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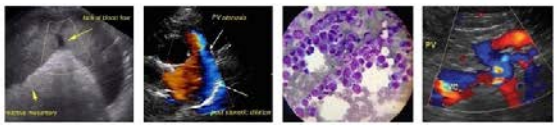

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Reilly Park

SPECIES

Canine

BREED

Lab X

SEX

Neutered Male

AGE

9 Years

WEIGHT

27.7 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

East Plains AH

REFERRING VET

Dr. Boyer

INVOICE

46550

DATE

4/11/23

PRESENTING CLINICAL SIGNS

Presented for slow urine stream - taking 5 x longer to urinate than normal - on and off visible hematuria - clinical exam unremarkable - prostate not palpable on rectal exam - urine culture negative 03/31/2023
Current Medications Clavamox 375 mg BID

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is subjectively over distended. Other than the heterogeneous mass-like lesion within the trigone, 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. No distinct cystoliths are observed. There is mineral sand/debris noted within the intraprostatic urethral lumen versus potential mineralization of the mass.

The prostate is enlarged, measuring 2.5 cm wide with a diffusely mildly heterogeneous and hypoechoic parenchyma. Normal distinct margins and symmetrical bilobed shape are maintained. However, the prostate appears to communicate with or be attached to heterogeneous mass-like tissue extending into the urinary bladder trigone.

The right kidney is normal in size (7.57 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 (7.77 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 marked pyelectasia measuring 1.6 cm in the sagittal view. There is no evidence of mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (2.0 cm long x 1.43 cm at the cranial pole and 0.74 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 (2.69 cm long x 0.77 cm at the cranial pole and 0.76 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.

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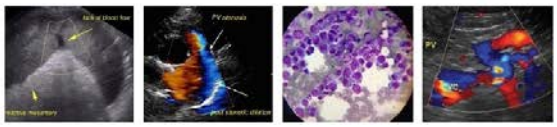

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Gastrointestinal

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.

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.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Prostatomegaly and urinary bladder trigone mass – Most concerning for infiltrative neoplasia such as transitional cell carcinoma versus other. Benign inflammatory disease, prostatitis/cystitis cannot be ruled out but is considered much less likely, given the location and appearance of the tissue.
- Marked left kidney pyelectasia – Likely secondary to partial lower urinary tract obstruction. However, secondary infection/pyelonephritis cannot be definitively ruled out.

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.

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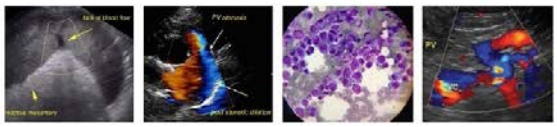

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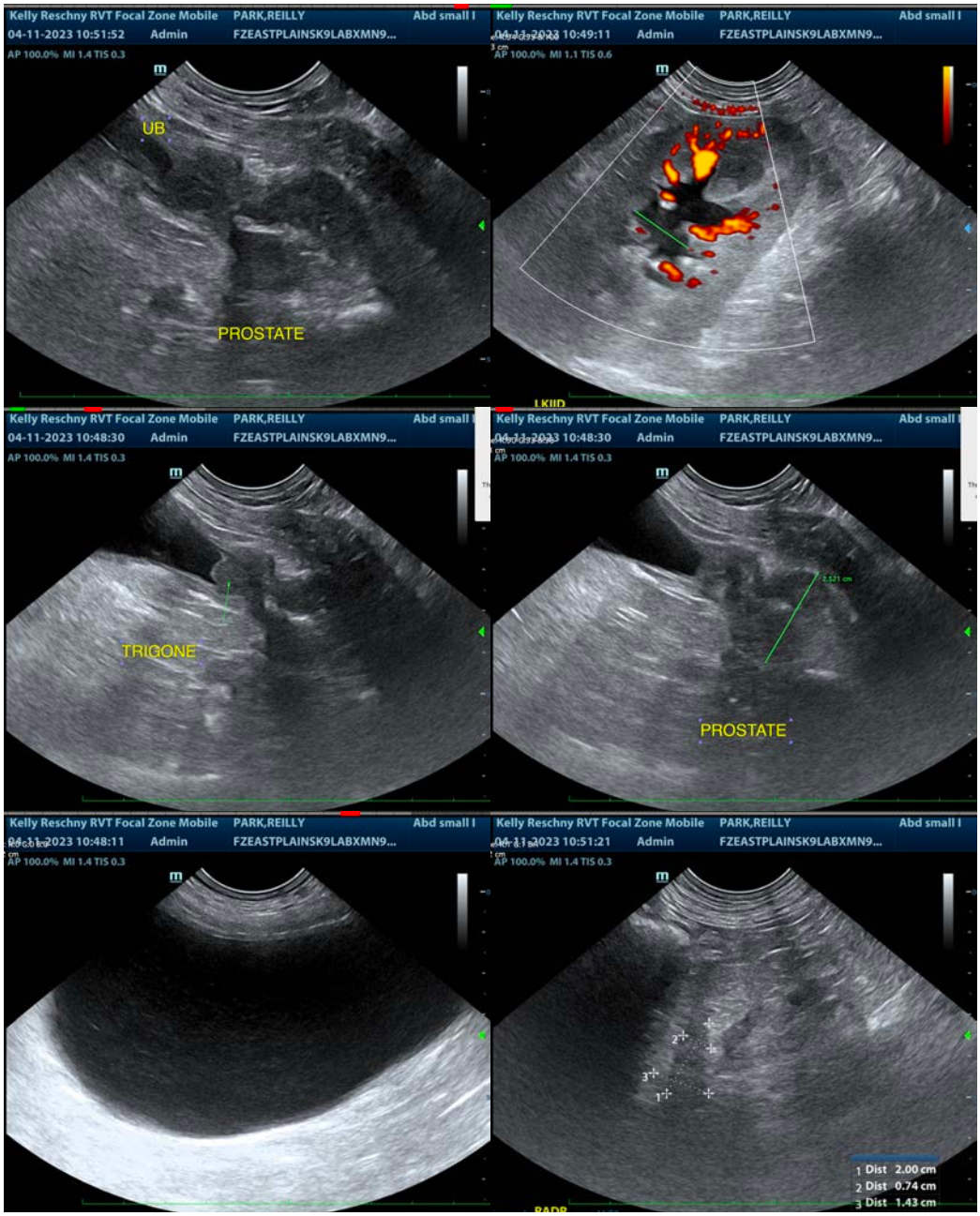

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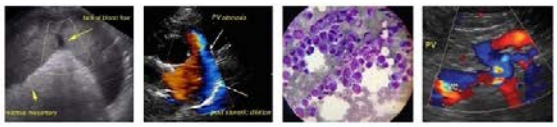

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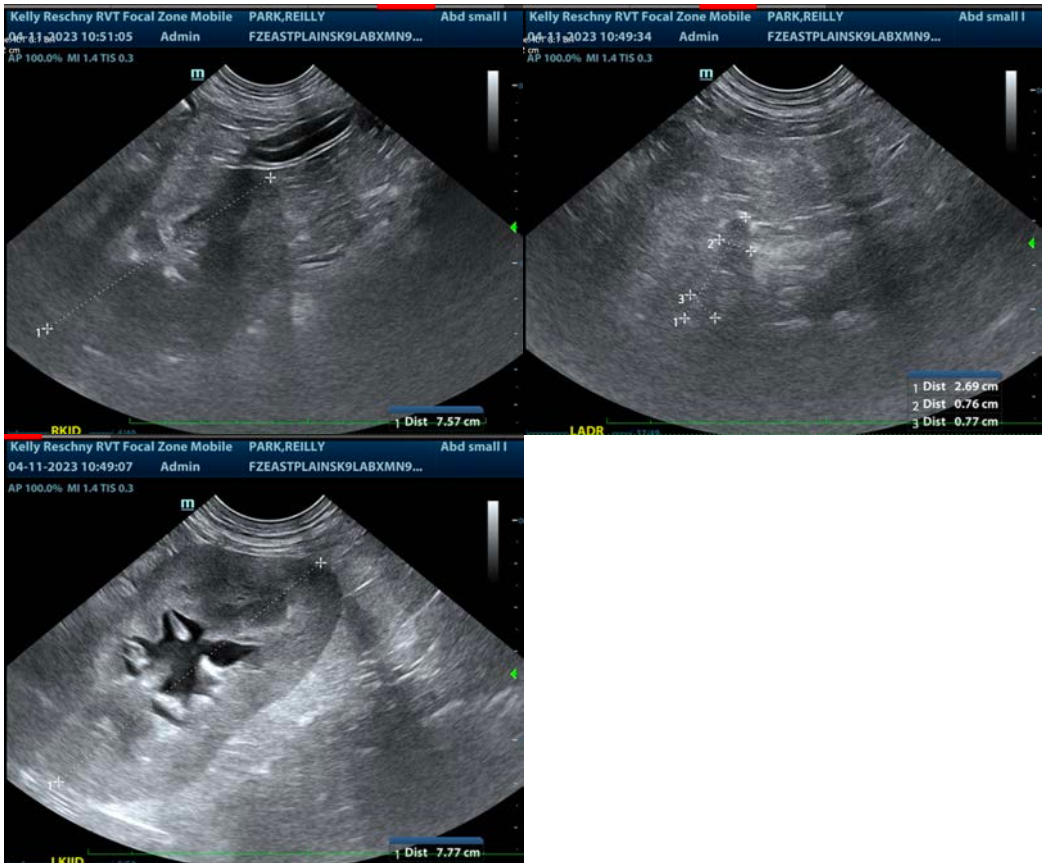

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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