



PATIENT

Dasher Bowers

SPECIES

Canine

BREED

GSD

SEX

Male

AGE

6 Years

WEIGHT

78 Pounds

INTERPRETED BY

Eric Lindquist, DMV

DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Sam Doverspike

HOSPITAL NAME

Franklin Animal Clinic

REFERRING VET

Dr. Sam Doverspike

INVOICE

46695

DATE

4/14/23

PRESENTING CLINICAL SIGNS

Presented w/ difficulty defecating and urinating. PE found a left sided Perineal Hernia & Enlarged Prostate. Also over distended bladder. Currently on Clavamox Lab Work shows Creat elevated at 3.1 and BUN at 42; Lyme +

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** was significantly overdistended with polypoid mineralizing mass. The bladder was evacuated, with significant wall thickening present, with an area of polypoid mineralization.

The **prostate** was uniformly enlarged (6.27 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. A paraprostatic cyst or abscess noted with echogenic debris. Other cystic changes also noted throughout the prostate. Periprostatic fluid noted. Significant inflammation noted around the prostate. 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.

The **left kidney** presented pyelectasia at 3.0 cm and overdistention. Left hydroureter present up to 1.0 cm at the renal pelvis. The ureter continued to the level of the trigone yet was impinged upon by the prostatic pathology.

The **right kidney** presented hydronephrosis and hydroureter. The right kidney measured 7.0 cm. Hydroureter measured 0.8 cm.

Adrenal Glands

The regions of the **adrenal glands** were unremarkable.

Spleen

The **spleen** presented subtle micronodular changes, relatively normal size. No evidence of significant pathology.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

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.



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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.

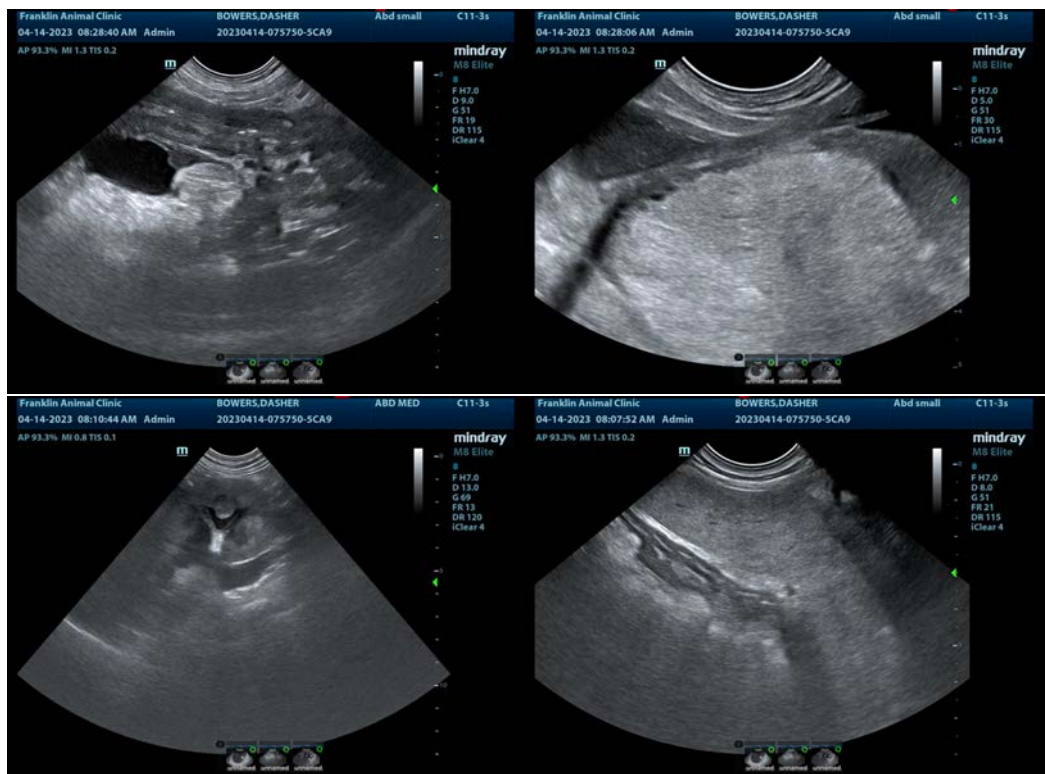
ULTRASONOGRAPHIC FINDINGS

- Extensive BPH prostate/prostatitis and paraprostatic cysts or abscesses
- Variable severe bladder wall thickening and secondary bilateral hydroureter
- Micronodular splenic changes
- Partially full stomach

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ultrasound guided drainage of the paraprostatic cyst or abscess performed with complication. However, significant inflammation is present throughout the pelvis.

Recommend assessment of cytology in this patient and culture. CT evaluation would also be warranted to assess the extent of the pelvic pathology. Traumatic catheterization of the bladder wall thickening may be appropriate as well to assess for carcinoma, given the mineralizing polypoid lesion in the bladder. IV fluid support, treatment for UTI, and correction of the azotemia indicated. Eventual neutering and reassessment of the tissue as it potentially regresses. Reassessment of the sonogram weekly post-neuter recommended, assuming no neoplasia is found upon aspirate or traumatic catheterization.





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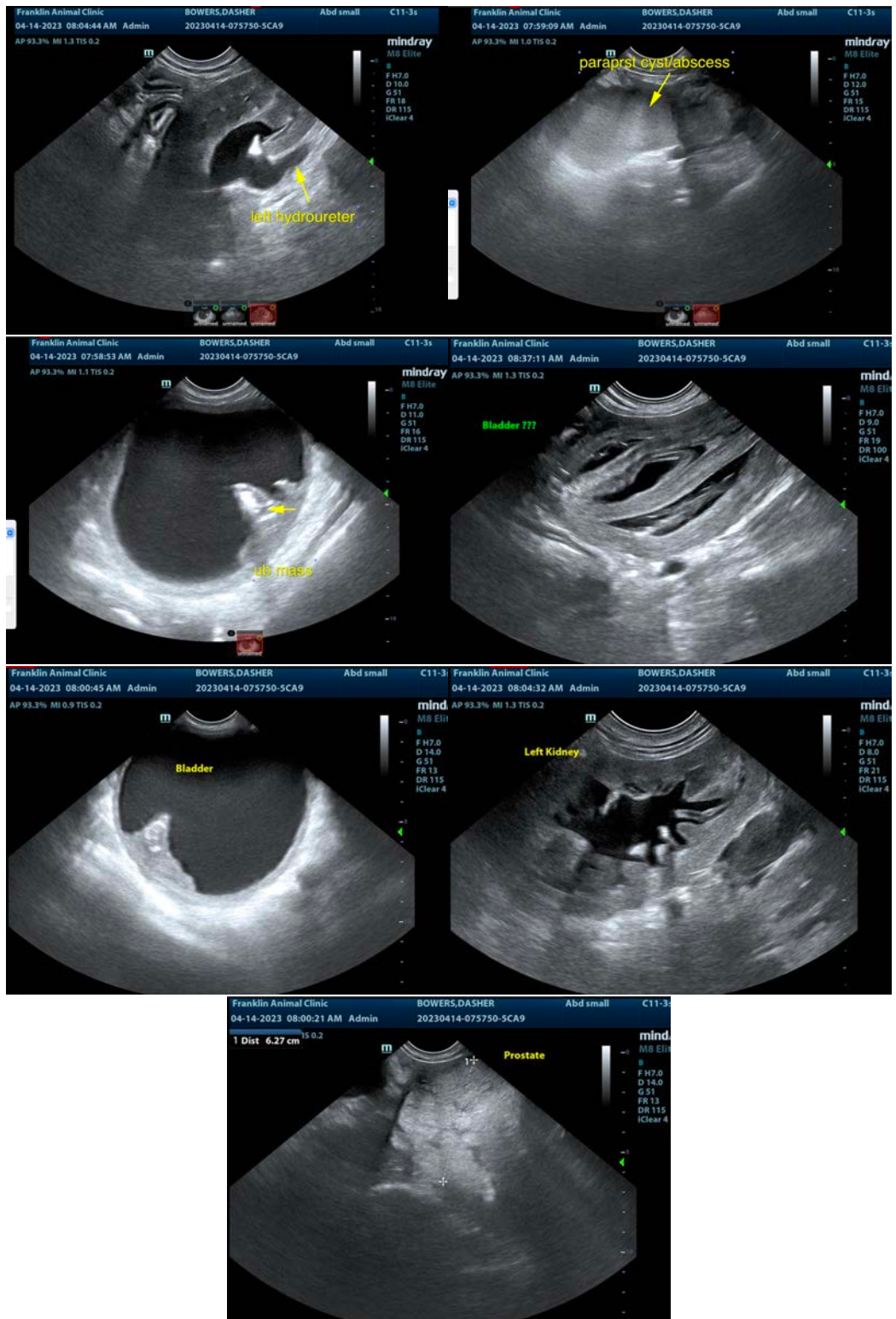
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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