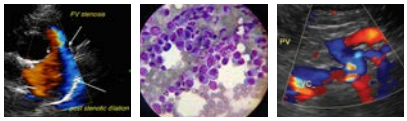
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

6/28/23

PATIENT

Sam Lucas

SPECIES

Canine

BREED

Bull Terrier

SEX

Neutered Male

AGE

6/21/13

WEIGHT

22.7 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

HOSPITAL NAME

Nexus Vet Specialists

REFERRING VET

Dr. Steele

INVOICE

43550

PRESENTING CLINICAL SIGNS

Balanoposthitis and paraphimosis. Owner first noted marked preputial discharge (purulent progressing to blood-tinged) and paraphimosis noted about an hour later. Seen at rDVM the following AM (6/13), paraphimosis and d/c had improved. Noted appearance of cellulitis of body wall dorsal to penis, penis diffusely hyperemic/irritated, flushed prepuce and fluid appeared cloudy, in house cytology reportedly inflammatory (neuts w/intracellular bacteria). Cefpodoxime prescribed. 6/15 re-presented and paraphimosis got worse, bulbus very enlarged and firm, no additional d/c. Rads--two small cystoliths, otherwise unremarkable. FNA of bulbus--marked hemorrhage but then bulbus reduced to normal in size, paraphimosis resolved (cytology inconclusive, mostly blood). Labs were unremarkable that day. Seen again 6/20 and bulbus was moderately enlarged again and firm but otherwise OK, no paraphimosis. Today on exam, no d/c, no paraphimosis, bulbus is moderately enlarged and somewhat firm but with a fluctuant quality. Exteriorized penis cranial to bulbus and it appeared WNL. Questionable mild preputial swelling surrounding bulbus. Not apparently painful.

Current Medications: Apoquel 16mg/day, Adequan 1.2mL monthly, Gabapentin 100mg BID, Galliprant 50mg/day, KanSix gentle pets (TCM) 4 daily, Simparica trio, Tacrolimus 0.02% BID OU, Vetriscience probiotic, Cefpodoxime.
Lab Results: Unremarkable labs 6/15 including PT/PTT.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic contents. No masses, inflammatory changes, or echogenic sediment are observed. A 0.89 cm shadowing cystolith is noted along the dependent wall. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal in size (6.54 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 (6.6 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 pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.55 cm at the cranial pole and 0.60 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 (0.58 cm at the cranial pole and 0.64 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. A 0.50 cm x 0.60 cm discrete hyperechoic nodule is noted in the deep left liver. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as 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.

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.

There are no appreciable abnormalities associated with the penis or prepuce examined in these images.

ULTRASONOGRAPHIC FINDINGS

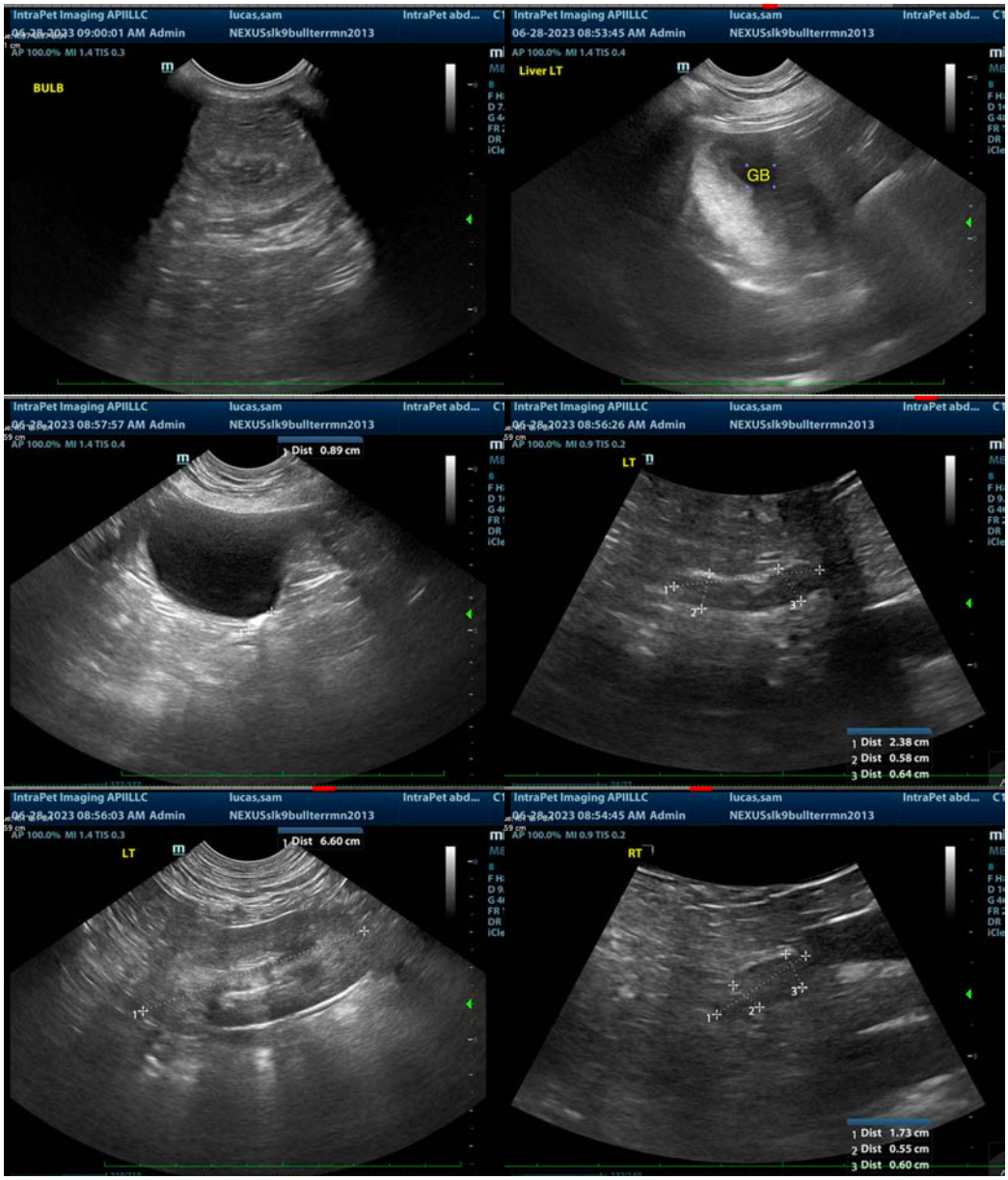
- Urinary bladder cystolith

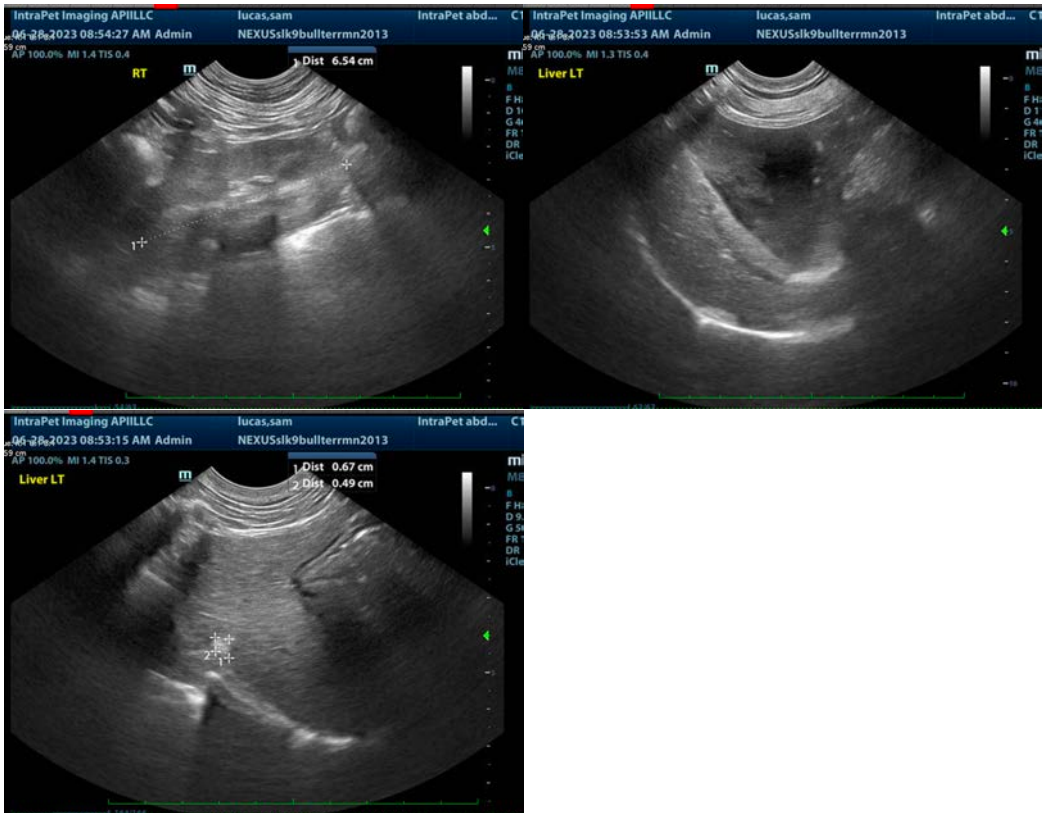
- Liver nodule- Differentials for a discrete liver nodule include primarily benign changes such as nodular hyperplasia, fibrosis of an old hematoma, granuloma, myelolipoma, etc.; however, while considered less likely, primary hepatic neoplasia, infiltrative round cell neoplasia and metastatic disease can mimic benign lesions and cannot be definitively ruled out.

- Moderate gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations regarding this exam will be implemented by Dr. Cara Steele.





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
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