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Clinical Sonography & Telecytology
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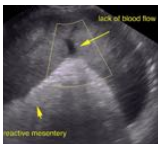

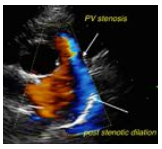

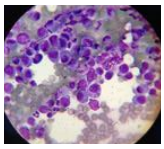
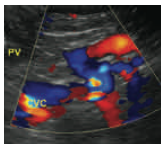

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1-800-838-4268 info@sonopath.com

PATIENT
Puck Newby

SPECIES
Canine

BREED
Labrador Retriever

SEX
Male

AGE
6 years

WEIGHT
73 lbs

INTERPRETED BY
Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Dr. Evoniuk

HOSPITAL NAME
State Ave

REFERRING VET
Dr. Evoniuk

INVOICE
31286

DATE
6/28/22

PRESENTING CLINICAL SIGNS

History: Started V+ on Sunday, not able to keep any food or water down Hx of eating random objects, O thinks P may have eaten a kids toy
Abnormal PE/Chem/CBC/UA Results: Chem WNL CBC: Neu: 12.33 EOS: 1.13 HGB: 18.6 Plt: 75

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **bladder** in this patient was mildly thickened with slight echogenic mural changes. A mild amount of sand was noted. Slight micropolypoid changes were noted. This is a frequent finding in older animals and may be linked to a history of chronic urinary tract infection or active urinary tract infection. Urinalysis would be recommended with culture if any evidence of inflammatory sediment is present. The region of the trigone and visible pelvic urethra were normal.

The **prostate** was uniformly enlarged 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. The prostate measured 4.6 cm in width.

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.

Adrenal Glands

The **adrenal glands** were not visualized.

Spleen

The **spleen** in this patient was mildly enlarged with uniform parenchyma and was folded upon itself caudally. This is a positional variant and is not pathological. There was no evidence of significant disease.

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.

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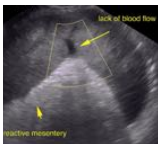
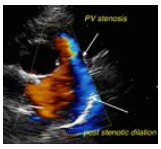
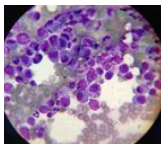
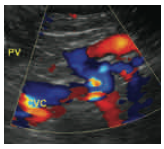

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Gastrointestinal

The **gastrointestinal tract** revealed an edematous wall and hyperperistalsis with no loss of mural detail. Minor enhanced surrounding fat was noted around the regions of the gastrointestinal serosa. Partial obstructive pattern was noted likely owing to adhesions and reactive mesentery.

Pancreas

The **pancreas** was mildly heterogenous, yet this is not the primary issue.

Free Abdomen

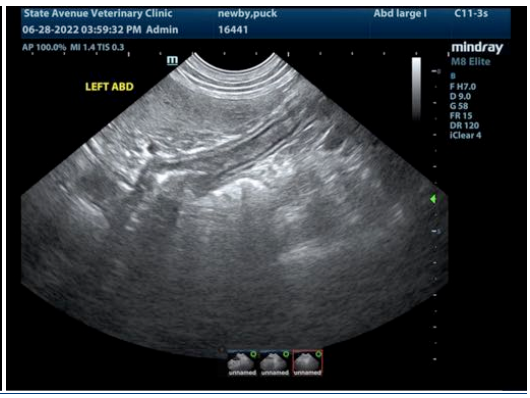
Some reactive mesentery was noted. There was no evidence of foreign body.

ULTRASONOGRAPHIC FINDINGS

Gastroenteritis or enterotoxins with reactive mesentery.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The dilation of the upper gastrointestinal tract continued to the ileocecal junction. This should be monitored carefully. IV fluid support, fecal test, plasma expanders, and treatment for enterotoxins are all indicated with recheck sonogram in 24-48 hours. Bowel movement should be monitored as well as eating. A portion of the small intestine may necessitate resection depending on response to therapy.



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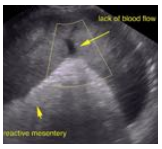
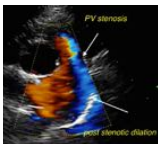
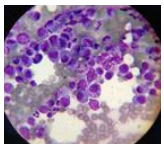
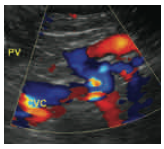

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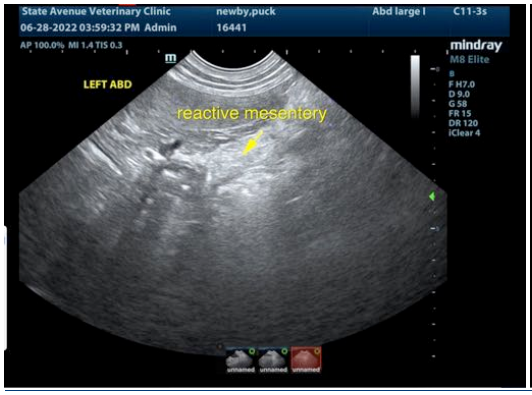

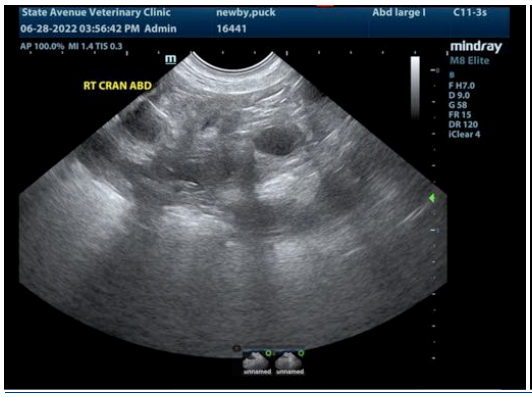

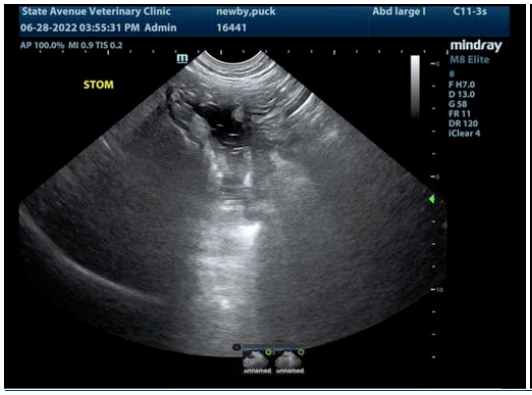

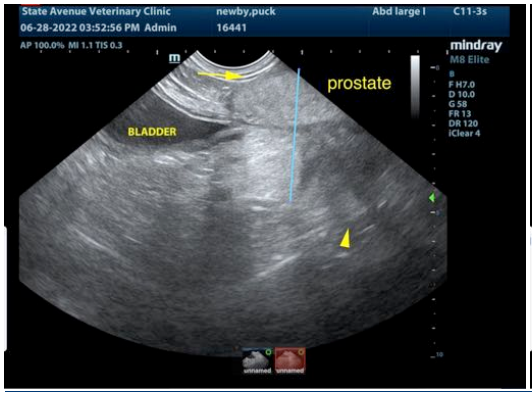

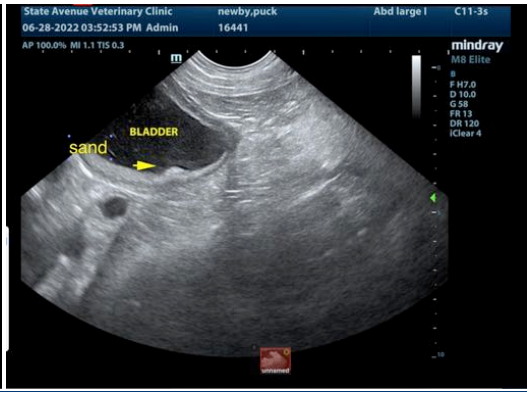

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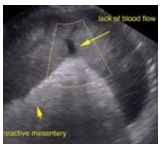
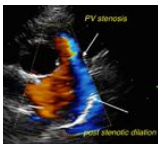
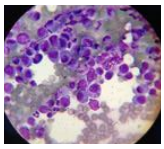
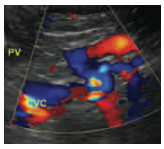

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@SonoPath.com