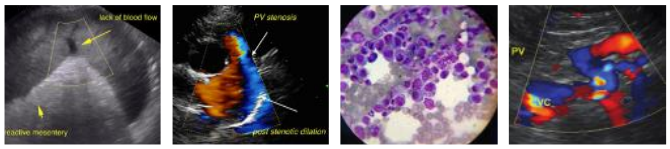
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Sven Gotch-Mitchell

SPECIES

Canine

BREED

Doberman

SEX

Intact Male

AGE

5

WEIGHT

38

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Evan Bell

HOSPITAL NAME

Cedarview AH

REFERRING VET

Evan Bell

INVOICE

23103

DATE

6/26/23

PRESENTING CLINICAL SIGNS

Recent history of hematuria. No history of stones, prostatitis, or trauma (but does play roughly with other dog). Urination will be red at the start, then normal yellow after, and odd drop of blood during the day. Being treated with thyrotabs for possible hypothyroidism - inconsistent thyroid levels in the past, low normal T4 and elevated TSH generally.

Abnormal PE/Chem/CBC/UA Results: BW - WNL History of low normal T4 and elevated TSH. USG 1.050 pH 7, WBC 10/hpf, RBC 10/hpf Radiograph - normal bladder, no visible stone noted in urethra or bladder, kidneys not included in study.

LIMITED ULTRASONOGRAPHIC EXAMINATION

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.

Prostate is symmetrically enlarged (6.9 cm wide) 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. The largest anechoic area/cyst measures approximately 1.0 cm in diameter. No mineral is noted.

Left kidney is normal in size (7.44 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. A hyperechoic band parallel to the corticomedullary border is present.

Right kidney is normal in size (7.87 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. A hyperechoic band parallel to the corticomedullary border is present.

ULTRASONOGRAPHIC FINDINGS

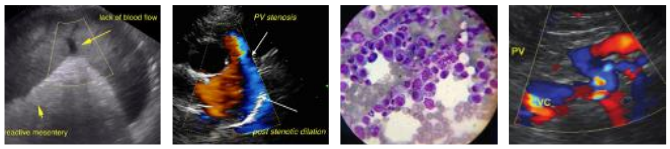
- Benign Prostatic Hyperplasia with cysts – Prostatic findings are most consistent with Benign Prostatic Hyperplasia (BPH) and concurrent benign prostatic cysts. Active prostatitis cannot be ruled out. Infiltrative neoplasia cannot be ruled out but is considered less likely.

- Medullary rim sign bilaterally - 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Just to definitively rule out a coagulopathy contributing to hematuria, full evaluation of this patients coagulation status, especially given the patients breed, is recommended.

Pending those results, the appearance of the prostate is more consistent with benign prostatic hyperplasia than an infiltrative or infectious prostatitis, however, prostatitis cannot be ruled out. Additional diagnostic recommendations could include urinalysis and urine culture, if indicated based on urinalysis results. Submission of urine to look for BRAF gene mutation, which is associated with



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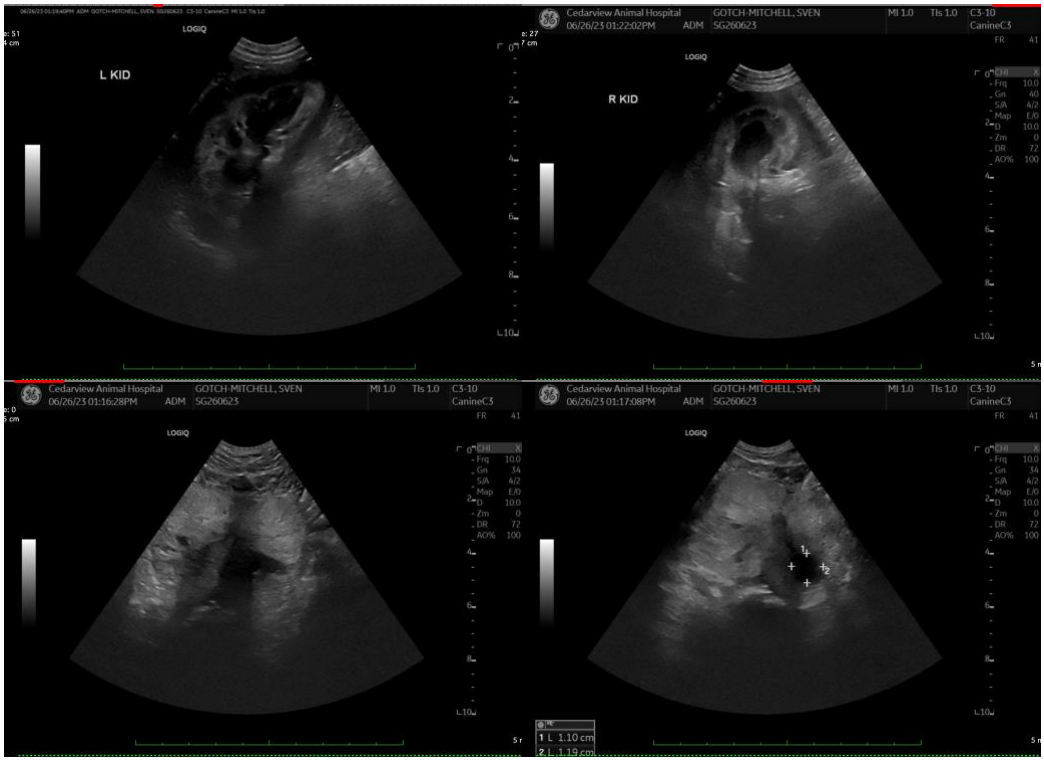
urinary bladder/prostate cancer, could be considered. Other diagnostic options include traumatic catheterization, fine needle aspirate (with small risk of tumor seeding/trailing) or cystoscopy for further sampling. In the meantime, empirical therapy with a broad-spectrum antibiotic (or ideally an antibiotic 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.

Assuming negative culture and negative BRAF, etc., ultimately, patient neutering is recommended to treat/prevent progression of suspected benign prostatic hyperplasia.



The information and recommendations provided are based on the images presented by the referring veterinarian. 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

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