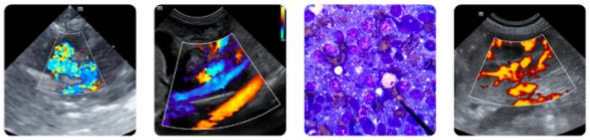


PATIENT

Maverick Lair

SPECIES

Canine

BREED

Black Mouth Cur Mix

SEX

Male

AGE

6 Years

WEIGHT

15.2 kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP

IMAGING PERFORMED BY

Natalia Franco

HOSPITAL NAME

Eagleson Veterinary Clinic

REFERRING VET

Dr. Mohammed Ammar

INVOICE

13126

DATE

01/13/26

PRESENTING CLINICAL SIGNS

Presented yesterday for anorexia, lethargy and inappropriate urination. Patient overall very lethargic and painful even with hospitalization and supportive care. Enlarged, painful kidneys and prostate on PE. Decreased urine production. AUS recommended for further evaluation of prostate and kidneys.

Abnormal PE/Chem/CBC/UA Results: Yesterday: CBC: Leukocytosis by neutrophilia 23.2 (2.3-9.8) Chem: BUN 63.9 (2.5-8.9); CA 2.99 (2.15-2.95); PHOS 5.43 (0.94-2.13); CREA 1420 (27-124) Pancreatic Lipase 312 (0-200) UA: USG 1.017; proteinuria; high RBC and WBC. No significant change after 12 hours hospitalization except from normalized calcium. Abdominal fluid clear, mild yellow tinge. Urine culture, abdominal fluid cytology and prostate FNA results pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was contracted in appearance without evidence of current lumen urine. Subjective mildly thickened urinary bladder wall although assessment of urinary bladder wall was limited owing to lack of urine. Foley catheter was present in the urinary bladder lumen extending into the visible proximal urethra.

The prostate was asymmetrically enlarged with nonhomogenous hypoechoic parenchyma exhibiting multiple prostatic cystic lesions. Some cystic lesions contained mildly echogenic fluid with an example of cystic lesion measuring 2.3 cm in diameter. No obvious prostatic mineralization. The prostate measured 5.3 cm x 3.7 cm.

No obvious medial iliac or sublumbar lymphadenopathy or masses.

The bilateral kidneys were normal in size and contour. A normal 1:3 cortex / medulla ratio with mildly enhanced corticomedullary parenchyma echogenicity and indistinct corticomedullary border demarcation were present. The kidneys exhibited mild to moderate hydronephrosis with fluid extending into the lateral diverticuli. Concurrent left and right proximal hydroureter. Increased left and right perinephric retroperitoneal echogenicity. The left kidney measured 7.5 cm in length. The right kidney measured 7.4 cm in length.

Adrenal Glands

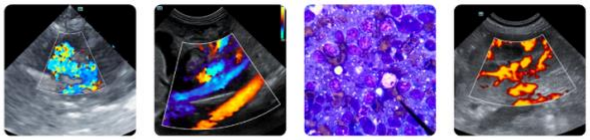
The left and right adrenal glands were not definitively visualized.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver & Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion.



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Transdiaphragmatic view revealed comet tail lung pattern, which is echogenic sound wave interface with microconsolidations within the caudal lung field. The lung field should not be visualized by sonogram unless pathology is present. Chest radiographs are recommended to rule out alveolar/lung disease such as neoplasia, thromboembolic disease, chronic inflammatory disease with microconsolidation.

The gallbladder was non distended in size with mild nonorganized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The stomach was nondistended containing a mild amount of retained gastric fluid.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

Caudal retroperitoneal to intermittent mild peritoneal effusion and increased retroperitoneal omental echogenicity. No evidence of mid abdomen mesenteric lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Asymmetrical prostatomegaly exhibiting nonhomogenous hypoechoic parenchyma with prostatic cystic lesions containing anechoic to mildly echogenic fluid- prostatitis, hyperplasia, neoplasia, prostatic cyst versus abscess, prostatic necrosis all possible.
- Empty yet subjective thickened urinary bladder with Foley catheter.
- Bilateral nephropathy exhibiting bilateral hydronephrosis and concurrent left and right proximal hydroureter.
- Subjective associated retroperitonitis including retroperitoneal to mild peritoneal effusion.
- Mild hypomotile gastritis with sonographically normal small bowel- suspect uremic gastritis.
- Transdiaphragmatic comet tail artifact.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Correlation with pending urine culture, abdominal fluid, cytology +/- culture and sensitivity and prostate FNA cytology is recommended for further clarification. Severe bilateral pyelonephritis and concurrent ureteritis with concern for non-visualized distal bilateral ureteral obstruction given bilateral hydronephrosis is warranted. Continued renal support with monitoring of urine output and body weight given the potential for acute renal failure is indicated for further prognosis. Extremely guarded prognosis is suspected.

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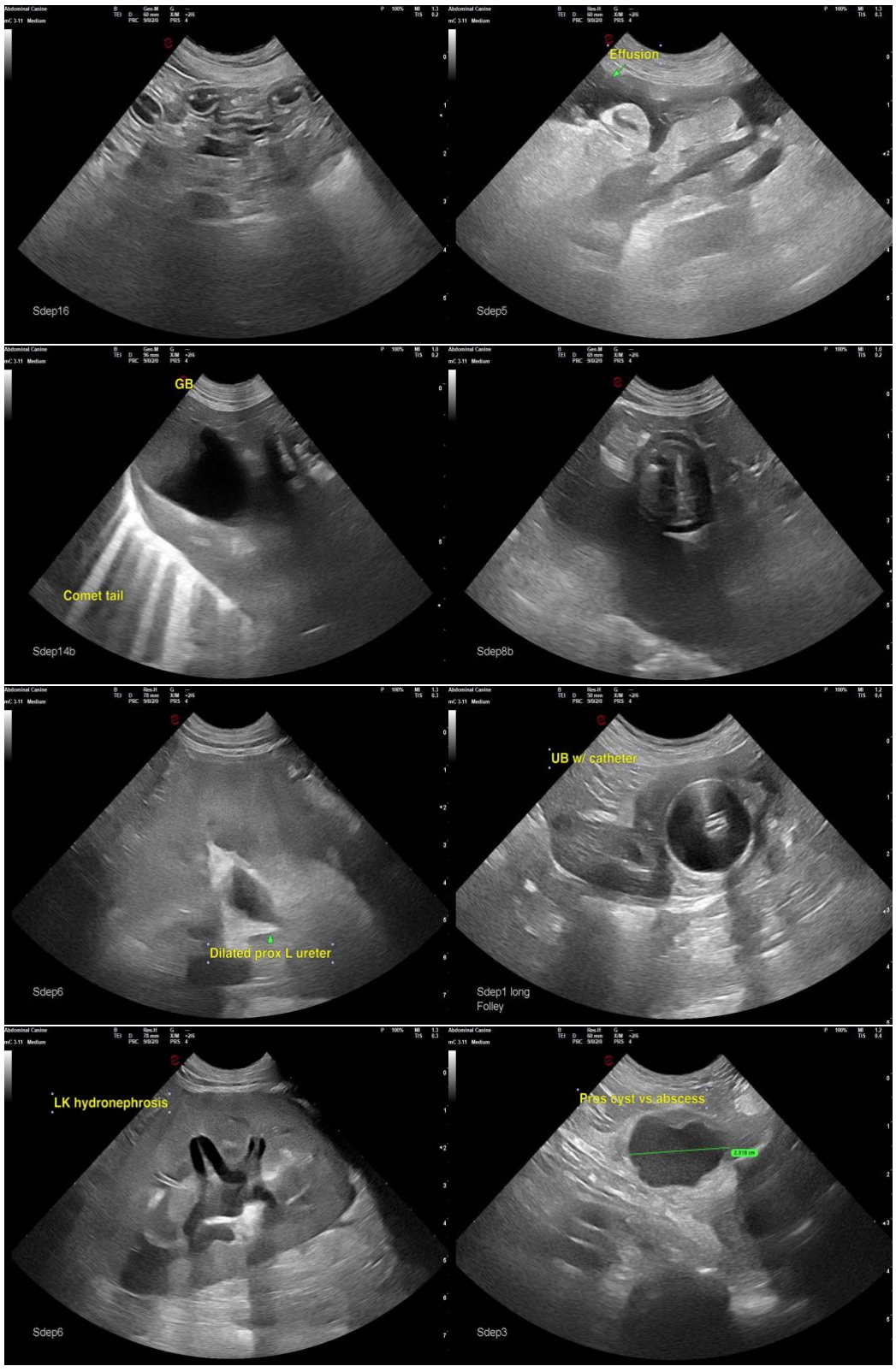

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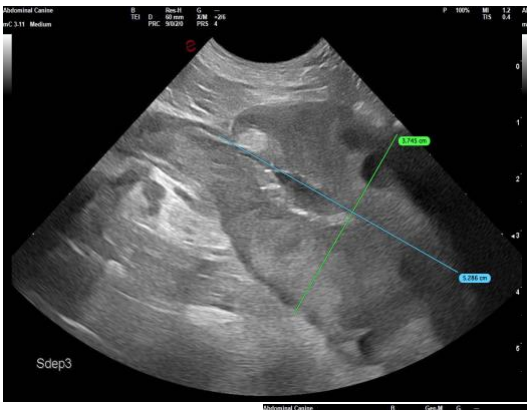

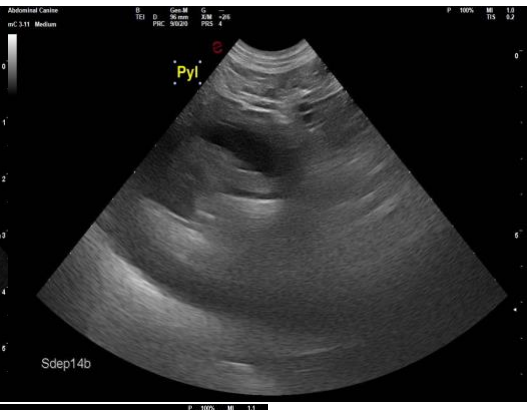

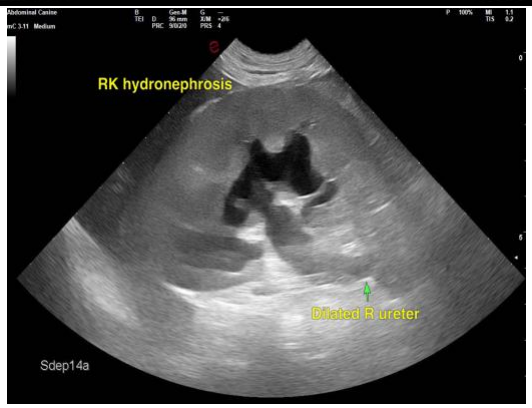

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com