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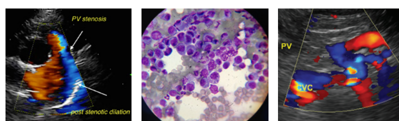

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DATE
3/16/22

PATIENT
Tazz-Too Burton

SPECIES
Canine

BREED
Pit Bull

SEX
Intact Male

AGE
5/27/11

WEIGHT
73.2 Pounds

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

IMAGING PERFORMED BY
Stephanie Pearce RDCS, RVT

HOSPITAL NAME
Banfield Columbia

REFERRING VET
Dr. Lee

INVOICE
36227

PRESENTING CLINICAL SIGNS

Lethargy and pain on abdomen/lumbar area for 2 weeks. Responded to pain meds but not fully. Elevated liver enzymes for a couple of years.

Current Medications: Clavamox 13mg/kg BID for 14 days, Rimadyl 2mg/kg BID for 10 days, Denamarin long term.
Lab Results: UA- WBCs, granular casts and proteinuria. Intracellular cocci bacteria. BW- mild lymphopenia, ALKP 1096, ALT 95 with liver supplement for 2 months.
Radiographs: Abdomen- 4.8cm round homogenous soft tissue opacity caudal to bladder found. Mild loss of serosal detail due to food ingesta and fecal material on GI loops.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

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 3.29 cm x 5.6 cm. It has a relatively normal shape with smooth external margins. The parenchyma is heterogeneous and hyperechoic with occasional discrete small cystic lesions. The prostate urethra appears normal with no evidence of irregularity, invasion, mass effect, or calculi. The omentum surrounding the prostate appears focally hyperechoic.

The left kidney has a normal shape and size (7.58 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 (7.12 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/borderline large in size measuring 0.97 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/plump in size measuring 0.80 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 large in size 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. No focal nodules or cystic lesions are observed.

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 is dilated with a large amount of fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 layering 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 normal and isoechoic to surrounding 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, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

Other
The left and right testicles are imaged. The right testicle appears normal. The left testicle has a small, ill-defined, hyperechoic region measuring approximately 0.69 cm x 0.59 cm, which could be consistent with an area of current inflammation, fibrosis, or an early nodule.

PRIMARY FINDINGS

- Large, hyperechoic prostate with occasional small cysts, which is surrounded by hyperechoic mesentery – Findings are most consistent with benign prostatic hypertrophy and suspected prostatitis.

- Large, 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.

- Moderate gallbladder sludge – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.

- Small, ill-defined, hyperechoic region in the left testicle – This is a subtle lesion. The significance is unknown. This could represent a current area of inflammation, a previous area of inflammation, or even an early nodule.

SECONDARY FINDINGS

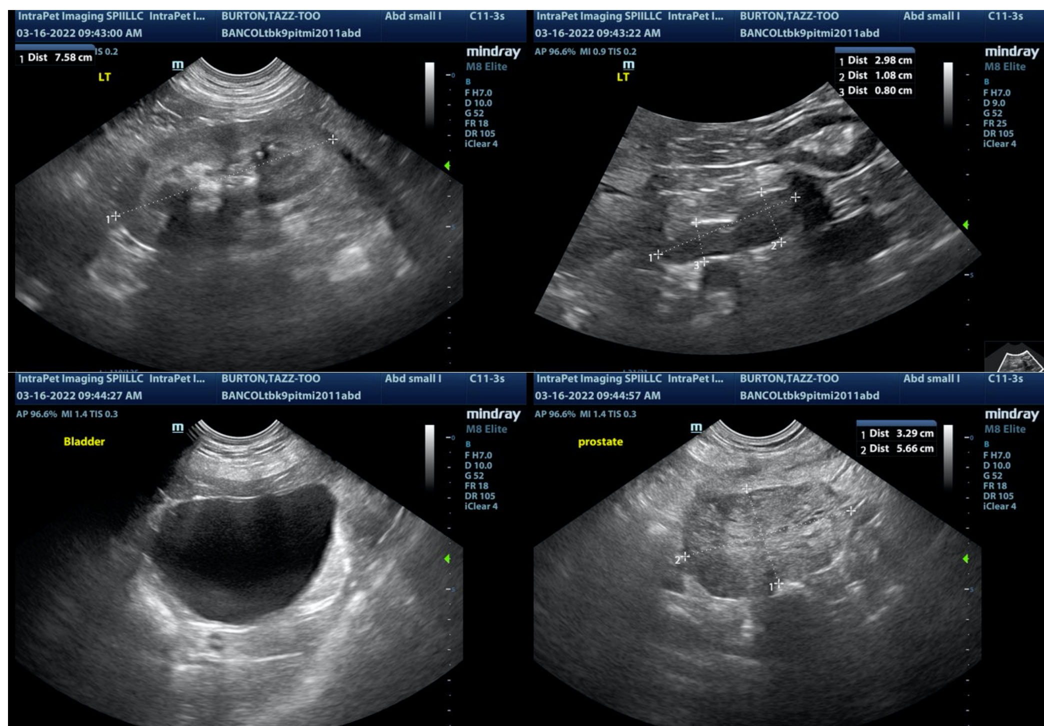
- Moderate ingesta within the gastric lumen – Correlate with feedings history and abdominal radiographs. If adequately fasted then consider such differentials as delayed gastric emptying or a partial outflow tract obstruction (none visualized).

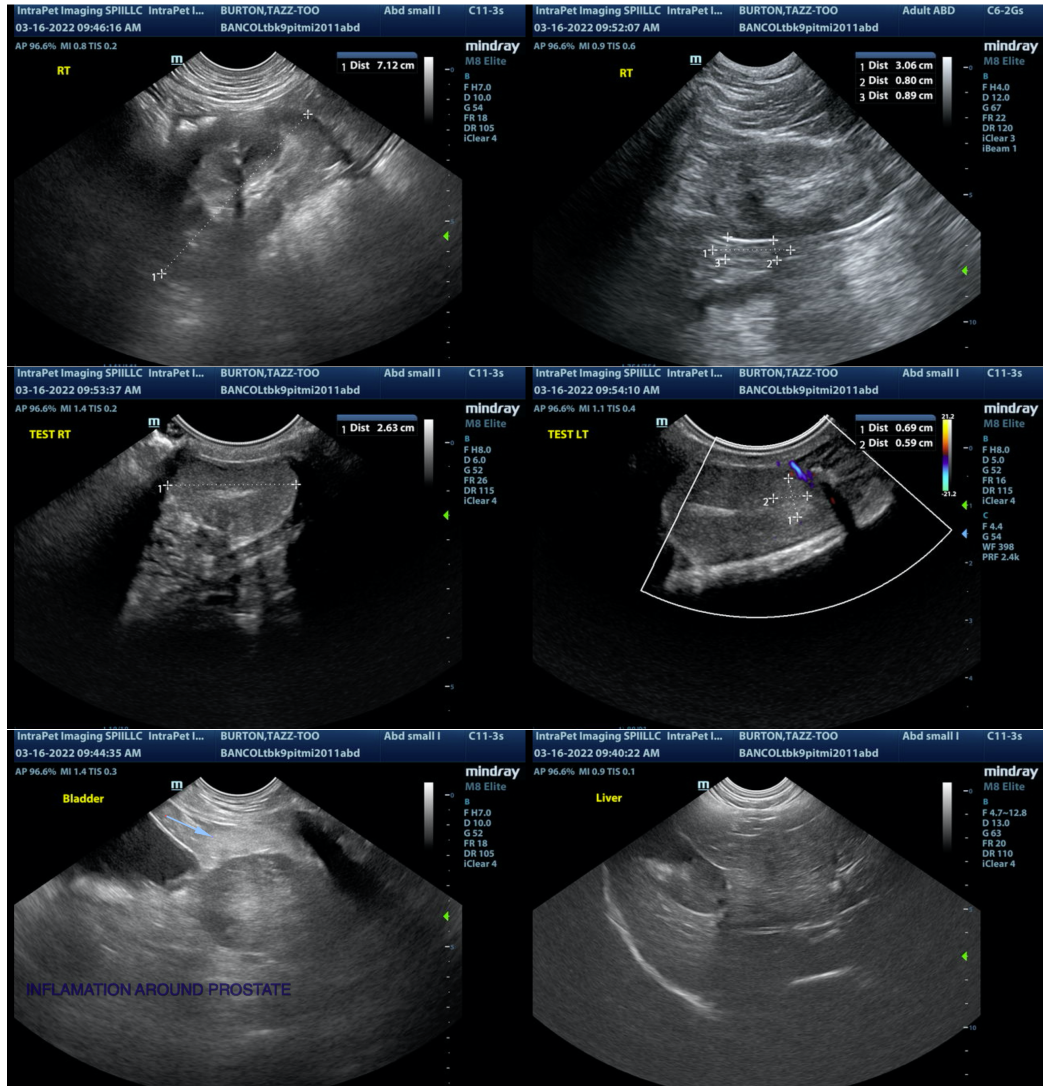
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Based on the history provided, I'm concerned about active prostatitis, and with the pain noted, possible discospondylitis. Recommend lumbar radiographs, urinalysis and culture, and neutering, as it is unlikely that the infection will clear up without shrinking the prostate as a nidus for infection. Additionally, there is an irregular area within the left testicle. This is ill-defined and subtle, but if neutering is performed, recommend submitting both testicles for histopathology.

I cannot definitively exclude the possibility of underlying prostatic neoplasia, but prostatitis appears most likely. If desired, a fine needle aspirate could be considered prior to surgery.

The liver is somewhat large and heterogeneous with no observed focal lesions. Given the elevation in ALP and the plump adrenals visualized, you could consider adrenal function testing if there are clinical signs of Cushing's present. Additionally, a fine needle aspirate and liver function test could be considered.





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.

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