



**PATIENT**

Nash Geer

**SPECIES**

Canine

**BREED**

Staffordshire Terrier

**SEX**

Male

**AGE**

5 Years

**WEIGHT**

55.2

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Heather

**HOSPITAL NAME**

ACC Flanders

**REFERRING VET**

Dr. Wagley

**INVOICE**

44141

**DATE**

1/12/23

**PRESENTING CLINICAL SIGNS**

Straining to urinate for months, enlarged prostate palpated in august and enlarged on x ray used urinary catheter after U/S to manually evacuate bladder for patient comfort.

Abnormal PE/Chem/CBC/UA Results: bw WNL in august cbc chem

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. There is pinpoint mineral density without shadow present near the trigone, but no evidence of obstruction and no overt cystoliths. No masses observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is symmetrically enlarged (3.7 cm wide) with smooth margins that are well differentiated from surrounding tissue. Normal bilobed shape is maintained. Parenchyma is diffusely hyperechoic. Several small anechoic cysts are noted. No mineral is noted.

The right kidney is normal in size (6.44 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (6.25 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

**Adrenal Glands**

The left adrenal gland is not able to be well visualized in these images.

The right adrenal gland is normal in size (0.56 cm at the cranial pole and 0.69 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

**Spleen**

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

**Liver**

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

**Gastrointestinal**



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The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

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**Pancreas**

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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**Free Abdomen**

There is no evidence of free peritoneal effusion noted in these images.

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There is no apparent lymphadenopathy noted in these images.

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**ULTRASONOGRAPHIC FINDINGS**

- **Benign Prostatic Hyperplasia with cysts** – Prostatic findings are most consistent with Benign Prostatic Hyperplasia (BPH) and concurrent benign prostatic cysts. Active prostatitis cannot be ruled out. Infiltrative neoplasia cannot be ruled out but is considered less likely.
- Large amount of urinary bladder debris with pinpoint mineral but no evidence of an obstruction or overt cystolithiasis noted.

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\*\*There is no visible evidence of urinary tract obstruction. Therefore, the stranguria is likely secondary to benign prostatic hyperplasia in addition to secondary urinary tract infection, possibly bacterial prostatitis, etc.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

**REFERRING VET**

Dr. Wagley

If not recently evaluated, a general overall metabolic health screen including CBC/Chem panel, electrolytes, a urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

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While waiting on urinalysis results or ultimately urine culture results, empirical antibiotics (being sure to choose one with good prostatic penetration such as a fluoroquinolone) and anti-inflammatories may begin to help alleviate clinical signs.

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Ultimately, the fastest way to shrink the prostate, resolve BPH, and eliminate the stranguria (if secondary to BPH) is neutering the patient. Therefore, if possible, patient neutering is recommended. If neutering is refused, there are other medical options including Finasteride. However, prostate shrinkage takes much longer with medical management and is therefore not recommended in a patient that is straining to urinate.



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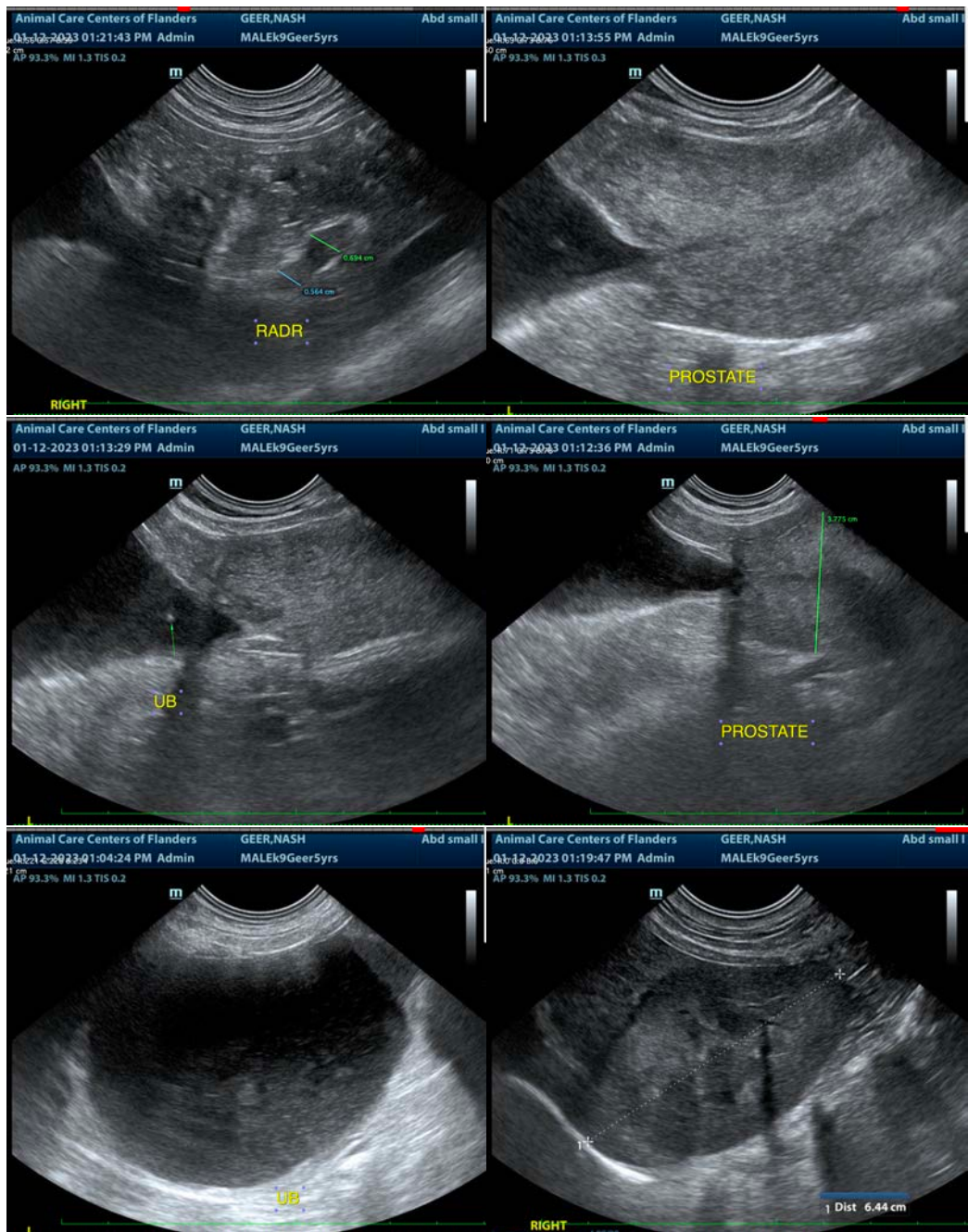
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Beth Johnson, DVM, DACVIM**  
Beth.Johnson@sonopath.com