



PATIENT

Hawk Leonescu

SPECIES

Canine

BREED

Labrador Retriever

SEX

Intact male

AGE

10 years

WEIGHT

62 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Melissa DaSilva

HOSPITAL NAME

Pocono Peak VC

REFERRING VET

Dr. Thompson

INVOICE

46594

DATE

8/14/23

PRESENTING CLINICAL SIGNS

History: Patient has had progressively decreasing appetite over the last 2 months, currently having projectile diarrhea and began vomiting during diagnostics today. At this time, patient is primarily eating people food. 3.5 lb weightloss since seen for benign mass removals on 6/13/23. Patient is a field trial athlete. Patient started on IV fluids & metronidazole infusion during ultrasound imaging.

Abnormal PE/Chem/CBC/UA Results: Icteric sclera, mucoid discharge OU
Decreased: PLT 105
Elevated: BASO 0.34, ALT 604, ALKP 302, TBIL 7.9

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. A moderate amount of debris was noted in the bladder. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae 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. The testicles were imaged and found to be uniform.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some 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. Left renal pyelectasia was noted. The left kidney measured 5.98 cm. The right kidney measured 8.02 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 right adrenal gland measured 3.95 x 1.31 cm at the caudal pole and 1.02 cm at the cranial pole. The left adrenal gland measured 4.0.3 x 0.86 cm at the caudal pole and 0.6 cm at the cranial pole.

Spleen

The **spleen** was uniformly enlarged with relatively uniform parenchyma without evidence of masses. The capsule was mildly swollen. This is most consistent with hypersplenism and reactive hyperplasia deriving from splenic white or red pulp. However, early infiltrative disease, such as lymphoma or mast cell neoplasia can, at times, present in this manner. True hypersplenism from an internal medicine standpoint causes sequestering of thrombocytes resulting in thrombocytopenia and anemia. Clinical manifestation of this phenomenon should be considered. US-guided FNA would be best in order to ensure only reactive hyperplasia is present. If clinical signs fit with potential neoplasia or mast cell disease, then Benadryl injection (1 mg/pound IM) 15 minutes prior to FNA would be recommended.



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Liver

The **liver** revealed diffuse, increased portal markings and hepatic remodeling. The liver was subnormal in size. The gallbladder was unremarkable without over distension. There was no evidence of post hepatic obstruction noted.

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Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. 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.

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ULTRASONOGRAPHIC FINDINGS

WEIGHT

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BPH prostate.

Age related renal changes with left renal pyelectasia.

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Hypersplenism.

Gastric stasis.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assessment for UTI/prostatitis is indicated. There was no evidence of neoplasia. FNA of the spleen and core liver biopsy would be ideal. However, the liver significantly small and therefore the target is fairly small and must be approach from an intercostal position. Ultrasound-guided FNA of the liver with 20-gauge needle could be considered to assess for inflammatory cell type, yet it would not assess structure. There was no evidence or suspicion of neoplasia. This is consistent with chronic fibrosing cholangitis, cholangiohepatitis with emerging cirrhosis. The prognosis is very guarded to poor long term. The patient is likely too old for primary copper storage disease, yet copper samples could be considered for quantitative evaluation. Leptospirosis titers are warranted to rule out underlying chronic Leptospirosis that may be the inducing issue. The prognosis is extremely guarded to poor.

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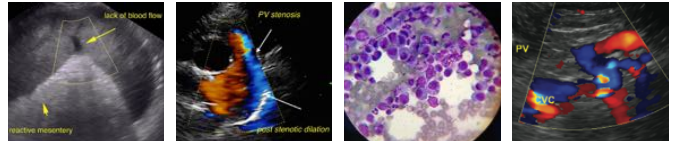
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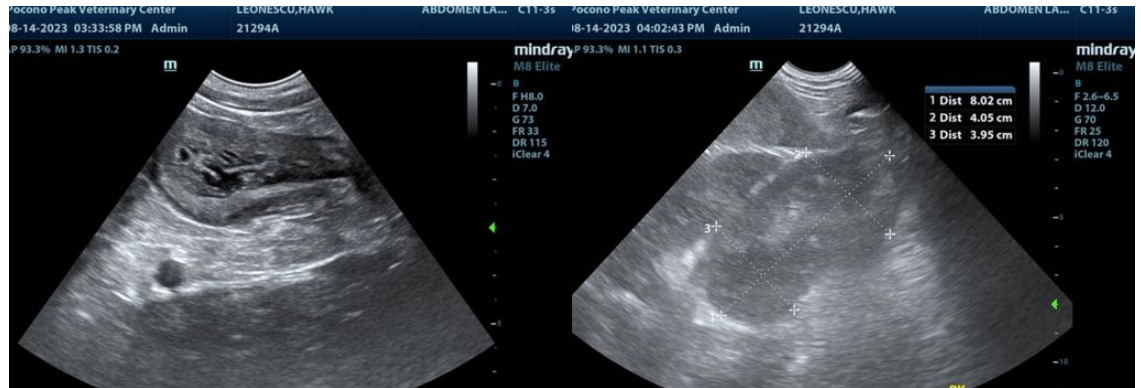
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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