



PATIENT

Rafiki Karimjee

SPECIES

Canine

BREED

German Shepherd

SEX

Male

AGE

7 Years

WEIGHT

47.5 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Nigel Gumley

HOSPITAL NAME

Cedarview AH

REFERRING VET

Dr. Nigel Gumley

INVOICE

45482

DATE

2/23/23

PRESENTING CLINICAL SIGNS

Chronic prostatomegaly treated periodically with finasteride (owner against neuter). Chronic DJD multiple joints plus LS disease. Con gabapentin and meloxicam long term. Presented for 1 week of anorexia and lethargy. AFAST found hyperechoic mesentery in cranial abdomen. Stopped meloxicam and started sucralfate and omeprazole; broke with hematochezia and mucoid diarrhea. Started on metronidazole. Today is eating better, brighter. Return for full abdominal US.

Abnormal PE/Chem/CBC/UA Results: Sedated with torb/dexdomitor. Bladder was grossly dilated and emptied via catheter during procedure. CBC: Leukocytosis (27K) and mature neutrophilia (24K), Alb = 22, Sodium = 138, Na/K = 28; Spec cPli = 304. UA large numbers sperm, 3+ protein, 6 WBCs/HPF, possible bacteria; culture and UPC pending. FNA taken of enlarged abdominal LNs and cytology pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately overdistended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is symmetrically enlarged 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. **See other.

The right kidney is difficult to fully visualize in these images. However, it is visualized on the edges of several clips without evident kidney pathology. A hyperechoic band parallel to the corticomedullary border is present.

The left kidney is normal in size (8.6 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 mineral or infarcts observed. Pyelectasia noted at 0.33 cm in the transverse view. A hyperechoic band parallel to the corticomedullary border is present.

Adrenal Glands

The right adrenal gland is normal in size (0.68 cm at the cranial pole and 0.63 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 (0.56 cm at the cranial pole and 0.59 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.



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Gallbladder is moderately distended with anechoic bile as well as mild 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.

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Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with 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. **See other.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Soft stool is noted.

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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

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In the caudal abdomen surrounding the prostate and the sublumbar area, there is a scant amount of anechoic free fluid as well as markedly enhanced hyperechoic mesenteric fat.

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.

Similarly, there is some enhanced hyperechoic fat in the cranial abdomen around the gastric fundus.

IMAGING PERFORMED BY

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ULTRASONOGRAPHIC FINDINGS

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- The prostatic findings are consistent with benign prostatic hyperplasia and concurrent benign cysts. However, given the marked inflammatory change and lymphadenopathy in the area, at minimum active prostatitis on top of BPH is suspected, and less likely but possible infiltrative neoplasia cannot be ruled out.

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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.

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- **Mild left kidney pyelectasia** – Differentials for pyelectasia include pyelonephritis, diuresis, congenital malformation or ureteral or lower urinary tract obstruction.

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- **Bilateral medullary rim sign** - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including FIP, lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The enhanced mesentery around the stomach may indicate some focal peritonitis secondary to gastritis or even microulceration. Given this patient's reported hematochezia and improvement since discontinuing nonsteroidals, recommendations include continued discontinuation of the nonsteroidals and management of gastritis/microulceration with antiemetics and gastroprotectants including sucralfate until patient has fully returned to normal. If gastrointestinal signs persist, a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

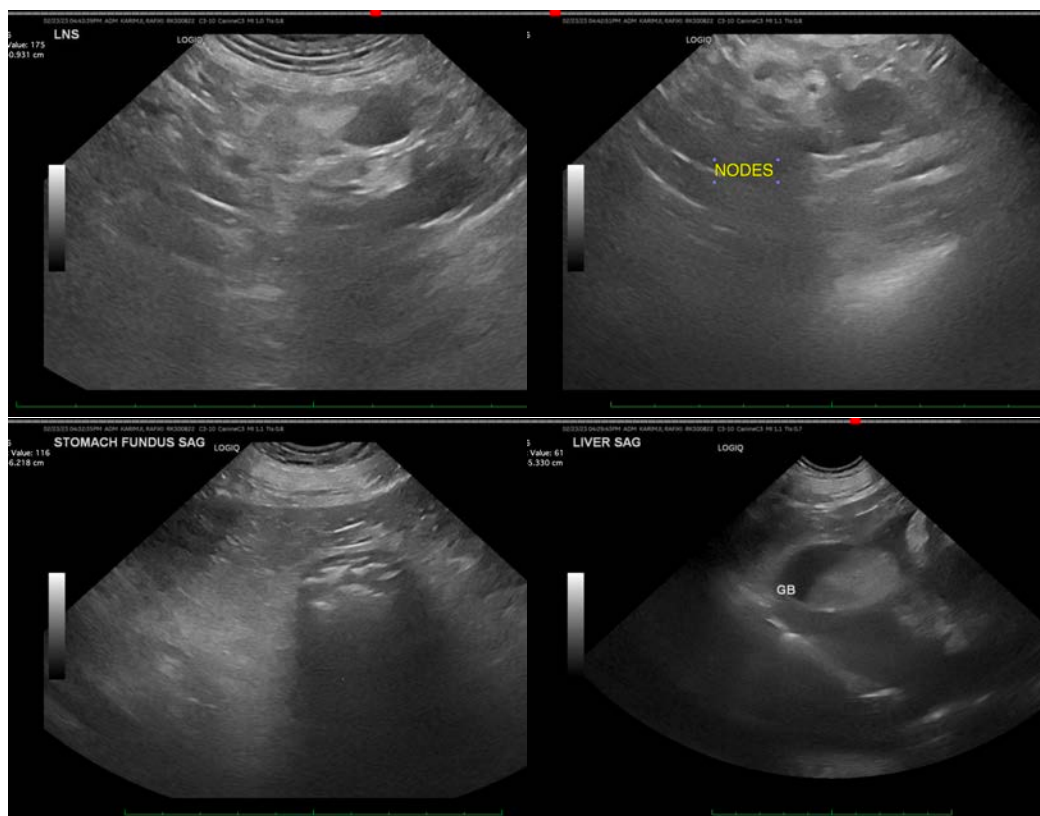
A fecal exam is also recommended. A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function, +/- a fecal enteropathogen PCR panel to Texas A&M GI Laboratory.

Regarding the prostate changes, however, as is reportedly already pending, 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 ratio is recommended.

As is also reportedly already pending, a fine needle aspirate of the enlarged lymph nodes is recommended for cytology +/- culture and sensitivity.

Pending results, antibiotic therapy may help alleviate some of the caudal abdominal inflammation and prostatic changes. However, if not, submission of urine to look for BRAF gene mutation, which has been associated with bladder and prostatic cancer could be considered, or alternatively a fine needle aspirate could be considered if patient's coagulation status is appropriate, with a small risk of tumor seeding/trailing.

Ultimately, patient neuter is strongly recommended.





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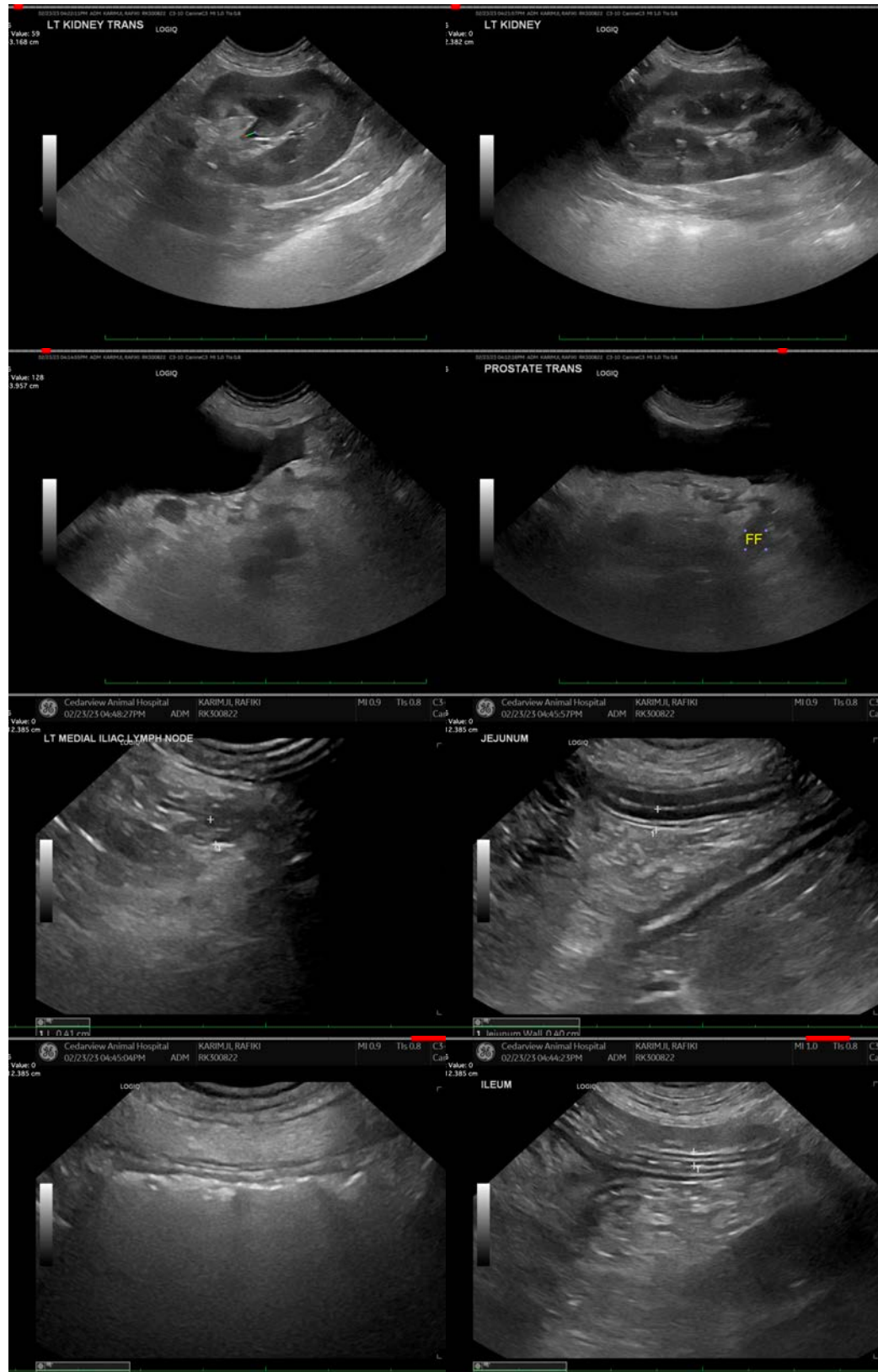
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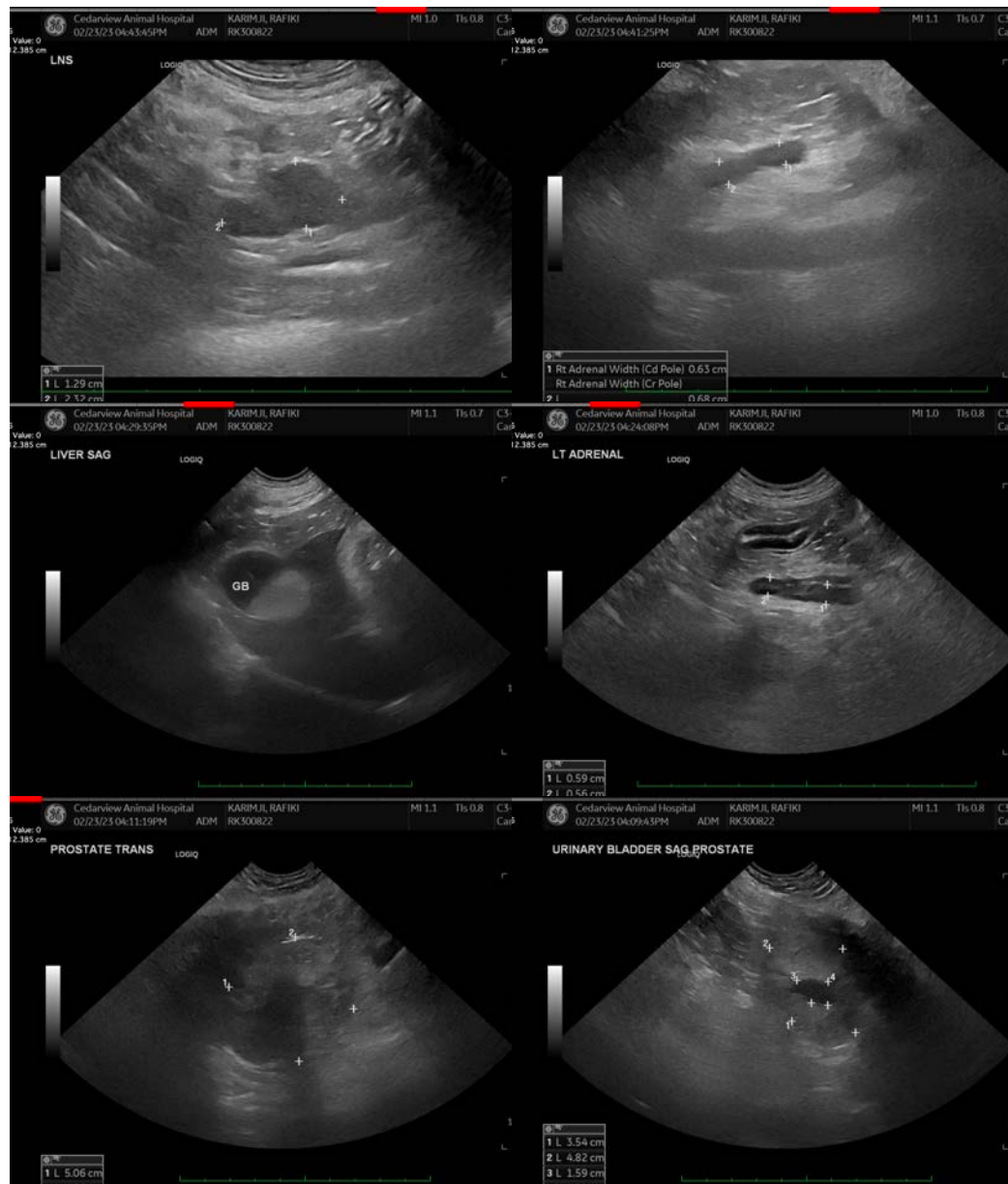
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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