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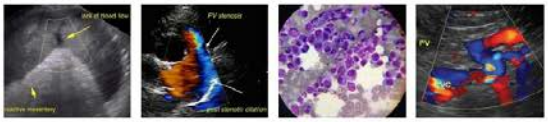

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Tia Guenther

SPECIES

Canine

BREED

Husky X

SEX

Neutered Male

AGE

10 Years 7 Months

WEIGHT

91 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Advanced PetCare of Nevada

REFERRING VET

Dr. Sarah Behrens

INVOICE

42029

DATE

10/12/22

PRESENTING CLINICAL SIGNS

sedation 0.05ml dexdormitor IV and butrophaniol 0.1ml IV- Meds: Gabapnetin- Presenting Complaint: ABD ultrasound. Hasn't fully pooped for 5 days- 3 days ago had runny bits of poop. Swollen paws, walks stiff. E/D well?: No, hasnt been eating more than a few bites for 5 days. Increased thirst. Presenting Complaint: NR- peeing in the house, wt loss, lethargy, bloodshot eyes. Dry nose and dry mouth. worried about diabetes. Lethargic for a week, Eating/Drinkingdecreasing in the last 2 days, drinking is normal possibly increased Urination/Defecation peeing in house, not incontinence. liquid diarrhea.

Abnormal PE/Chem/CBC/UA Results: UA- blood 2+, protein 2+, USG 1010 CHEM: AST 141, ALP 453, SDMA 8 CREATININE 0.9 BUN 10

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Mineral sand/debris is settled along the dependent wall. Apical urinary bladder wall is diffusely thick (0.56 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

The prostate is large measuring 4.28 cm thick. Parenchyma is diffusely heterogeneous and relatively hypoechoic, and contains multifocal mineral densities. Normal distinct margins and symmetrical bilobed shape are maintained.

The right kidney is normal in size (7.6 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 or infarcts observed. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted.

The left kidney is normal in size (7.7 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 or infarcts observed. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted.

Adrenal Glands

The right adrenal gland is normal in size (1.4 cm at the cranial pole ad 0.97 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.98 cm at the cranial pole and 0.99 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.

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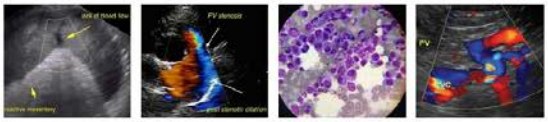

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Liver

Liver is subjectively enlarged (swollen contour). Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. No focal nodules or masses are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. Pyloric outflow tract appears patent.

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.

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

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.

Free Abdomen

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

The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

Sublumbar lymph nodes are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

PRIMARY FINDINGS

- **Heterogeneous, hypoechoic, mineralized prostatomegaly** – Differentials include both active prostatitis as well as infiltrative neoplasia and cannot be differentiated without tissue sampling.

- **Chronic Cystitis -** Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes. Mineral sand/debris is present.

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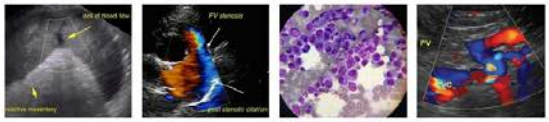

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- **Aggressive sublumbar lymph nodes –** most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.
- **Reactive mesenteric lymph nodes –** Infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- **Hypoechoic hepatomegaly** – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.

SECONDARY FINDINGS

- **Hyperechoic splenic nodules –** most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.
- **Gallbladder debris -** Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- Non-obstructive dystrophic mineralization in the kidneys bilaterally

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Urinalysis and urine culture, if indicated based on urinalysis results, are recommended. Submission of urine to look for BRAF gene mutation, which is associated with urinary bladder cancer, could be considered. Other diagnostic options include traumatic catheterization, fine needle aspirate (with small risk of tumor seeding/trailing) or cystoscopy for further sampling.

Additionally, a fine needle aspirate of the sublumbar lymph nodes could be considered if patient's coagulation status is appropriate.

In the meantime, medical management with antibiotics, ideally based on culture and sensitivity results, as well as an anti-inflammatory may help begin alleviating clinical signs while awaiting test results.

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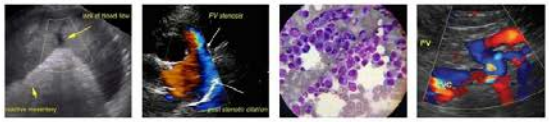

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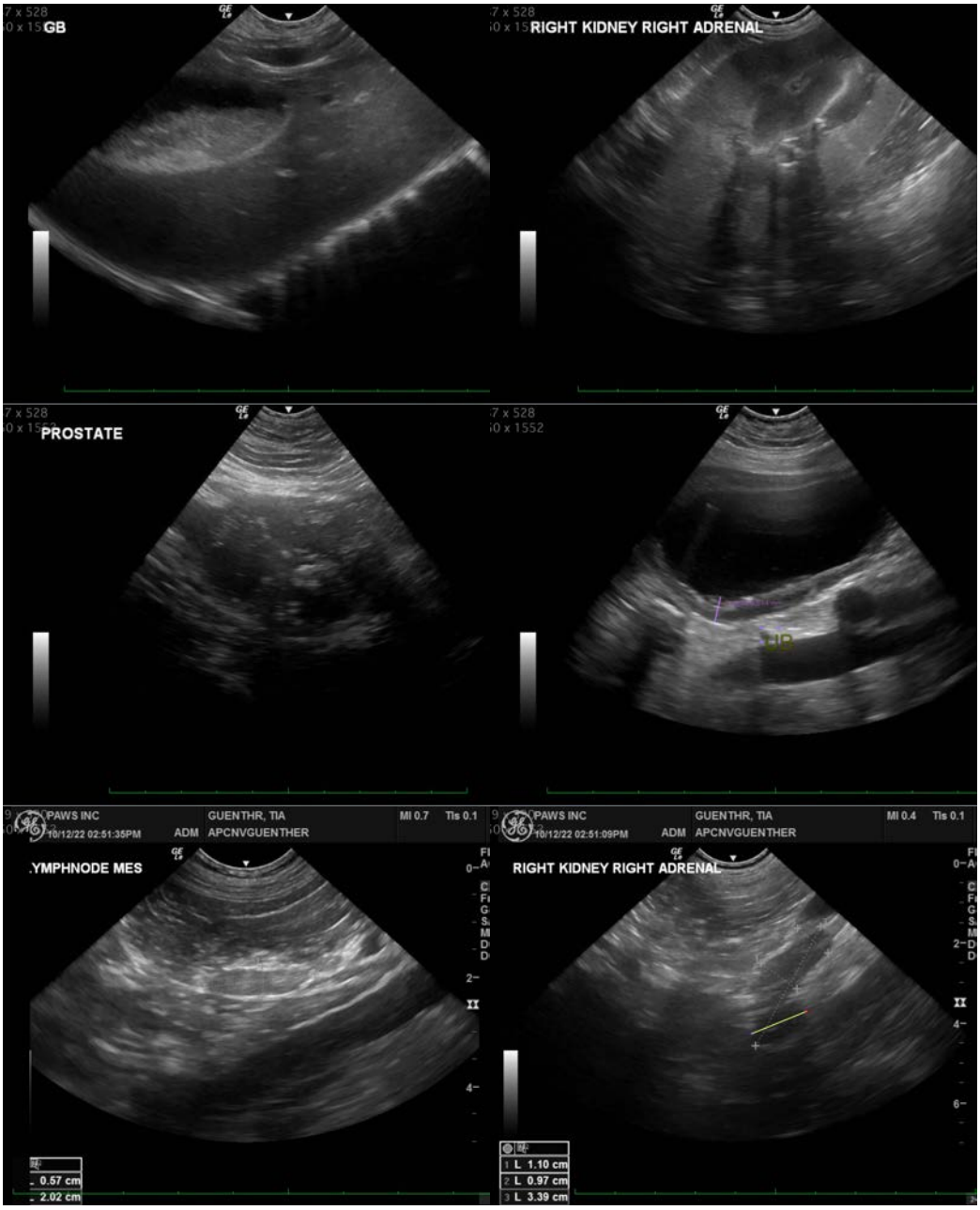

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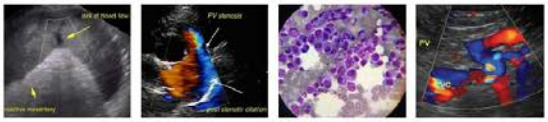

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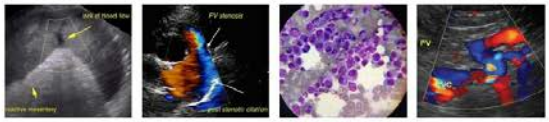

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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