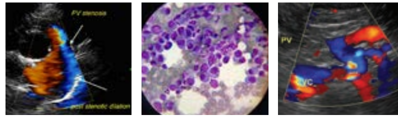


DATE
8/2422

PATIENT
Ernie Bay

SPECIES
Canine

BREED
Labradoodle

SEX
Intact Male

AGE
3/25/15

WEIGHT
30.4 Pounds

INTERPRETED BY
Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY
Rachel Brilhart RDMS

HOSPITAL NAME
Frederick Road VH

REFERRING VET
Dr. Beyer

INVOICE
40708

PRESENTING CLINICAL SIGNS

Approx. 6-8 month history of episodes where Ernie will collapse in his rear limbs, cower, shake and become very /anxious/clingy. These episodes last less than a minute, and after, he will return to his normal self. There have been 3 witnessed episodes over the past 6 months.
Went to neurologist-open diagnosis-partial seizures vs cardiovascular. No MRI performed. Breeding dog one of puppies diagnosed with addisons couple episodes of hematuria-unknown cause (trauma after breeding vs prostate vs UTI (negative) vs other) subjectively has hypoechoic area on prostate with in-house u/s

Current Medications: None other than flea/tick/hwp. Gabapenton PO prior to scan.
Lab Results: Most recent BW 5/2022: mildly low cholesterol 111 (131-345), resting cortisol 2.4. USG 1.013 (owner supposed to drop off first am urine for USG), in-house urine culture negative.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

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 symmetrically enlarged (4.78 cm thick) with smooth margins that are well differentiated from surrounding tissue. Normal bilobed shape is maintained. Parenchyma is heterogenous with scattered hyperechoic foci present. No mineral or cysts are noted.

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 (6.1 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 (2.3 cm long x 0.73 cm at the cranial pole and 0.69 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 (2.0 cm long x 0.67 cm at the cranial pole and 0.52 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. A non-capsule disrupting hyperechoic nodule is noted in the caudal pole of the left adrenal gland. 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 1.0 cm round, mixed, primarily hypoechoic nodule is noted near the tail of the spleen. 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 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 (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 and sublumbar 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

- **Benign Prostatic Hyperplasia –** Prostatic findings are most consistent with Benign Prostatic Hyperplasia (BPH) and hyperechoic foci consistent with increased vascularity and fibrosis often associated with BPH. Active prostatitis cannot be ruled out. Infiltrative neoplasia cannot be ruled out but is considered less likely.

- **Hyperechoic adrenal nodule (left adrenal gland) –** Differentials include primary adrenal cortical adenoma or adenocarcinoma, pheochromocytoma, myelolipoma, adrenal hyperplasia secondary to pituitary disease or metastatic disease. Ultrasound alone cannot differentiate between functional and non-functional nodules and/or between benign and malignant disease. Small nodules without other evidence of abdominal disease (to suggest metastatic disease) and/or clinical signs (to suggest adrenal disease) are most often incidental and should be monitored.

- **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.

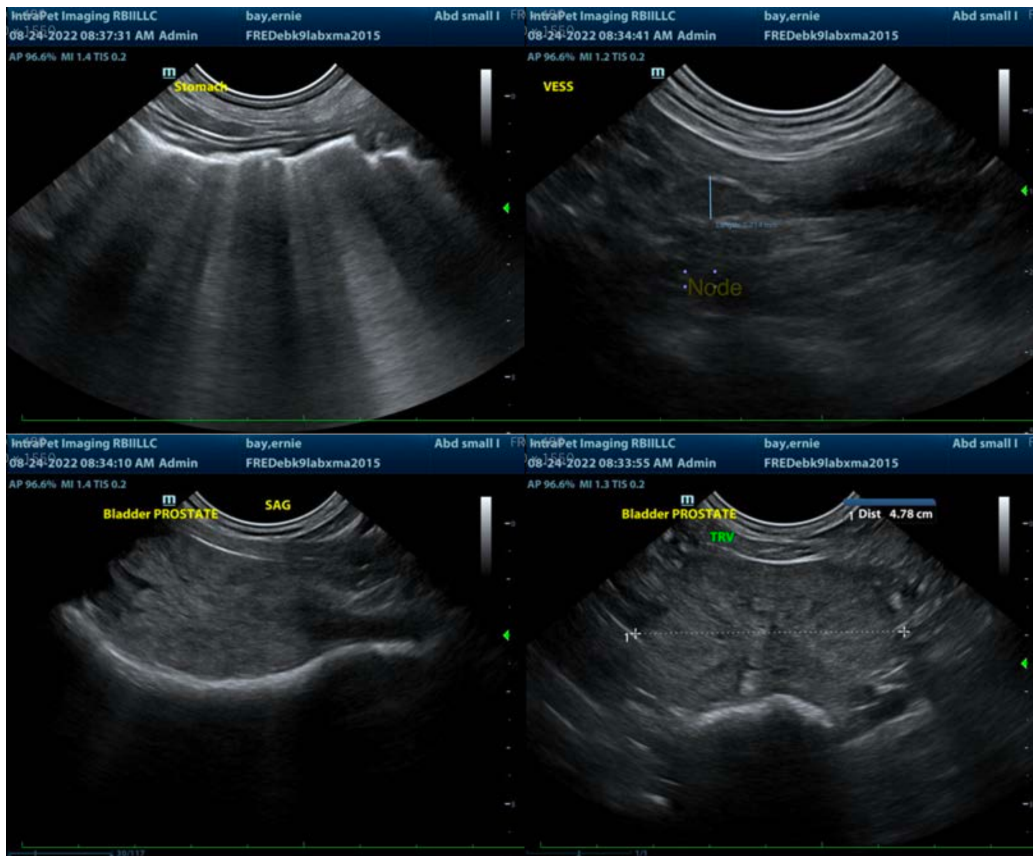
- **Reactive mesenteric and sublumbar lymph nodes –** infiltrative neoplastic disease cannot be ruled out but is considered less likely.

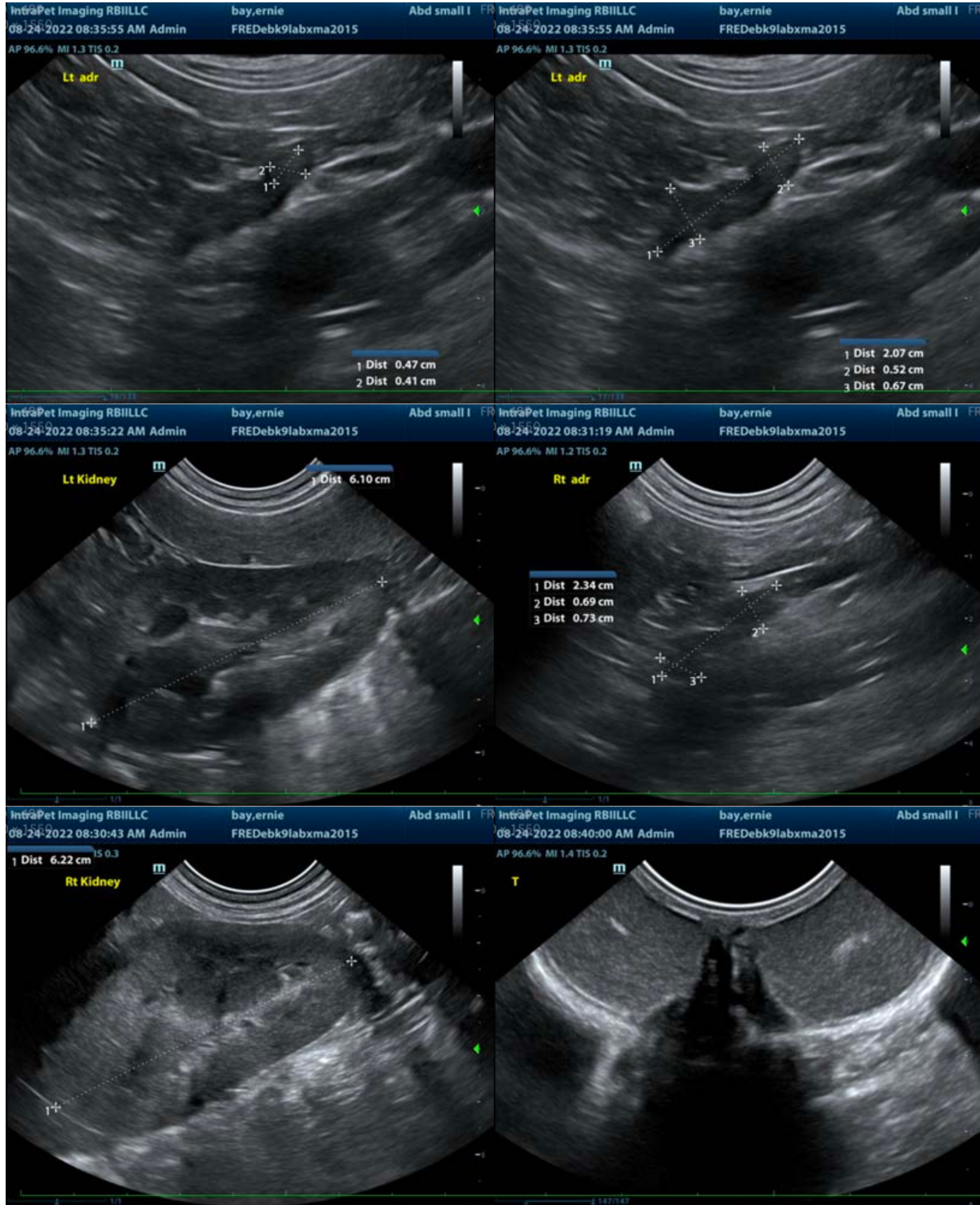
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no obvious ultrasonographically visible explanation for this patient's collapse/neurologic activity. The adrenal nodule is likely an incidental finding. However, a blood pressure is recommended if not recently evaluated, given the history of episodes. A fine needle aspirate of the splenic nodule could be considered if patient's coagulation status is appropriate. However, the appearance trends towards the benign, and monitoring for progression is also a reasonable approach.

This patient's reported intermittent hematuria is likely secondary to benign prostatic hyperplasia, possibly prostatitis, and given his concurrent medical condition, neutering is recommended if possible.

An echocardiogram/cardiac evaluation could be considered to rule out syncopal events. However, if not, further evaluation with the neurologists with this new information is recommended to guide advanced imaging such as MRI versus treatment of the episodes.

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Lt adr
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2 Dist 0.41 cm
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2 Dist 0.52 cm
3 Dist 0.67 cm
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3 Dist 0.73 cm
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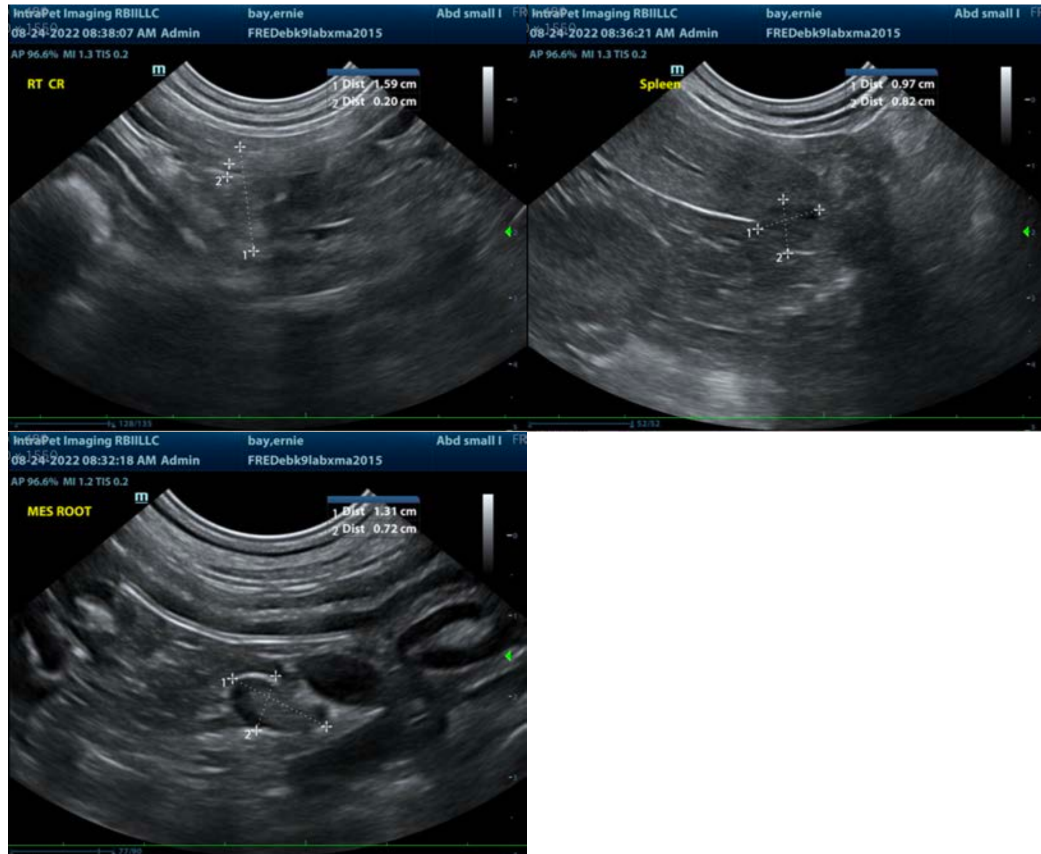

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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