



PATIENT

Otis Morshead

SPECIES

Canine

BREED

Chihuahua

SEX

Neutered Male

AGE

3 Years

WEIGHT

13.5 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Erica Harmon

HOSPITAL NAME

Willamette VH

REFERRING VET

Dr. Erica Harmon

INVOICE

39734

DATE

7/22/22

PRESENTING CLINICAL SIGNS

P presented 7/20 PM for pain from an unknown origin, intermittent yelping, pain not isolated in exam, no obvious spinal or cervical pain or abdominal pain, p yelps with rectal exam and rectal temp but unsure if actual pain or temperament. P has HX of blood at prepuce roughly 1-2 months ago, UA performed at that time, unremarkable, rDVM worried about poss prostate enlargement at that time. Prostate normal on PE 7/20 pm, seen at rDVM 7/21, poss prostate pain at that time. Full abdominal u/s to look for cause for possible pain. Last ate at 6pm prior to u/s. 3 view whole body rads on 7/20 pm unremarkable, CBC/CHEM 10/EPOC 7/20 pm all unremarkable

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately 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 mildly enlarged (1.5 cm thick). Parenchyma is diffusely homogenous and relatively hyperechoic. Normal distinct margins and symmetrical bilobed shape are maintained. This finding could very well be normal patient variant, especially if patient was neutered later than puppyhood; however, if patient was neutered as a puppy, prostatitis or, less likely, infiltrative neoplasia cannot be ruled out. This finding should be interpreted in combination with clinical signs, urinalysis results, etc. and either further investigated or monitored, as indicated.

The right kidney is normal in size (4.2 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.

The left kidney is normal in size (4.2 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.

Adrenal Glands

The right adrenal gland is unable to be well visualized in these images.

The left adrenal gland is normal in size (0.51 cm), 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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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. 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 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

- **Mild prostatomegaly** – could very well be normal patient variant. However, in the face of clinical signs such as the previously reported blood from the prepuce and/or the more recently reported prostate pain, prostatitis or much less likely infiltrative neoplasia cannot be ruled out.
- **Bilateral medullary rim sign** - 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

Recommendations include:

- Urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.
- If this patient has battled prostatitis, especially bacterial, discospondylitis could be considered as a cause of the non-specific pain response. Therefore, if specific spinal pain cannot be located and/or discospondylitis cannot be diagnosed, empirical broad-spectrum antibiotics as well as symptomatic supportive care for possible spinal pain in the form of anti-inflammatories or even steroids (if not contraindicated based on other patient factors) +/- muscle relaxers, etc. could be considered with monitoring for improvement.



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- Additionally, consultation with a neurologist for possible advanced imaging such as MRI could be considered.

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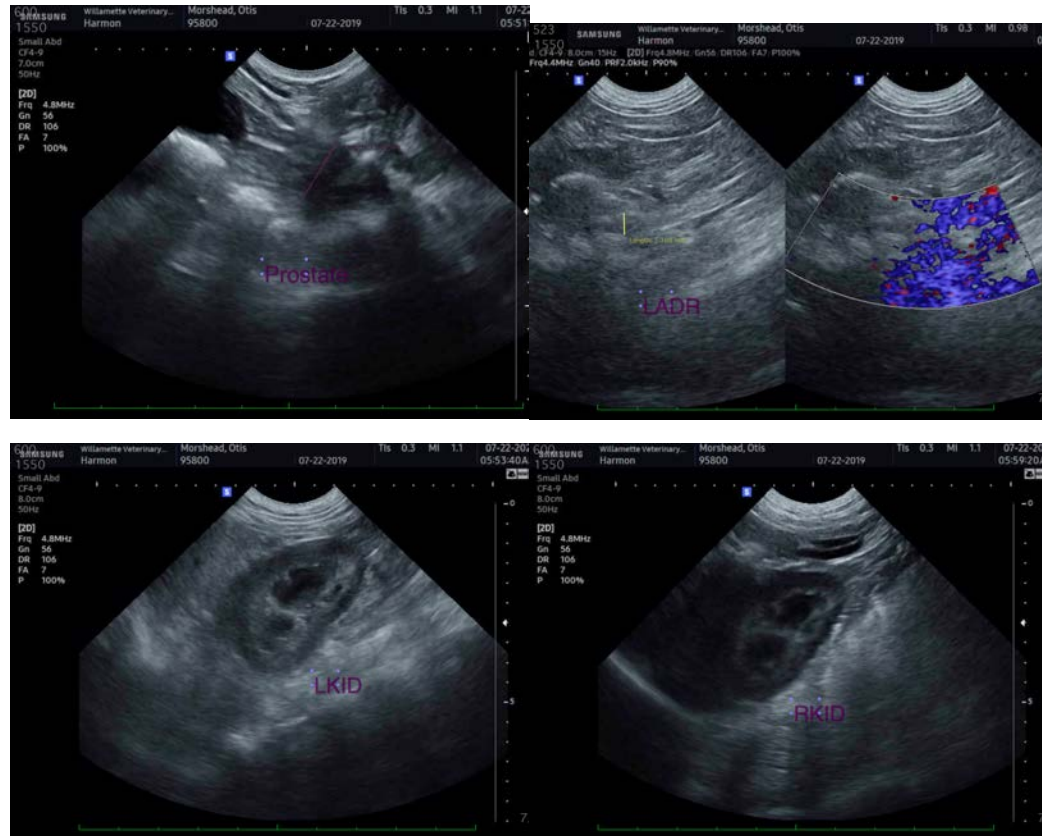
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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