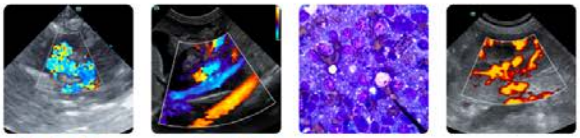


SonoPath www.animalsoundsnw.com info@animalsoundsnw.com 541.357.9423

PATIENT

Dexter Driskill

SPECIES

Canine

BREED

Heeler x

SEX

Neutered Male

AGE

7 Years

WEIGHT

27.7 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

VCA River Road

REFERRING VET

Dr. Wadford

INVOICE

74352

DATE

4/9/26

PRESENTING CLINICAL SIGNS

P presented on 3/14 for painful distended abdomen, and stranguria. Initial exam enlarged/painful prostate, no obvious pain/enlargement appreciated today (4/6). Sent home on Marbofloxacin, carprofen, gabapentin and bethanechol. Symptoms resolved and now have returned 2-3 weeks (approx 1 week after finishing initial meds). Today 4/6 - Painful distended bladder, removed 700mL via urinary catheter, P unable to urinate at home. Rectal palpation was non-painful and NSF, preputial/penile exam unremarkable.

ABNORMAL Labwork Values: 3/14: CBC/Chem NSF, UA w/culture: positive staph spp. Radiographs with and without contrast of the urinary bladder performed no uroliths observed. 4/6: CBC WNL/ Chem Mild post renal azotemia: BUN 47.5, cre 1.6, otherwise wnl. Thx/Abd rads unremarkable, advised abd U/s. Repeat UA/culture - sent out – pending.

Current Medications: Gabapentin - 200 mg TID, Prazosin - 1 mg TID, possible Bethanechol - 10 mg TID

Radiographic Findings: Antech Review

1. Unremarkable postprandial abdomen, a definitive cause for the signs is not seen.
2. Unremarkable thorax.
3. Multifocal chronic intervertebral disc disease.

Recommend an abdominal ultrasound for further evaluation of the urogenital tract.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended 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.

The prostate is largely normal for a neutered dog, measuring 1.0 cm wide in the sagittal view, with normal echotexture, echogenicity, symmetrical shape, etc. Having said that, there are some very subtle pinpoint mineral densities that appear within the parenchyma versus within the intraprostatic urethral lumen.

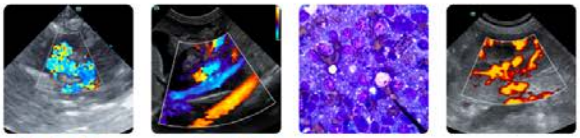
The right kidney is normal is size (5.77 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (5.88 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 right adrenal gland is normal in size (1.7 cm at cranial pole and 0.57 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.47 cm at cranial pole and 0.45 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.



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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

The visible stomach wall is normal in thickness 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. 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 pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

Medial iliac 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.

ULTRASONOGRAPHIC FINDINGS

- The prostatic changes are very mild/subtle, and the mineralization likely represents a chronic inflammatory change, normal aging variant versus other. Having said that, infiltrative neoplasia and associated mineralization can't be definitively ruled out.
- Mild reactive medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

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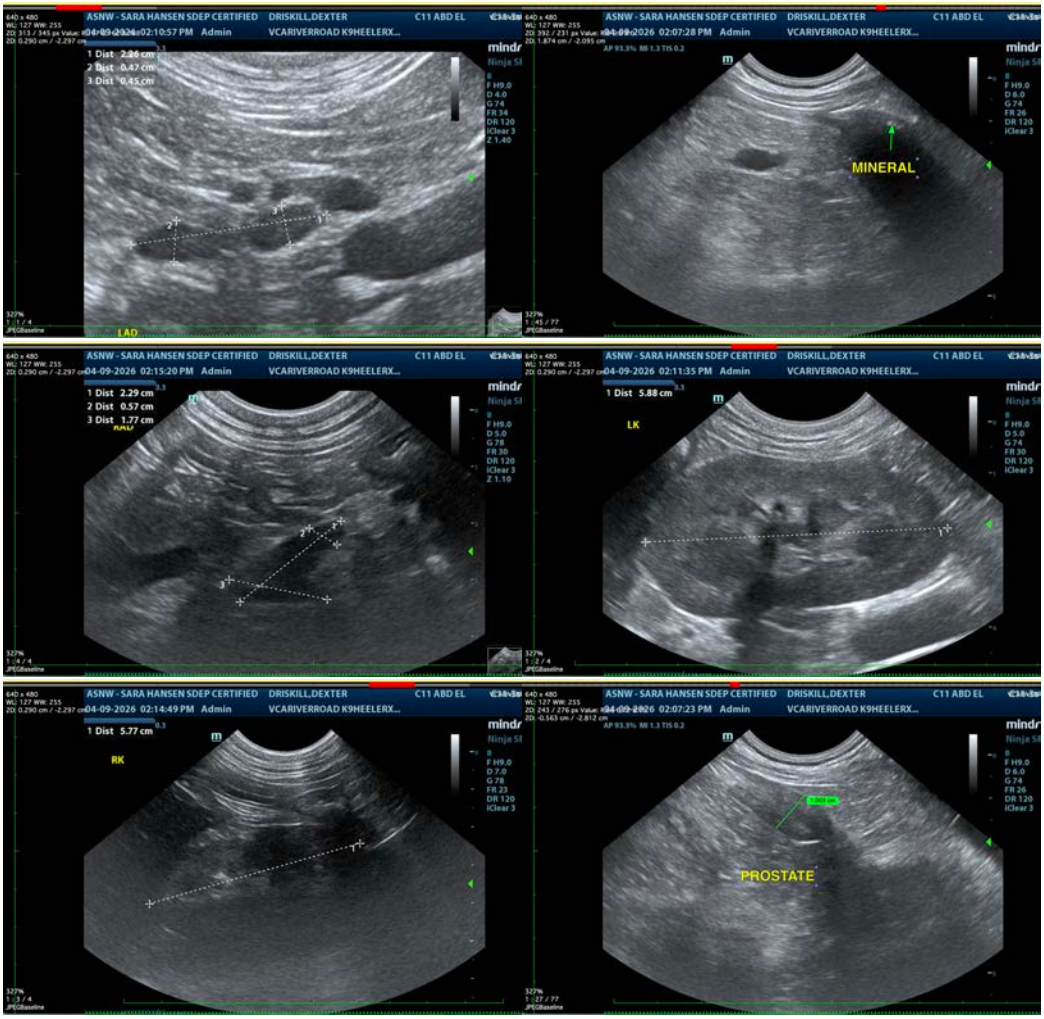
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If a urinary tract infection/bacterial prostatitis has been ruled out and clinical signs persist, submission of urine to look for BRAF gene mutation could be considered to more definitively investigate possible infiltrative uroepithelial neoplasia. Additionally, and/or alternatively, direct sampling of the prostate for cytology, culture and sensitivity, etc. could be considered if patient's coagulation status is appropriate.

Ultimately, advanced imaging, even cystoscopy, etc. and/or further neurologic evaluation for possible underlying causes of stranguria, etc. may be warranted.



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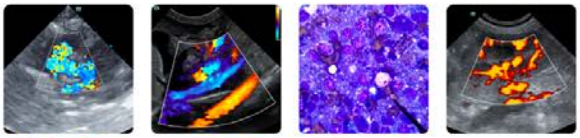

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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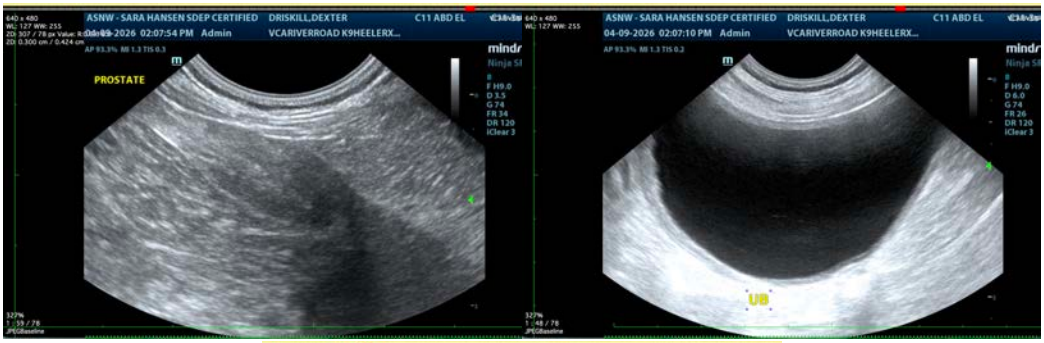

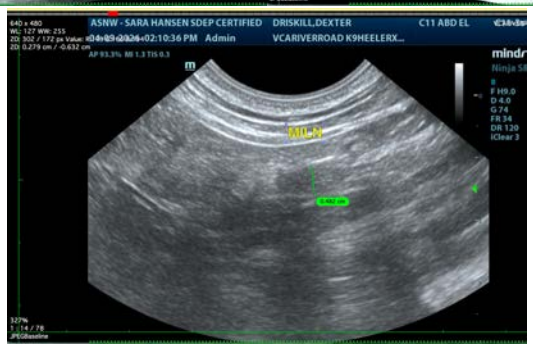

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com