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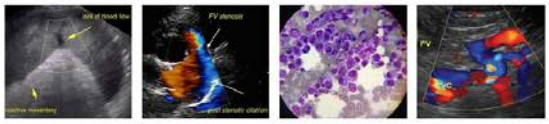

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

BonBon Cordova

SPECIES

Canine

BREED

American Eskimo

SEX

Intact Male

AGE

5/2/10

WEIGHT

9.6 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Advanced PetCare of Nevada

REFERRING VET

Dr. Hazelwood

INVOICE

45188

DATE

2/15/23

PRESENTING CLINICAL SIGNS

Owner's took Bon Bon to ER June 2022 for bloody urination – they also noted some urine leaking at this time and excessive licking of prepuce. ER saw 2 fluid filled pockets that merge within prostate and suspected prostate abscess. UA showed hematuria and proteinuria. They recommended following up with primary DVM, recommended neuter, and prescribed Clavamox, Carprofen, and Gabapentin. O really does not want to neuter. Advised of concerns with differing testicle sizes which can also indicate neoplasia. O still not wanting to neuter at this time. Given inflammation in prostate, response to NSAID, normal labwork recently at ER, and chronic intermittent pain/lameness in right forelimb, recommend chronic daily use of NSAID and see how P does. Seen November 2022 for hematochezia – which he has had happened recurrent since starting NSAIDs. Stopped all NSAIDs at this time. O had not seen hematuria since last visit with P in July. Saw patient January for recheck U/S: Testicles remain abnormal with right testicle enlarged compared to left. Prostate changes are still present and the hypoechoic/fluid filled areas have enlarged and prostate appears larger as well. New mass on right pelvic limb . O reiterated that he is doing well at home with only the arthritis being problematic for him, but he still requests to go on his twice daily walks.

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, hyperechoic, and irregular, with at least two large irregular cystic regions, the right measuring 0.82 cm x 1.47 cm, the left at 2.51 cm x 3.58 cm. The prostate itself measures at greater than 3.78 cm x 3.05 cm. The area of the prostatic urethra appears normal with no evidence of a mass effect or calculi.

The left kidney has a normal shape and size (4.6 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 (5.47 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 0.59 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 0.60 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.

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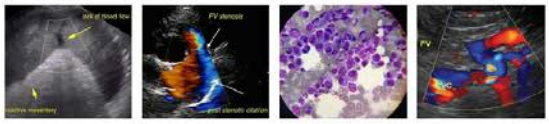

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Spleen

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 echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There are numerous ill-defined hypoechoic cystic nodular lesions. There is a left cystic lesion measuring 1.01 cm and hypoechoic nodules measuring 0.95 cm and 0.91 cm.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. 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. Duodenum wall measures 0.42 cm. Jejunum wall measures 0.37 cm. 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

There is free fluid and inflammation around the bladder neck. There is no evidence of a diffuse lymphadenopathy, but both sublumbar lymph nodes appear slightly irregular and cystic, the right measuring 0.62 cm in height and the left measuring 0.56 cm in height in the sagittal view. The omentum is largely within normal limits.

Other

The left and right testicles are visualized. The left testicle is smaller, measuring 2.17 cm x 1.1 cm. The right testicle is larger measuring 2.3 cm x 0.90 cm with a somewhat ill-defined hypoechoic nodule measuring 0.53 cm x 0.63 cm.

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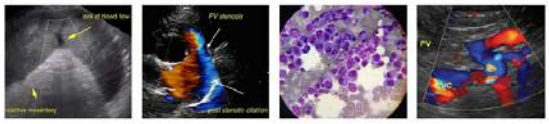

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ULTRASONOGRAPHIC FINDINGS

- Large, hyperechoic, irregular prostate with large intrahepatic cysts/abscesses – Findings are most consistent with BPH +/- prostatitis and prostatic cysts/abscesses.
- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.
- 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.
- Heterogeneous liver with numerous ill-defined hypoechoic nodules – 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. The nodules observed trend toward a more benign process but underlying neoplasia cannot be ruled out.
- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.
- Free fluid in the region of the bladder neck as well as prominent/cystic sublumbar lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Hypoechoic nodule in the right testicle – There is a nodule visualized in the testicle. Consider such differentials as benign or neoplastic lesions such as Leydig cell tumor, Sertoli cell tumor, seminoma, granuloma, etc. Recommend neuter with histopathology (as treatment of choice), or cytology.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The prostate is large, hyperechoic, and cystic. The cystic lesions are relatively anechoic, so more consistent with cysts than abscesses, but this can change at any point. Options moving forward include drainage of these cystic lesions with fluid analysis, cytology, aerobic and anaerobic cultures, +/- installation of Baytril if an abscess is suspected, and blocking testosterone ideally by neutering, as this would allow assessment and removal of the testicular mass present, or medically with Finasteride (this involves lifelong treatment). Without the blockage of testosterone, these lesions will return, and there is concern that progression will lead to more clinical signs.

There is decreased corticomedullary distinction in both kidneys. Recommend blood pressure, urinalysis and culture as a baseline.

Additionally, the pancreas is somewhat prominent. This is likely consistent with previous episodes of pancreatic inflammation.

The liver appears heterogeneous and has ill-defined nodules. The appearance of these nodules trends towards a benign appearance, but an underlying neoplastic process cannot be ruled out. If significant liver enzyme elevations are present, you could consider a liver function test, fine needle aspirate of the liver, etc.

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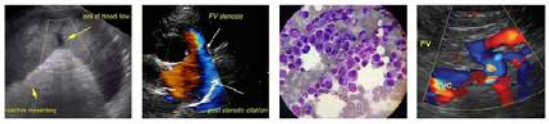

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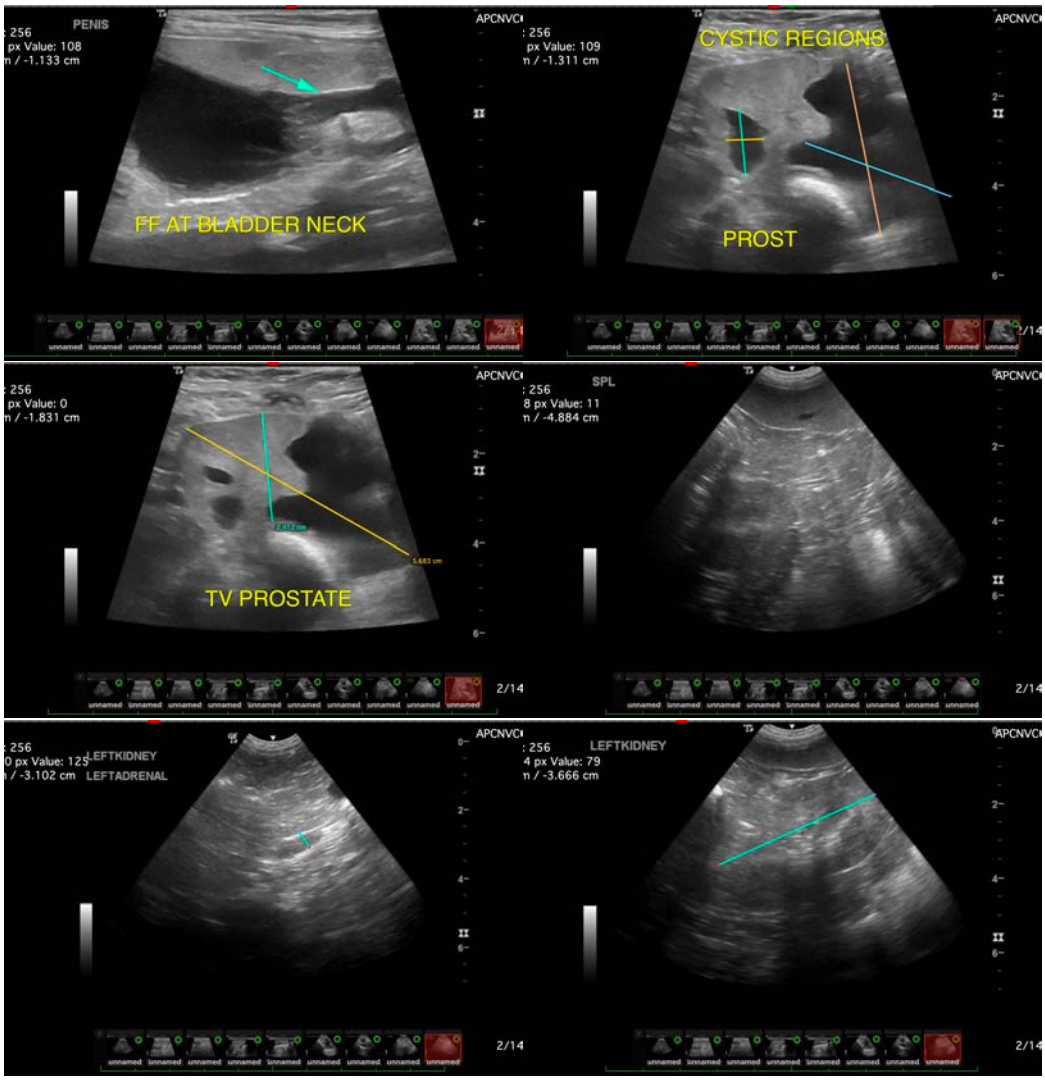
The sublumbar lymph nodes are somewhat prominent and cystic. This is likely due to chronic antigenic stimulation, but metastatic disease cannot be ruled out. Additionally, there is some free fluid in the pelvic region, most consistent with inflammatory response.

There is a nodule in the right testicle. This could be a benign or neoplastic lesion. A fine needle aspirate could be considered, although neutering with histopathology would be ideal.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.



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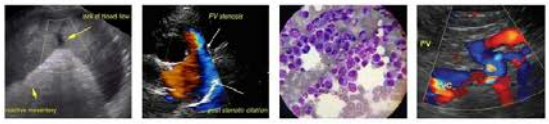

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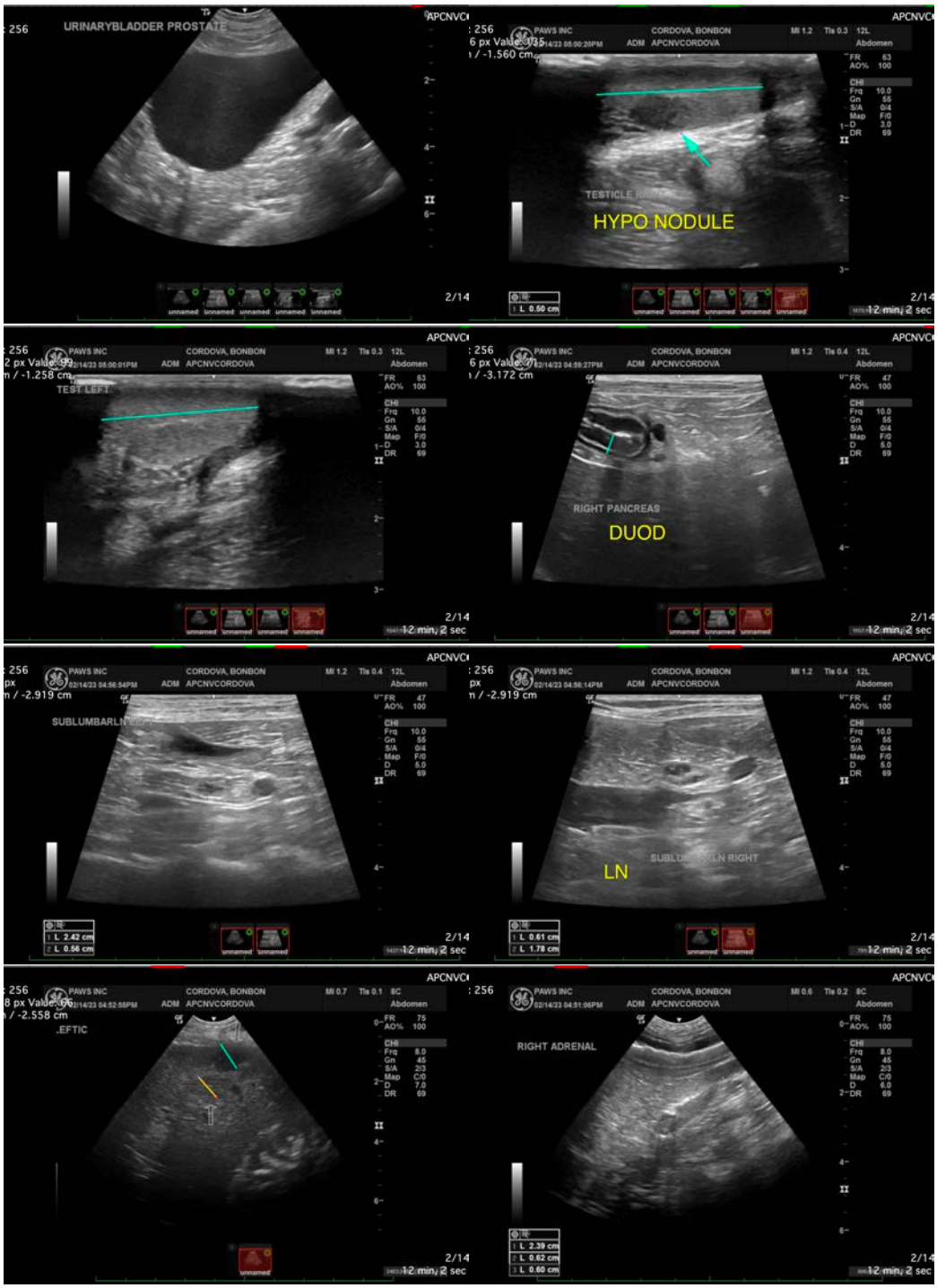

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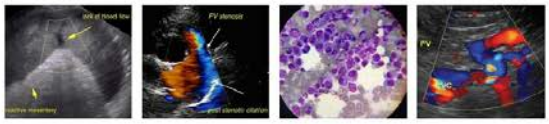

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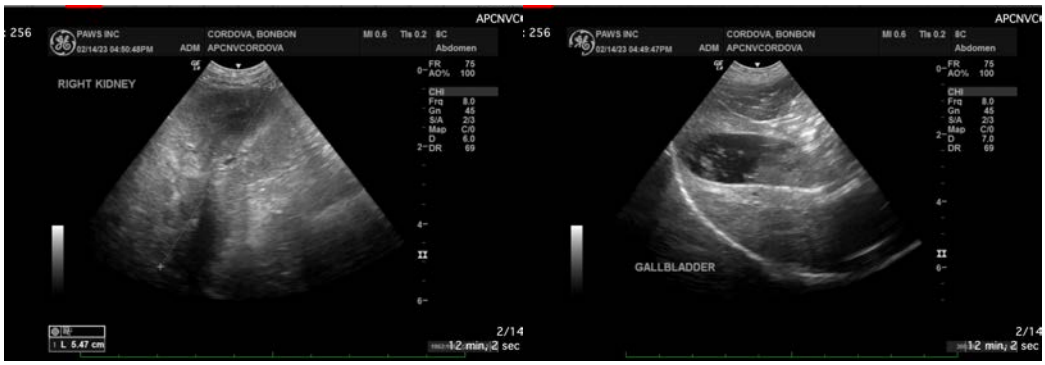

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

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