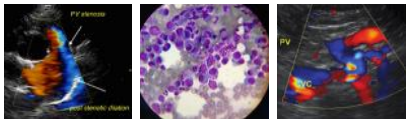
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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**DATE**
12/2/22

**PATIENT**
Finn Dettman

**SPECIES**
Canine

**BREED**
Weimeraner

**SEX**
Intact Male

**AGE**
7/7/12

**WEIGHT**
94 Pounds

**INTERPRETED BY**
Eric Lindquist, DMV
DABVP, Cert. IVUSS

**HOSPITAL NAME**
Bel Air VH

**REFERRING VET**
Dr. Schmidt

**INVOICE**
18947

## PRESENTING CLINICAL SIGNS

History: Mild degenerative valve disease, Stage B1, Mild mitral valve regurgitation causing murmur. High normal Heart size w/ low normal heart muscle function. Ventricular arrhythmia. Grade 1/6 Left apical systolic murmur, regular rhythm with premature beats.

Current Medications: Trazadone 150mg Give 1-2hrs prior to US, No heart meds Rx'd
Lab Results: Echo - No cardio tumors or other structural heart disease noted to cause arrhythmia
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Oral trazadone.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized, and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal.

The **prostate** was uniformly enlarged (6.0 cm) with lobar swelling appeared to impinge upon the urethra and mildly deviate the descending colon. The prostatic tissue was hyperechoic containing focal areas of decreased echogenicity. These changes are suggestive of either chronic inflammatory episodes, benign cystic pathology or both. Underlying neoplasia cannot be completely ruled-out but is lower on the differential list. This presentation is most consistent with benign prostatic hyperplasia with possible active prostatitis. Neutering or off-label Finasteride (Propecia) (0.1-0.5 mg/kg Sid) treatment is indicated +/- FNA or prostatic wash cytology and culture. This is a moderate to severe change.

A hypoechoic nodule was noted in the **right testicle**, measuring 4.0 mm. The left testicle was uniform. The epididymides were unremarkable.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some minor age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The right kidney measured 8.2 cm. The left kidney measured 8.95 cm.

### *Adrenal Glands*

The **right adrenal gland** revealed a hypoechoic expansive nodule at the cranial pole, measuring1.64 cm x 1.45 cm. The right adrenal gland measured 3.38 cm x 1.56 cm at the cranial pole and 0.9 cm at the caudal pole.

The **left adrenal gland** measured the upper limits of normal size, slightly enlarged at the caudal pole, measuring 3.69 cm x 1.15 cm at the caudal pole and 0.68 cm at the cranial pole.

### *Spleen*

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

### *Liver*

The **liver** was uniformly swollen with minor, excessive gallbladder debris and over distension with dependent and suspended bile without evidence of overt mucocele formation. However, excessive sludge was present. The liver presented coarse architecture with mildly increased portal markings and subtle, mixed echogenic changes. This is consistent with vacuolar hepatopathy and some level of remodeling and history of inflammatory component. There was no overt suspicion of neoplasia.

### *Gastrointestinal*

There was some residual chyme and gas was noted in the **stomach**, yet not pathological. This is consistent with end post prandial presentation. Transit of chyme into the small intestine was normal. Curvilinear patterns were maintained throughout the GI tract. No evidence of pathology. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

### *Pancreas*

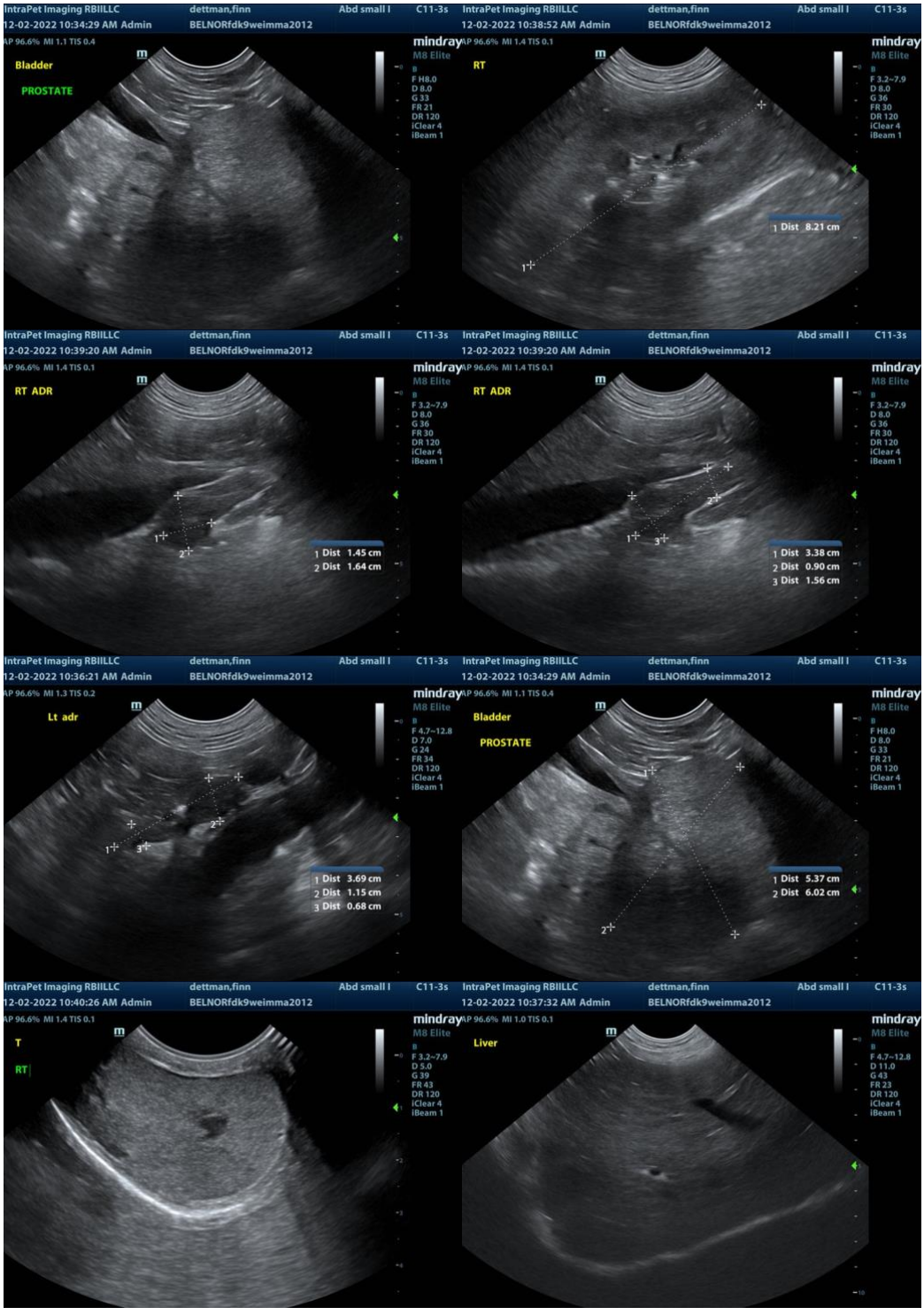
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

## ULTRASONOGRAPHIC FINDINGS

- Moderate BPH prostate
- Right testicular nodule, subjectively benign
- Right adrenal nodule and swollen irregular left adrenal gland
- Hepatopathy
- Age-related renal changes
- Partially full stomach

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Neutering would be ideal in this patient, however, if this is not an option and an alternative protocol could be considered. Finasteride at 1 mg/kg/day can be utilized as an off-label approach to reducing prostatic size in BPH cases. Coverage for prostatitis would also likely be appropriate with Fluoroquinolone/Baytril or similar. A recheck sonogram is recommended in 3-4 weeks with reassessment of the urinalysis and evaluation of any inflammatory sediment. Full adrenal work up would be ideal, especially if any hypertension or isosthenuria is present. Urine catecholamine may be appropriate if hypertension is an issue. If the patient appears cushingoid, work for Cushings is warranted. Either PDH or adrenal dependent Cushings could be considered possible in this patient.




**The information and recommendations provided are based on the images presented by the**

**referring veterinarian. 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.

**Eric Lindquist**, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
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