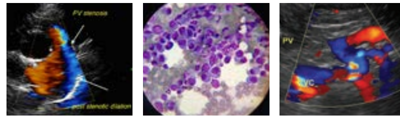
IMAGING PERFORMED BY

IntraPet.com



SonoPath

Clinical Sonography & Telecytology

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DATE

8/23/23

PATIENT

Stevie Laurie

SPECIES

Canine

BREED

Labrador X

SEX

Neutered Male

AGE

12/14/11

WEIGHT

47.6 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

HOSPITAL NAME

Everhart Vet Hospital
Cross Keys

REFERRING VET

Dr. Notarangelo

INVOICE

44887

PRESENTING CLINICAL SIGNS

8 week history of hematuria and dribbling bloody fluid, seen as new client. AFAST bladder initially very inflamed with debris/clot/pus seen, cystocentesis urine revealed infection, responded to antibiotics but owner noted relapse after meds discontinued, repeat urine was improved and cultured negative but signs have persisted. Most recent recheck 8/17, discovered large, cystic-appearing prostate. Urine from bladder normal in color but leaking brownish red fluid. Culture is pending from cystocentesis

Current Medications: Carprofen 75mg tablet 8/17/2023, Enrofloxacin 136mg tablet 8/17/2023, Trazodone HCl 100mg tablet 8/17/2023, Clavacillin 375mg tablet 7/25/2023, Proviable Forte Med/Large 7/19/2023 Cefpodoxime 100mg tablet 6/22/2023
Lab Results: 8/17/23 AFAST bladder: no obvious mass/clot but enlarged cystic prostate, urine/culture pending. 7/19/23: pH8.5, SG 1.031, pro 2+, blood 4-10, culture negative. 6/22/23: WBC 21.7 K, neu 17K, UA SG 1.046, pH 9, pro 3+, WBC 11-20, cocci <10
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended.

The prostate is primarily symmetrically enlarged, measuring 3.97 cm wide with predominantly smooth margins that maintain differentiation from surrounding tissue. Parenchyma is markedly heterogeneous with multifocal mineral densities and several anechoic areas.

The right kidney is normal in size (6.22 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 (6.46 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 (0.66 cm at the cranial pole and 0.63 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 (0.66 cm at the cranial pole and 0.66 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. 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.

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.

The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

- Heterogeneous, mineralized, cystic prostatomegaly – This could represent an ongoing or potentially resolving prostatitis, given this patient's reported history. Having said that, especially given the mineralization, infiltrative neoplasia cannot be definitively ruled out.

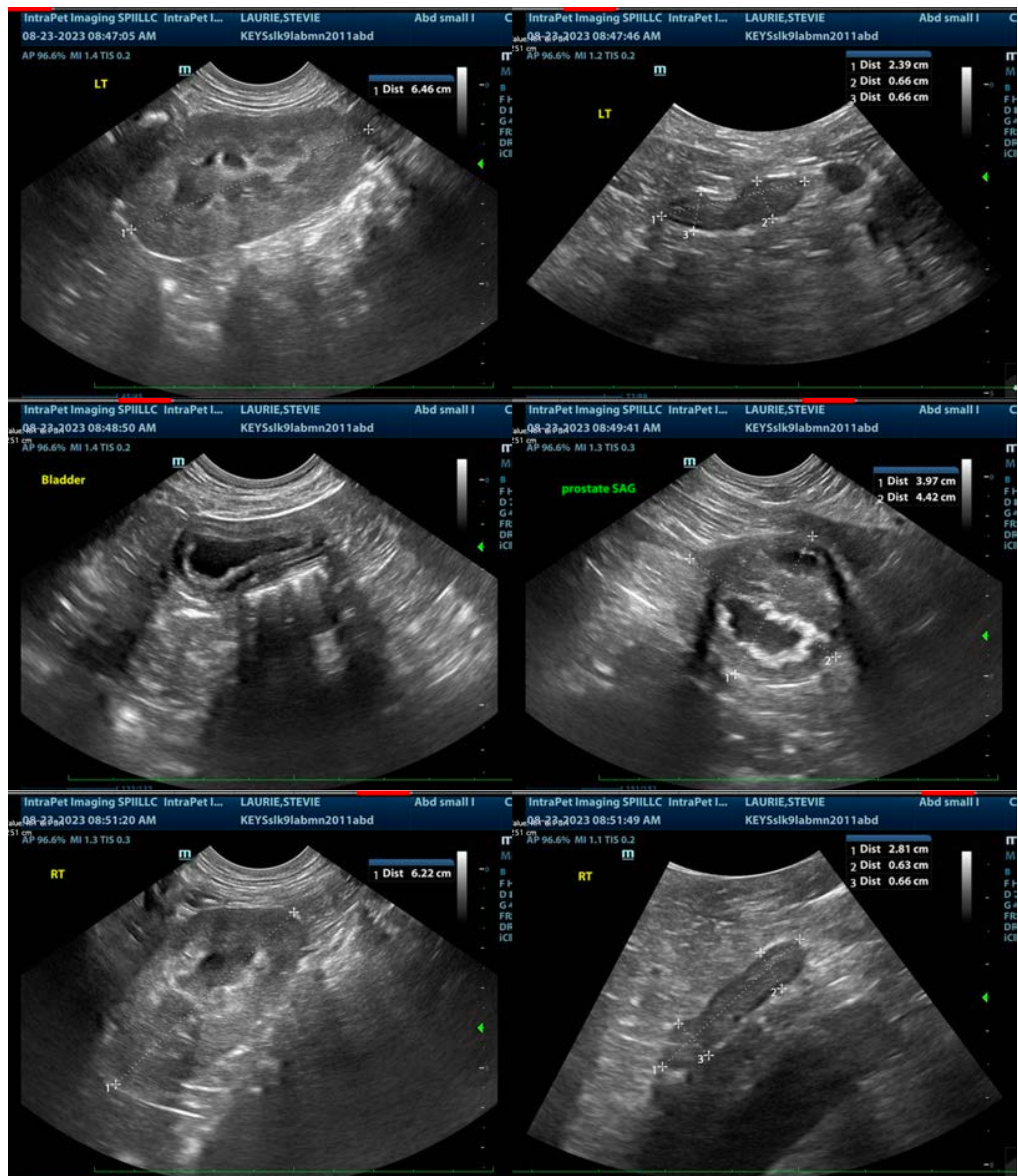
- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

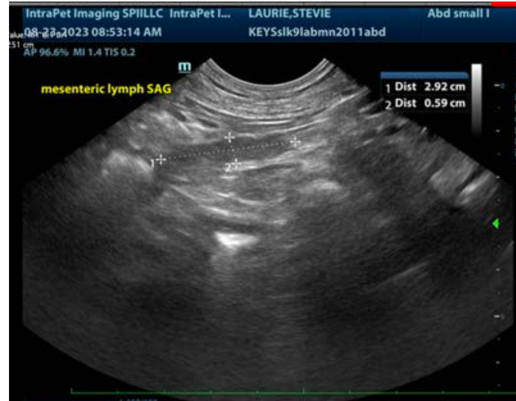
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Submission of urine to look for BRAF gene mutation which is associated with urinary bladder/prostate cancer is recommended.

Additionally, pending results, other diagnostic options include a fine needle aspirate of the prostate with small risk of tumor seeding/trailing if this neoplasia, for both cytology as well as culture and sensitivity in case this patient's ongoing clinical signs are related to an ongoing prostatic infection without a representative sample able to be obtained via cystocentesis, and therefore resulting "false negative" results.





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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