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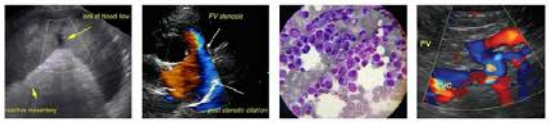


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Sunny Garbedian

SPECIES

Canine

BREED

Weimaraner

SEX

Neutered Male

AGE

7 Years

WEIGHT

75 Pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Sierra Animal Wellness Center

REFERRING VET

Dr. Peggy Roberts

INVOICE

33359

DATE

12/8/21

PRESENTING CLINICAL SIGNS

DOB 12/14 Weimaraner BW 75# Neutered 12/2/21 to remove a Sertoli cell tumor in one testicle. Had prostatitis 1/30/20 successfully treated with 4 weeks of ciprofloxacin now has a significant bump on the right side of his prostate. Slightly painful. Abdominal and thoracic xrays negative for masses. Peggy Roberts, DVM

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The prostate is large in size, measuring 4.2 cm in height on the sagittal view. It has a somewhat irregular shape with relatively smooth external margins. The parenchyma is heterogeneous in general, but there is a discreet hypoechoic focal lesion in the caudal aspect of the prostate measuring 1.74 cm x 2.06 cm. The prostatic urethra appears normal with no evience of irregularity, invasion of mass effect or calculi. Findings are suspicious for a cyst or abscess. A very hypoechoic mass effect cannot be excluded.

The left kidney has a normal shape and size (8.68 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (8.4 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.74 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

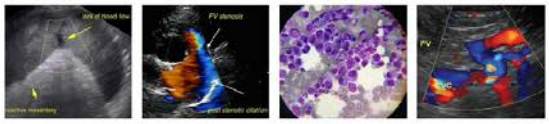
The right adrenal gland is normal in size measuring 0.51 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size and hypoechoic. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.



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The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured as normal (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are prominent mesenteric lymph nodes visualized, measuring 0.55 cm and 0.59 cm in diameter. The omentum is of normal echogenicity.

PRIMARY FINDINGS

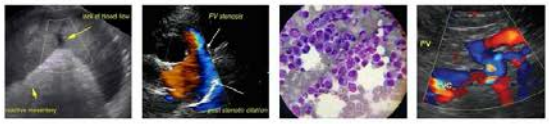
- Large, heterogeneous prostate with focal, hypoechoic cystic lesion – Differentials include cyst, abscess, nodule, other.
- Subjectively heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. If liver enzymes are normal, this may be within normal limits for this individual.

SECONDARY FINDINGS

- Prominent, mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Prominent mesenteric lymph nodes – most likely reactive.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This patient has a large, heterogeneous prostate. This is likely normal for a dog one week post neutering, but a focal hypoechoic lesion is present. The history reports prostatitis, which was treated with



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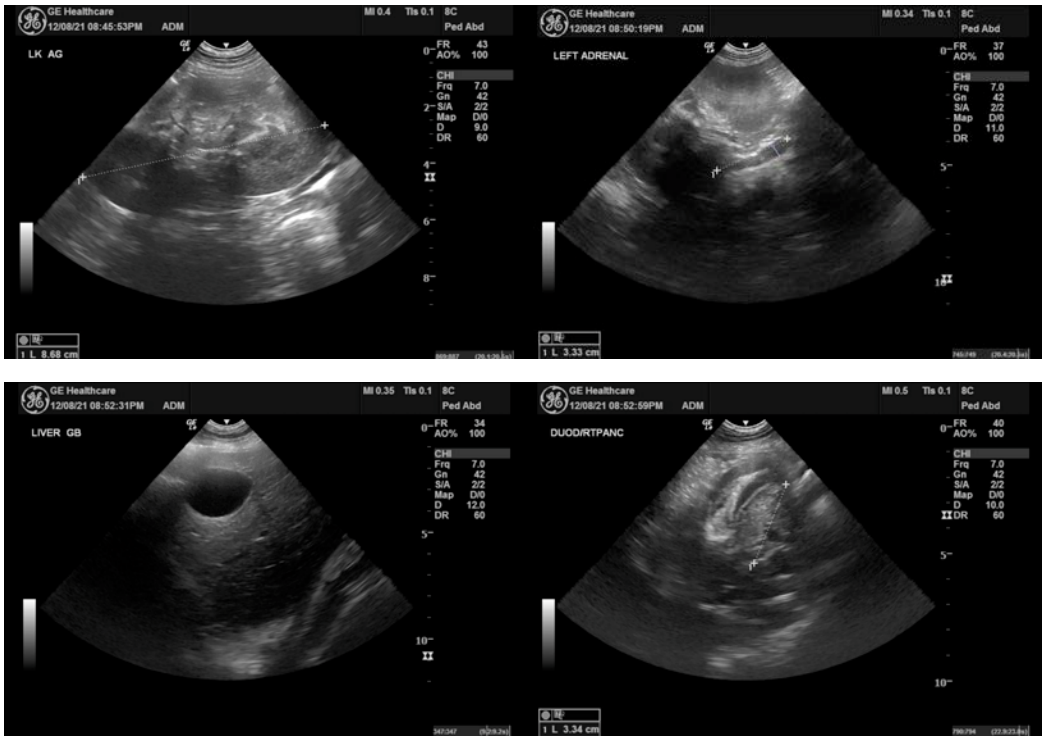
antibiotics. There is concern that this lesion could either be a cyst or an ebscess. The history of prostatitis increases the concern for possible abscess. If the prostatitis was treated based on culture and sensitivity results, you could consider an additional 6-8 weeks of appropriate antibiotic therapy and rescanning to see if the lesion is smaller. If a culture and sensitivity was not obtained prior to starting antibiotics, then I would recommend obtaining a urine culture with a sterile placed urinary catheter at the level of the prostate, and gentle prostatic massage to try to obtain a representative sample. Recommend urinalysis on this sample as well. If the culture is positive, you could consider continuing appropriate antibiotics and rechecking in 6-8 weeks.

Ideally, this lesion would be aspirated and sampled with cytology and culture done on the aspirate in addition to considering the installation of Baytril into the lesion. This is a big dog, and the pelvis appears to obstruct visualization in many views, so I am not sure if this would be possible or not. If the lesion persists and is not reachable for aspiration/drainage, then surgical debridement, sampling, and possible omentalization could be necessary, particularly if the lesion is getting larger. Additionally, I cannot exclude the possibility that this is a hypoechoic nodule, but a cyst or abscess would be primary differentials.



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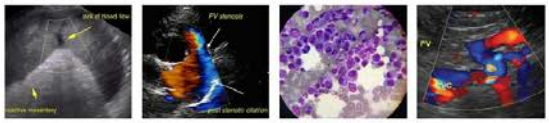

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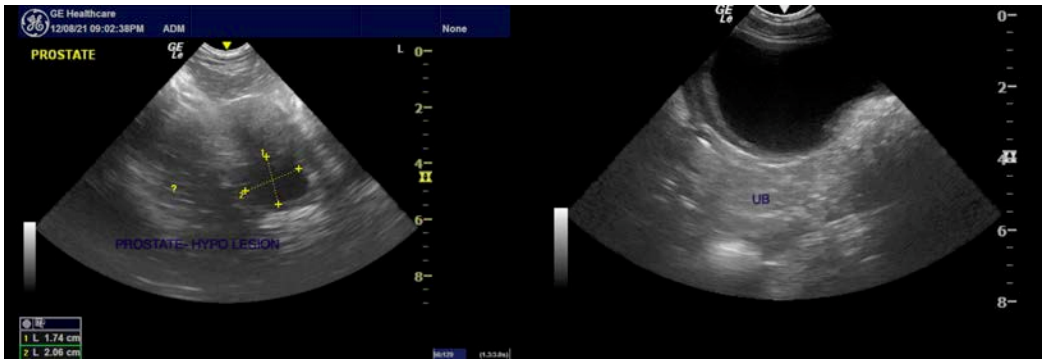

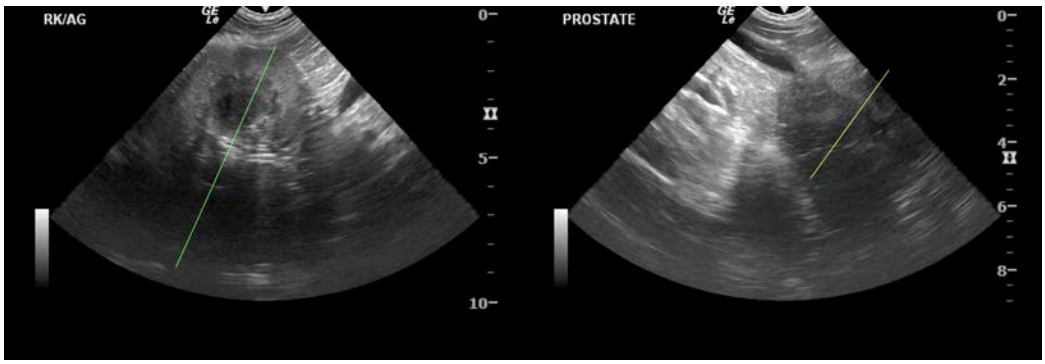

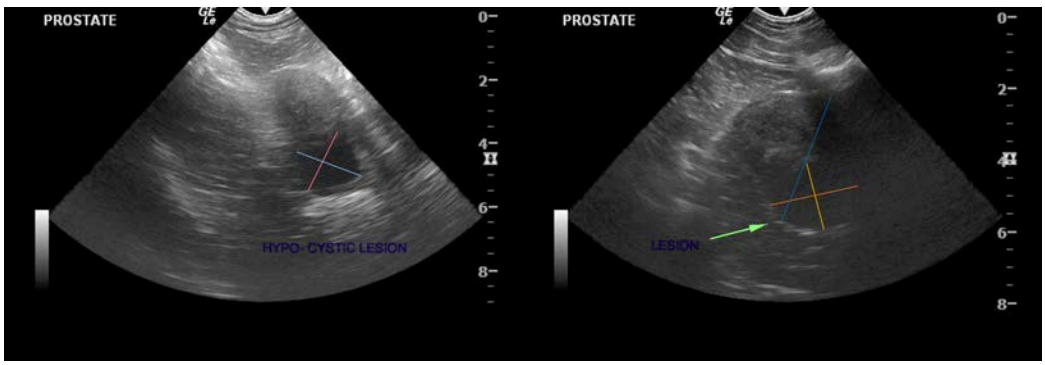

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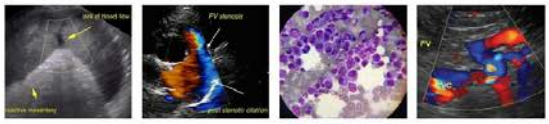

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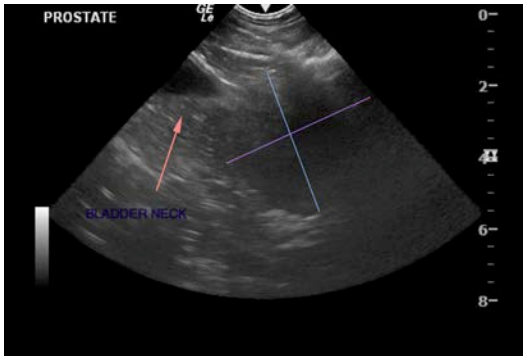

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

kathleen.sennello@sonopath.com