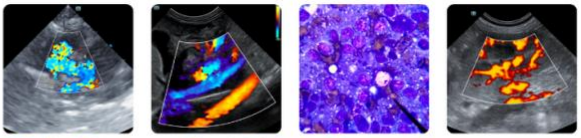


PATIENT

Darwin Van Atta

SPECIES

Canine

BREED

Maltese Mix

SEX

Neutered Male

AGE

10 Years 4 Months

WEIGHT

12.1 Pounds

INTERPRETED BY

Beth Johnson, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Vincent Ravancho, CVT

HOSPITAL NAME

Brenda King, VMD

REFERRING VET

Dr. King

INVOICE

37071

DATE

5/11/26

PRESENTING CLINICAL SIGNS

History: Enlarged prostate. Cysto urine to Antech, no growth on Culture.
Abnormal PE/Chem/CBC/UA Results: U/A - pH 8.5, protein 1+, Occult blood 2+, RBC 4-10

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

In the area of the prostate is an approximately 1.7 cm x 2.1 cm irregular hypoechoic mass lesion that appears to potentially extend into the trigone, where mineralization is noted. Otherwise, the urinary bladder is adequately distended with anechoic contents. The urinary bladder and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The left kidney measures 3.76 cm. The right kidney measures 4.03 cm.

Adrenal Glands

Left adrenal gland is normal in size (0.43 cm at cranial pole and 0.56 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is unable to be visualized in these images.

Spleen

Spleen is subjectively large in size with a swollen and scalloped/undulating capsular contour. Multifocal coalescing anechoic densities/cysts/nodules are noted throughout the parenchyma. Splenic vasculature appears normal. Enhanced hyperechoic surrounding fat is noted.

Liver

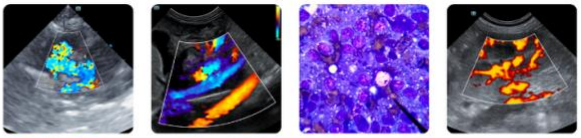
Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal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

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 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. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is mildly distended with



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echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is 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.

The medial iliac lymph node is 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.

Other

The visible heart base (RA) and pericardium are unremarkable without obvious pathology noted in these images at this time. If cardiac function evaluation is desired, a full echocardiogram is recommended.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The appearance of the prostate, especially if the mineralization is mineralized tissue, is most concerning for infiltrative neoplasia. Having said that, a chronic inflammatory but benign prostatitis with concurrent cystolithiasis, while thought less likely, can't be definitively ruled out.
- Aggressive medial iliac lymphadenopathy- concerning for infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.
- The appearance of the spleen is similarly concerning for infiltrative or potentially metastatic neoplastic disease, although benign cysts, hematomas, extra-medullary hematopoiesis, etc., can mimic that appearance and can't be ruled out without tissue sampling.

Secondary Findings

- Moderate age-related kidney changes

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/prostate cancer, could

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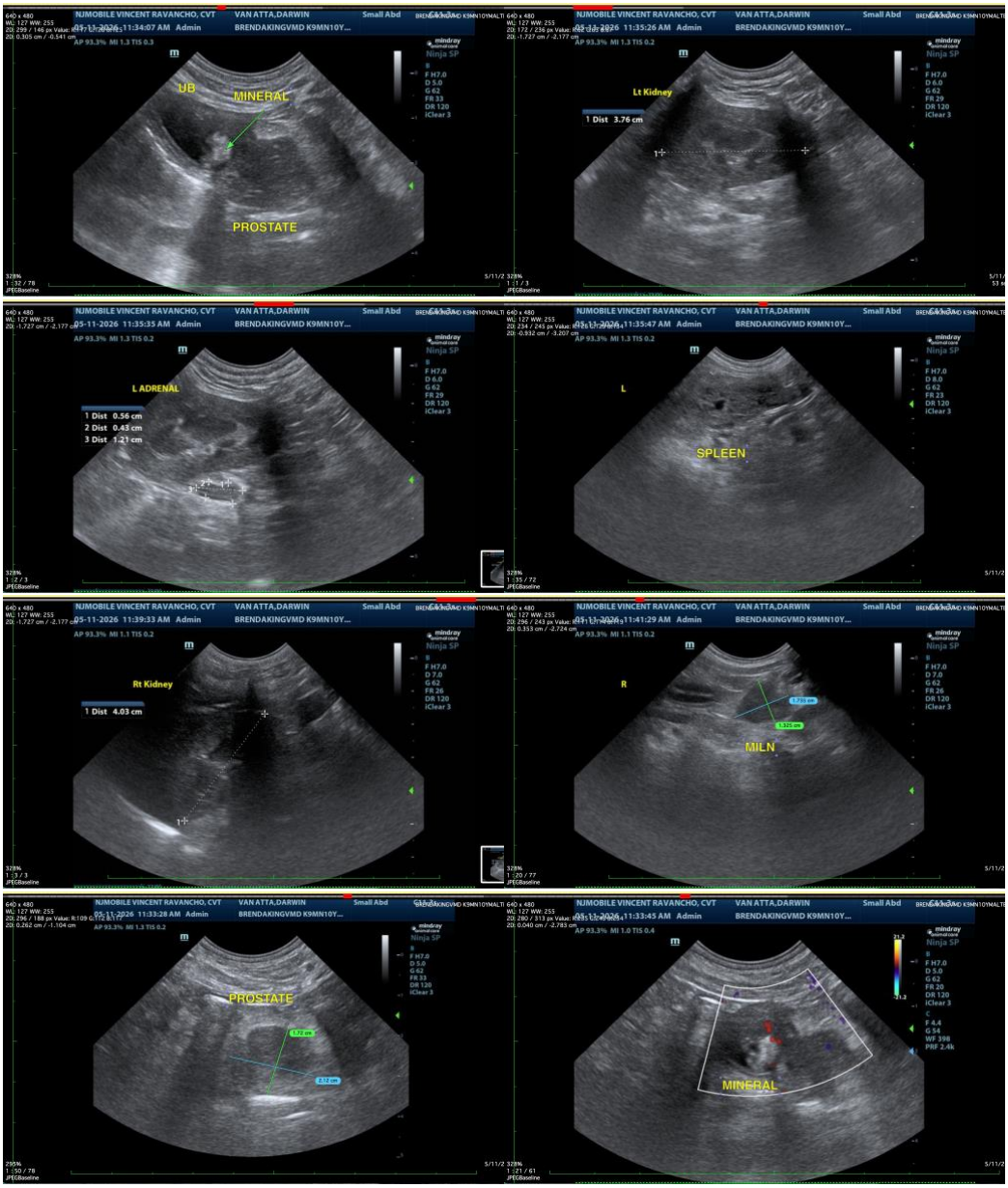
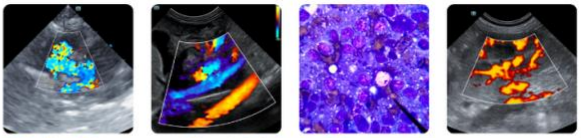
be considered. Other diagnostic options include traumatic catheterization, fine needle aspirate (with small risk of tumor seeding/trailing) or cystoscopy for further sampling. In the meantime, empirical therapy with a broad-spectrum antibiotic (or ideally an antibiotic based on culture and sensitivity results) as well as an anti-inflammatory (unless otherwise contraindicated based on patient co-morbidities) may begin to help alleviate clinical signs.

Additionally, fine needle aspirates of the enlarged lymph nodes +/- spleen could be considered if patient's coagulation status is appropriate.



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



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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