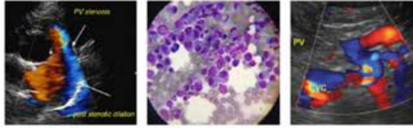
IMAGING PERFORMED BY

SVS Mobile Imaging MI 734 - 637 - 7711
svsimagingmi@gmail.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT
Emmett Arab

SPECIES
Canine

BREED
Siberian Husky

SEX
Neutered Male

AGE
7.5 Years

WEIGHT
83.6 Pounds

INTERPRETED BY
Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY
Amy Mayhew, LVT

HOSPITAL NAME
SVS Imaging MI

REFERRING VET
Dr. Kelly Totin

INVOICE
43844

DATE
7/6/23

PRESENTING CLINICAL SIGNS

Dribbling urine and isosthenuria

Abnormal PE/Chem/CBC/UA Results: USG 1.007 Hx of hematuria no true infection noted. Rads shows no uroliths Enlarged prostate 3 weeks prior with resolution on Baytril, no improvement on dribbling.

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 (2.03 cm wide). Parenchyma is diffusely homogenous and relatively hyperechoic. Normal distinct margins and symmetrical bilobed shape are maintained. This finding is likely normal patient variant, especially if patient was neutered as an adult; 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 (7.18 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 (7.77 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 (0.68 cm at the cranial pole and 0.60 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

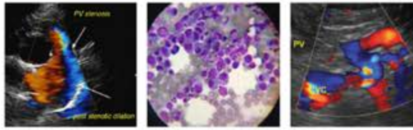
The left adrenal gland is normal in size (0.49 cm at the cranial pole and 0.49 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

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). A 0.80 cm in diameter non-capsule disrupting hypo- to anechoic nodule is noted in the mid body. 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.



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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.

PRIMARY FINDINGS

- Mild prostatomegaly – likely normal patient variant for this dog. However, given the history, residual prostatitis cannot be definitively ruled out and should be suspected in the face of ongoing supportive clinical signs.

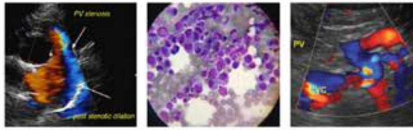
- Moderate gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted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

SECONDARY FINDINGS

- Hypo to anechoic splenic nodule – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's dilute urine, the dribbling may be secondary to polyuria/polydipsia, potentially subclinical polyuria/polydipsia, and could be still related to a chronic smoldering or non-fully resolved bacterial prostatitis, given this patient's history. A fine needle aspirate of the prostate could be considered if patient's coagulation status is appropriate. Alternatively, a prostatic wash could be considered, or even ultimately cystoscopy could be considered if urine dribbling persists.



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If further diagnostics are not elected at this time, especially if patient's clinical signs resolved while recently on antibiotics, restarting antibiotics and potentially treating for a slightly longer course could be considered.

Beyond that, further investigation of other possible causes for urine dribbling including spinal/neurologic disease, orthopedic problems, etc., especially given this patient's concurrent reported intermittent pain, is recommended.

Liver Rt Sag

Rt Adrenal

Right Kidney

Spleen Head

Lt Adrenal

Left kidney

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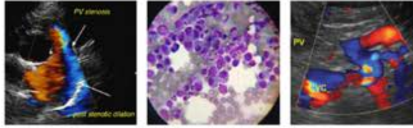

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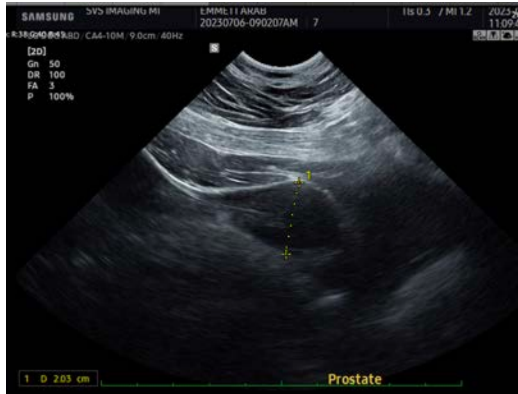

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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