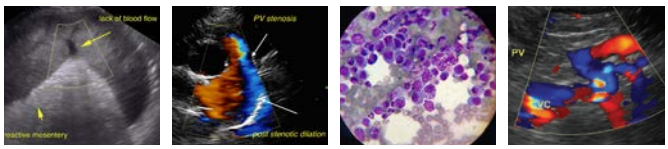
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Bear Wood

SPECIES
Canine

BREED
Lab X

SEX
Intact Male

AGE
12 Years

WEIGHT
79.8 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Harold Mike Beard

HOSPITAL NAME
Animal Care Vet Center

REFERRING VET
Dr. Harold Mike Beard

INVOICE
39209

DATE
7/6/22

PRESENTING CLINICAL SIGNS

Diagnosed with prostatitis one year ago. Has a pendulous abdomen. Has arthritis in back and hips. Abnormal PE/Chem/CBC/UA Results: CBC normal. Chemistry normal. UA dilute urine, protein. Survey radiographs do reveal an enlarged prostate gland and a interstitial pattern in the lungs. Heart appears normal size radiographically, no murmur.

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.

The prostate is symmetrically enlarged 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. No mineral is noted.

The right kidney is normal in size (7.1 cm) 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 echogenicity and mild loss of corticomedullary distinction. Mild pyelectasia is noted. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted.

The left kidney is normal in size (5.8 cm) 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 echogenicity and mild loss of corticomedullary distinction. Mild pyelectasia is noted. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted.

Adrenal Glands

The left adrenal gland is enlarged in size (1.2 cm at the cranial pole and 1.2 cm at the caudal pole). Normal shape and contour are maintained. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The cranial pole of the right adrenal gland cannot be well visualized in these images. The caudal pole is enlarged at 0.64 cm. Normal shape and contour are maintained. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

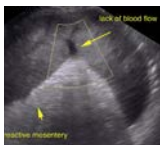
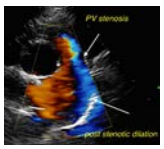
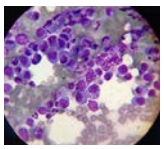
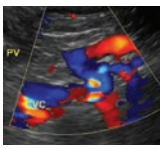
Spleen

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 enlarged with mildly irregular margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

GB contains a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

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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 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 (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.

PRIMARY FINDINGS

- Bilateral adrenomegaly – consistent with adrenal hyperplasia secondary to pituitary depending hyperadrenocorticism vs normal variant. **The cranial pole of the right adrenal gland was not visualized.
- Heterogenous Liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- 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.
- Benign prostatic hyperplasia with cysts – Prostatic findings are most consistent with benign prostatic hyperplasia and concurrent benign prostatic cysts.

SECONDARY FINDINGS

- Age related kidney change – This finding is expected/consistent with age-related mild degenerative disease and should be interpreted clinically in combination with laboratory changes.
- Bilateral pyelectasia and non-obstructive dystrophic mineralization –Differentials for pyelectasia include pyelonephritis, diuresis, congenital malformation or ureteral or lower urinary tract obstruction.

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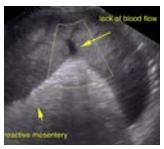
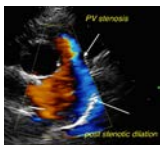
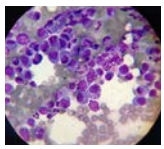
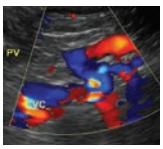

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The prostatic changes in these images are most consistent with benign prostatic hyperplasia and should be interpreted in combination with any clinical signs of lower urinary tract disease, infection, etc. Given this patient's reported potbellied appearance and dilute urine combined with the ultrasound images in this study, hyperadrenocorticism is possible.

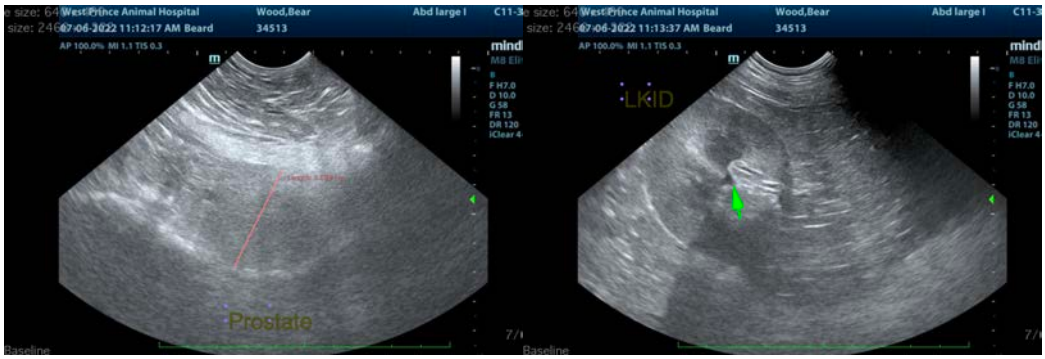
The described adrenal gland, liver and gallbladder changes are all suggestive of hyperadrenocorticism. If clinical signs of hyperadrenocorticism, such as polyuria, polydipsia, polyphagia, panting, hair loss, hypertension, etc. are present, testing for hyperadrenocorticism with a LDDS test is warranted. If a LDDS test has been evaluated with a normal result, investigation of possible atypical hyperadrenocorticism with a full ACTH stimulation adrenal panel to the University of Tennessee could be considered.

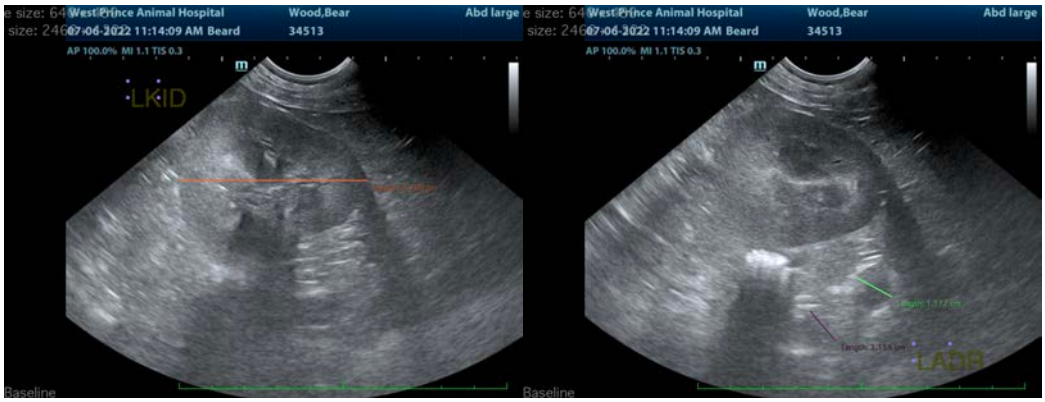
If clinicals signs are not present, monitoring is recommended with testing pursued when/if clinical signs develop.

If not recently evaluated, blood pressure is recommended.

If not recently evaluated, a urinalysis and, if indicated based on urinalysis results, urine culture are also recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

Images of full right adrenal gland would be good since we suspect hyperadrenocorticism.





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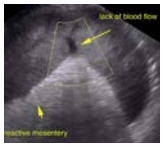
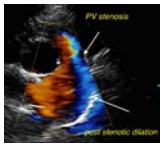
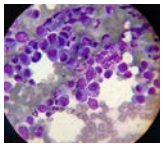
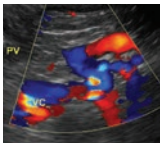

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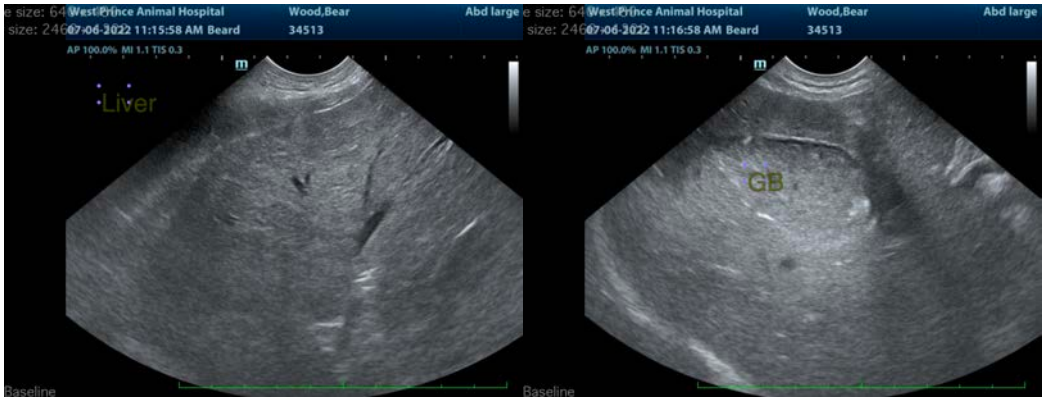

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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