiting for 2-3 days. Was neutered during puppyhood, no historical cryptorchidism. Physical exam: BCS 9/9, tense abdomen, dribbling urine, firm & enlarged prostate palpable on rectal exam. 1 lateral radiograph taken: distended bladder, no radio-opaque uroliths or urethroliths, large round soft tissue mass caudal to bladder with multifocal mineral specks. AFAST: free fluid score 0/4, no obvious uroliths, large, mottled mass caudal to bladder, suspicious of prostatomegaly. Urinary catheter passed under sedation with very little resistance, removed 1L of grossly dark yellow turbid urine. There was a moment of transient grossly hemorrhagic urine when ucath was passed, this urine was collected for urinalysis & culture

Current Medications: dexmedetomidine, methadone, propofol, maropitant, trazodone, gabapentin

Abnormal PE/Chem/CBC/UA Results: ABNORMAL Labwork Values mild hypokalemia (3.2), no azotemia, tT4 normal, catheterized urine sample collected for urinalysis & culture, USG 1016, pH 7.0, significant proteinuria 500mg/dL, significant hematuria 250RBC/microL, mild pyuria (WBC 7/hpf) rad attached.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is non-distended. There is an anechoic inflated foley catheter balloon in place in the urinary bladder trigone. The bladder lumen is inadequately distended to evaluate the bladder wall.

The prostate is severely enlarged with irregular margins and mixed hyper- and hypoechoic nodular changes throughout the parenchyma. The prostatic urethra appears subjectively compressed.

The kidneys are normal in size and structure, with appropriate corticomedullary definition and cortex to medulla ratio. The cortices are uniform in texture with normal echogenic relationship to liver and spleen. The medullary structure differed distinctly from the cortex and no evidence of pyelectasis is present. The capsules are uniform without significant irregularities noted. Left kidney measures 7.33 cm. Right kidney measures 7.62 cm.

Adrenal Glands

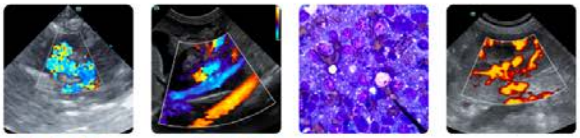
Both adrenal glands are visualized and have normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. Left measures 0.47 cm x 2.23 cm. Right measures 0.46 cm x 3.18 cm.

Spleen

The spleen (1.98 cm at the hilus) is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented.

Liver

The liver is subjectively normal liver size, contour, and structure. Parenchymal echogenicity is naturally coarse and hypoechoic to the spleen. Vasculature is within normal limits with no evidence of congestion.



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The gallbladder contains a minimal amount of suspended echogenic debris and dependent sediment. The cystic and common bile ducts are normal. There is no intra- or extrahepatic biliary dilation.

Gastrointestinal

The gastrointestinal tract is non-distended with a patent pyloroduodenal junction and Ileocecocolic junction. There is no shadowing foreign material or evidence of mechanical obstruction. The majority of the gastrointestinal walls are normal in thickness with maintenance of normal wall layering. There is a focal region of small intestine with a thickened wall and minimally distended lumen. The submucosal layer appears to be thickened and prominent, and there is a mild to moderate loss of normal wall layering. The lesion does not appear to be obstructive at this time.

Pancreas

The base and limbs of the pancreas are isoechoic to surrounding omental fat. The pancreatic duct and capsular contour are normal. There is no overt evidence of active inflammatory or neoplastic disease.

Free Abdomen

There is a mild volume of anechoic free fluid in the caudal abdomen. There is no significant lymphadenopathy noted.

ULTRASONOGRAPHIC FINDINGS

- The changes to the prostate likely represent infiltrative neoplastic disease, especially given the patient's neutered status. Benign prostatic hypertrophy is considered much less likely. Additionally, prostatitis cannot be definitively ruled out but is considered less likely given the current appearance.
- The gallbladder contains echogenic, suspended and dependent unorganized debris. This is not yet to the level of an organized mucocele, however early/developing mucocele cannot be ruled out. This dependent sediment is often an incidental finding or may be associated with concurrent endocrine disease such as hyperadrenocorticism or diabetes mellitus.
- The focal gastrointestinal lesion likely represents infiltrative disease such as inflammatory bowel disease or other chronic enteropathy. Additionally, infiltrative neoplastic disease such as round cell neoplasia can't be definitively excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominocentesis with fluid analysis is recommended to further evaluate the peritoneal effusion. Given the history of potential urethral obstruction, uroabdomen is considered a possibility. Paired creatinine and electrolytes should be performed on the fluid and serum to evaluate for potential uroabdomen.

Fine needle aspirates of the prostate with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.

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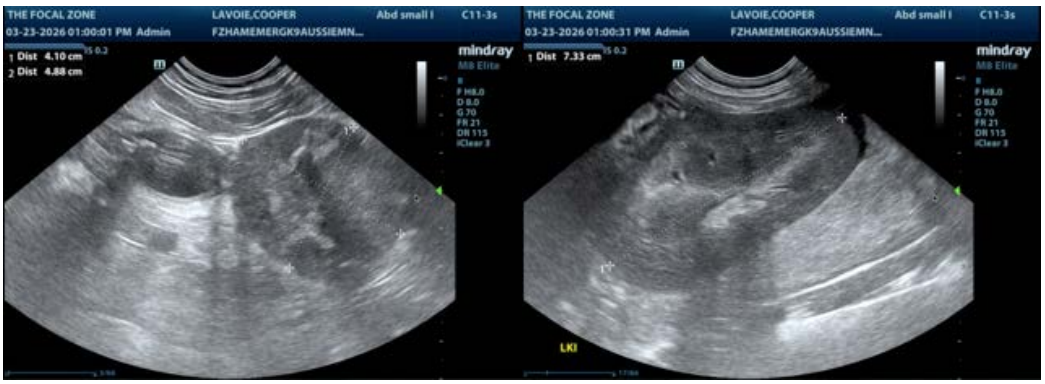

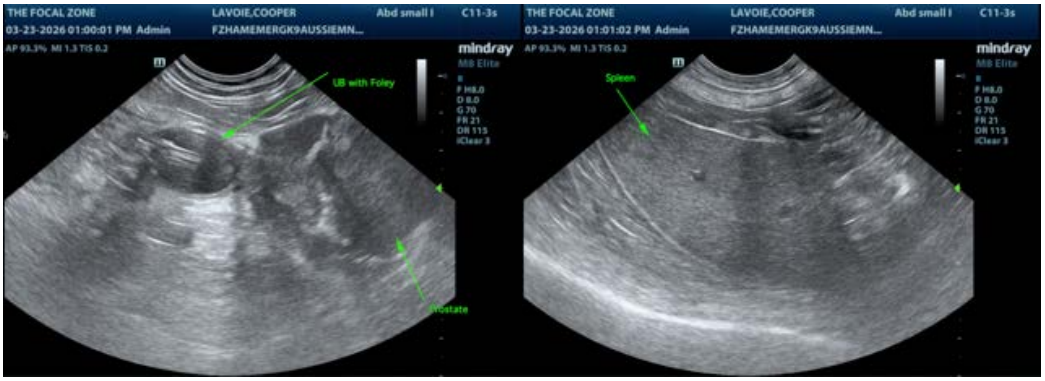

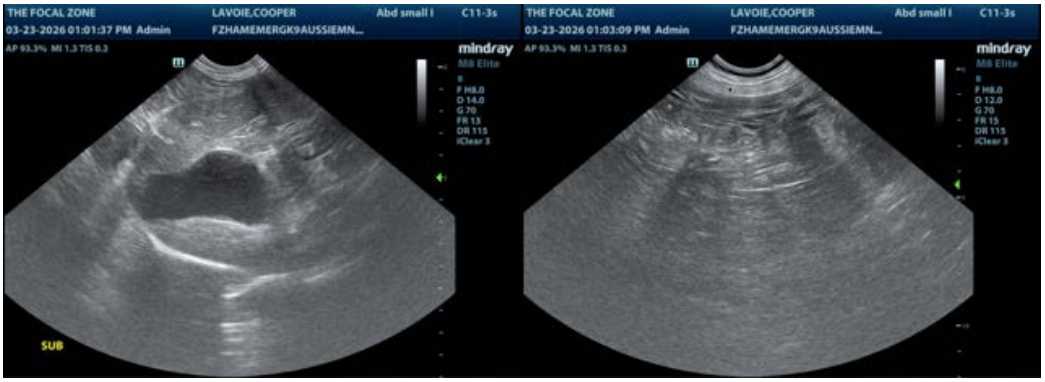

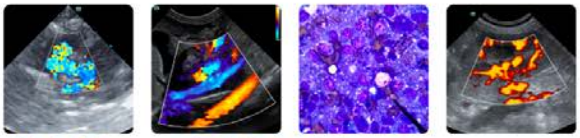

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com