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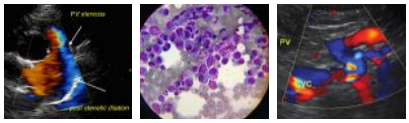

SonoPath
Clinical Sonography & Telecytology
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DATE
5/13/22

PATIENT
Bullet Gelzer

SPECIES
Canine

BREED
Briard

SEX
Intact Male

AGE
5/12/10

WEIGHT
67.7 Pounds

INTERPRETED BY
Eric Lindquist, DMV DABVP, Cert. IVUSS

HOSPITAL NAME
Animal Emergency Hospital

REFERRING VET
Dr. Willer

INVOICE
15174

PRESENTING CLINICAL SIGNS

History: Sam Ate gorgonzola cheese last night- seemed fine; early this morning- started to pace, be restless, went outside- had a normal bowel movement; but continued to be restless; then had diarrhea and then vomit owner called PPH- per PPH- not a concern- possible GI upset owner is not aware of him getting into anything else treated for GI issues a few years ago- similar event; history of kidney infection/UTI always had a sensitive stomach 2 years ago- at U of Penn- had thyroid tumor removed- per owner- very easy to remove; got all of it is on clindamycin, prednisolone (currently on EOD), pentoxifylline for the nails. Fever, tachycardia, tense abdomen

Current Medications: None listed.
Radiographs: Thorax 2 view- possible calcified region near the end of the ribs vs beginning of lesions. Abdomen 2 View- decreased detail in the caudal abdomen with a very large prostate noted.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** presented a minor amount of dependent debris, a grouping of which measured 2.57 cm.

The **prostate** was uniformly enlarged with moderate 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. The prostate measured 5.0 cm. Edema lines were noted in the prostate, consistent with prostatitis.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 8.56 cm. The right kidney measured 8.9 cm.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 2.51 cm x 0.66 cm at the caudal pole and 0.69 cm at the cranial pole. The right adrenal gland measured 2.88 cm x 0.74 cm at the caudal pole and 0.89 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** 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. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

The **gallbladder** was overdistended with regional inflammation. some striating bile was noted, consistent with inflamed mucocele.

Gastrointestinal

The upper **gastrointestinal tract** in this patient revealed minor, edematous wall. There was no evidence of foreign bodies. Minor areas of fluctuant fluid accumulation were noted within the lumen with hyperperistalsis. This pattern continued to the ileocecal valve. The colon revealed a fluid filled lumen. This presentation is most consistent with gastrointestinal irritation/inflammation without obstruction.

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.

Free Abdomen

A trace amount of **free fluid** was noted in the caudal abdomen.

Other

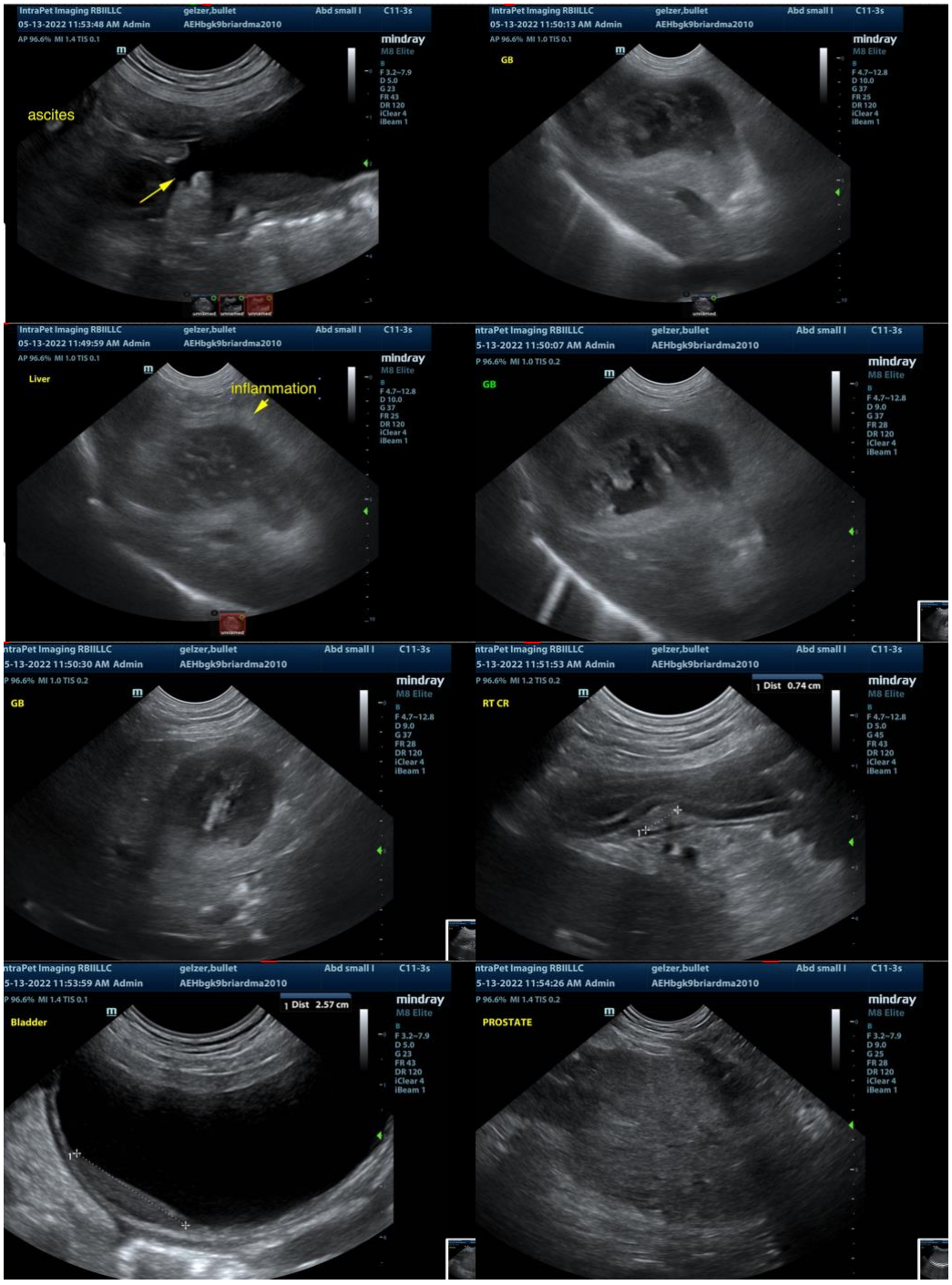
The **testicles** were imaged and found to be uniform. No evident pathology.

ULTRASONOGRAPHIC FINDINGS

- Inflamed gallbladder mucocele, may be medically manageable, however, cholecystectomy is likely in this patients best interest.
- Gastroenteritis
- BPH prostate with edema lines noted in the prostate, consistent with prostatitis
- Free fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Cholecystectomy would be ideal in this patient as well as neuter. Medical management could be considered; however, removal of the gallbladder would likely be necessary in the long term. Enrofloxacin/metronidazole combination, plasma expanders and coagulation panel all indicated. However, all aspects of mucocele formation with concurrent pericapsular inflammation are present to make this a surgical gallbladder. Free fluid in the caudal abdomen may be deriving from gallbladder inflammation or leakage or possibly related to the prostate.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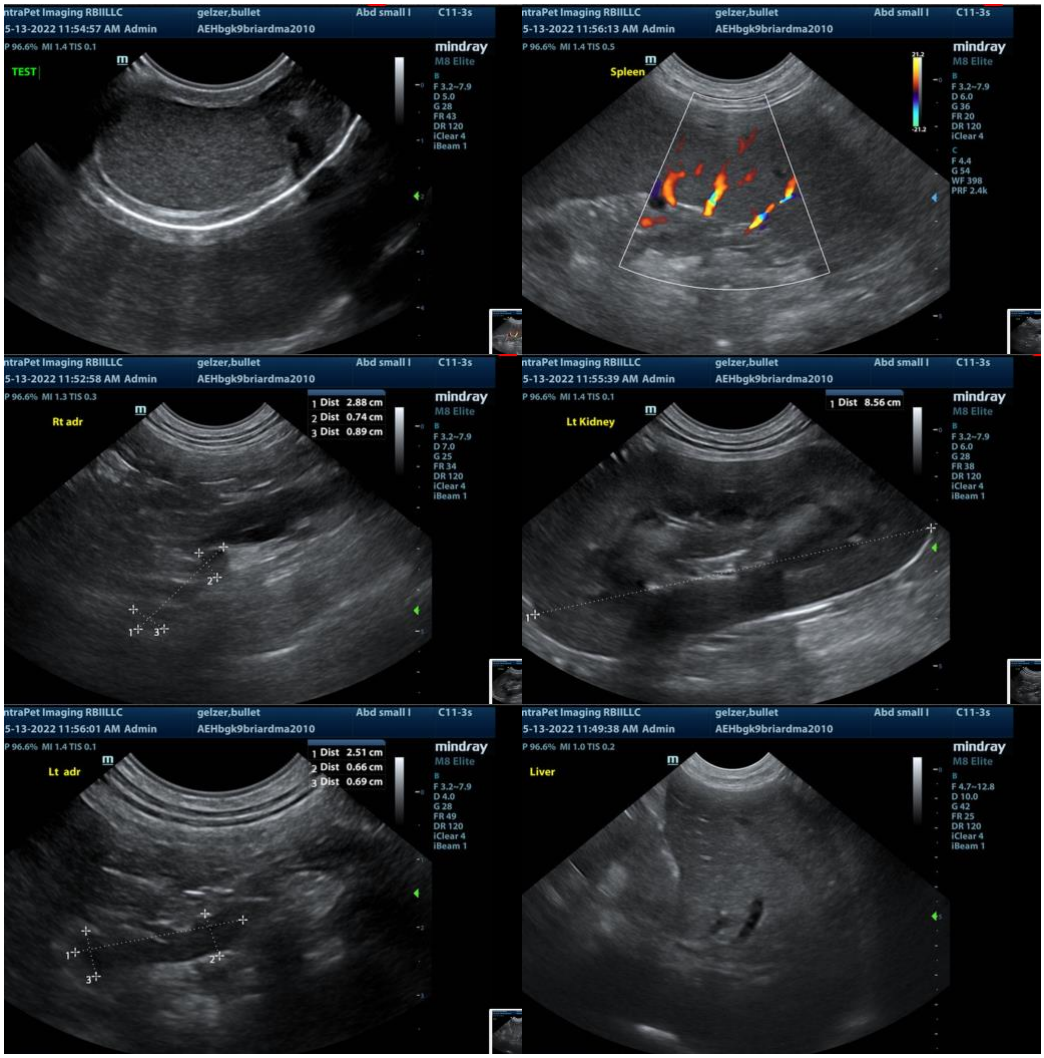

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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