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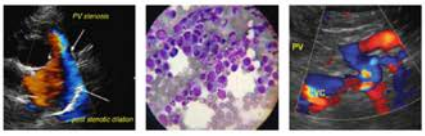

SonoPath
Clinical Sonography & Telecytology
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PATIENT

Bennie Wengren

SPECIES

Canine

BREED

Yorkie

SEX

Male

AGE

13 Years 5 Months

WEIGHT

6.8 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Wixom Family Pet Practice

INVOICE

38116

DATE

6/1/22

PRESENTING CLINICAL SIGNS

Current Medications: Galliprant 10mg PO SID, Clavamox 62.5mg PO BID, last doses yesterday morning. Patient History: Was limping and having urinary accidents last week, started on the above meds and didn't eat yesterday morning and was vomiting foam/fluid, did eat last night, limping and urinations have improved.
Abnormal PE/Chem/CBC/UA Results: **see attached BW BW-mild increase ALP UA-hematuria, cocci bacteriuria, pyuria Mild to moderate tartar/gingivitis, cataract OD, left testicle larger than right, feels smooth, non painful, prostate enlarged. Very mild decrease CP RR.

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, measuring 3.29 cm in width in the sagittal view. It has an irregular shape with irregular external margins. The parenchyma is severely heterogeneous and hyperechoic with discrete focal cystic lesions throughout. The prostate urethra appears normal with no evidence of irregularity, invasion, mass effect, or calculi.

The left kidney has a normal shape and size (3.46 cm). Overall echogenicity is slightly hyperechoic with poor 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 (3.7 cm). Overall echogenicity is slightly hyperechoic with poor 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 0.47 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 0.49 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 hyperechoic and homogenous in echotexture. The visible portions of the vasculature and biliary tract appear normal. There are numerous ill-defined, hypoechoic nodules within the parenchyma measuring 0.8, 0.78, 0.74 cm. These lesions do not appear to disrupt the hepatic architecture.

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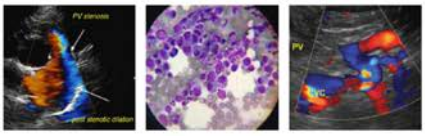

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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

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 measured 0.36 cm. Jejunum wall measured 0.31 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 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 were visualized. The left testicle is larger than the right, measuring 2.3 cm in length with a hyperechoic nodule measuring 0.83 cm and numerous hypoechoic motheaten lesions measuring 0.78 cm. The right testicle is smaller, measuring 1.9 cm in length with a hyperechoic nodule measuring 0.34 cm.

PRIMARY FINDINGS

- Large, irregular, cystic prostate – most consistent with benign prostatic hypertrophy +/- prostatitis and prostatic abscesses/cysts. Recommend urinalysis and culture and a fine needle aspirate of the prostate to determine if these cystic lesions are abscesses.

- Large, hyperechoic liver with ill-defined hypoechoic nodules – The diffuse hepatic changes are non-specific and can be seen with vacuolar hepatopathy, reactive change, nodular hyperplasia or, less likely, inflammatory/immune-mediated disease, infiltrative neoplasia, or other hepatopathy. The hypoechoic lesions trend towards being more benign in appearance, but an underlying neoplastic lesion cannot be excluded as a possibility.

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

- Large, nodular right testicle with a smaller left testicle with a hyperechoic nodule – These lesions could represent benign or cancerous nodules.

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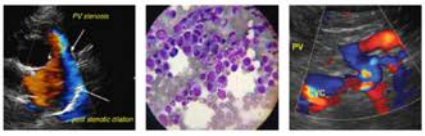

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SECONDARY FINDINGS

- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The prostate is large and cystic. These findings are consistent with benign prostatic hypertrophy, and there is concern for concurrent prostatitis based on the history of a suspected urinary tract infection. Hopefully a culture is pending. If not, recommend a culture despite currently being on antibiotics. If a sample of fluid from the prostate can be obtained, you could consider performing a culture on that. Recommend neutering and prolonged antibiotic therapy with cultures while on antibiotics, and routinely after discontinuation, as there is concern that the prostate may be a source of chronic infection.

The liver is large and hyperechoic with some ill-defined nodules/lesions. The significance of this is unclear. This is likely unrelated to the current illness, but a liver function test and fine needle aspirate of the liver could be considered (provided coagulation parameters are normal).

Both testicles are somewhat irregular with nodule type lesions. Recommend submitting histopathology at the time of neuter.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.

It is unclear if this patient's vomiting is secondary to the prostate, or if it could be secondary to antibiotic therapy, etc. Recommend symptomatic care for gastrointestinal upset. Consider IV antibiotics for a few days while contemplating neutering this pet.

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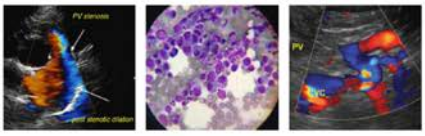

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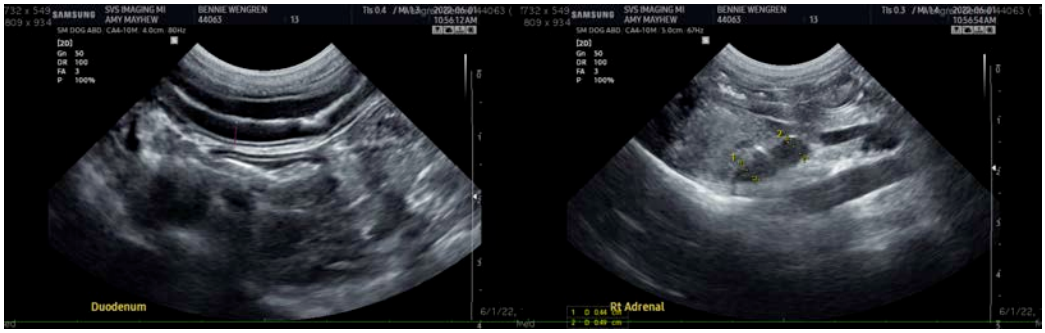

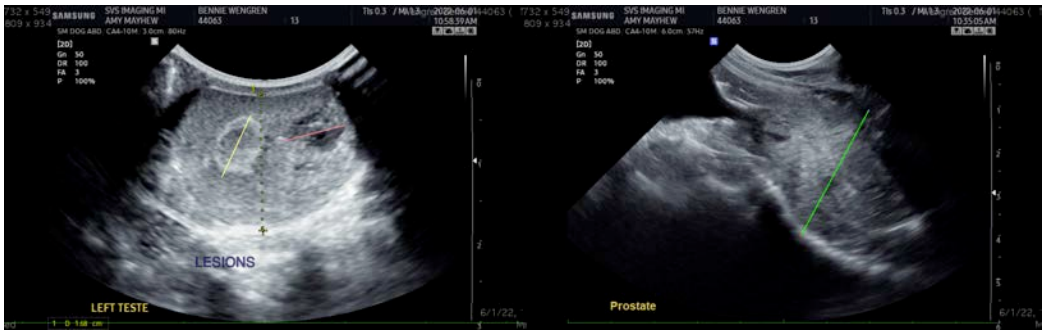

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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