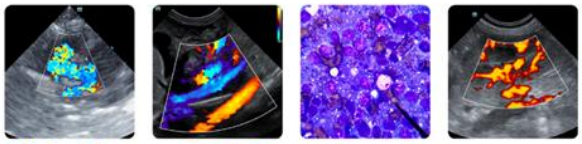


PATIENT

Ben Ward

SPECIES

Canine

BREED

Jack Russel Terrier

SEX

MN

AGE

9yr

WEIGHT

8.2kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Cypress Veterinary Clinic

REFERRING VET

Laura Johnson, VMD

INVOICE
23616

DATE
01/19/2026

PRESENTING CLINICAL SIGNS

- AUS to further evaluate straining to defecate, new onset urinary urgency and incontinence with accidents in the house, weight loss (~ 3 lbs) and vomiting. Concern for prostatic disease vs TCC vs other neoplasia vs GI dz. Stool consistency varies: sometimes larger and more formed, other times thin and ribbon-like. Rectal exam showed a 1.5 cm firm, round mass palpated with slight prominence of the right side, presumed prostate. Mobile and not painful on palpation. Since just after Christmas P has had diarrhea and has been straining and going frequently. over last couple days P has had urgency to urinate. Playing with other dog and stopped to vomit. Vomits intermittently - O not able to see a pattern but seems to be on an empty stomach. UA shows mod cocci and WBC, however, UC showed no growth, GI Panel was WNL. PMH: Grade 3-4/6 HM
- Diet: GI biome wet food
- Meds: pimobendan, metro
- AUS pre-hosp sedation: Gabapentin / Trazodone

Abnormal PE/Chem/CBC/UA Results: - CBC: Hct 51.3%, Neut 12.168 H, Mono 0.961 H, Plts 409, remainder NSF - Chem: NSF - UA: USG 1.022, pH 7, Pro 1+, WBC 15-20/hpf, RBC 10-15/hpf, Bact mod cocci 9-40.hpf, epi cell 1+ (1-2/hpf), Previous urinalysis showed elevated epithelial cells - UC: No growth - BRAF urine collection kit provided to O: Pending - AXR: stomach full of food, small urinary bladder, no obvious foreign body, minimal stool present - GI Panel: Spec cPL: 30 (0 - 200 µg/L); Trypsin-like Immuno-reactivity (TLI): 18.0 (5.0 - 35.0 ug/L); Cobalamin (B-12): 637 (284 - 836 ng/L); Folate: 6.5 (4.8 - 19.0 µg/L) - Comp fecal, diarrhea panel: NPS, neg PCR panel for enteropathogenic organisms - T4: 1.4-n

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

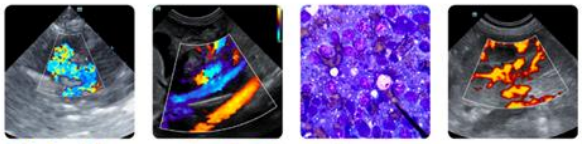
Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with mild non-dependent particulate urine sediment. The ureteral papillae were normal. The ureters were not visible, which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 4.9 cm in length. The right kidney measured 4.7 cm in length.

The area of the iliac trifurcation was free of pathology including no evidence of medial iliac or sublumbar lymphadenopathy or masses.

The residual prostate was mildly enlarged with intact, mildly symmetrical capsule contour exhibiting mild non-homogenous to hypoechoic parenchyma with pinpoint hyperechoic parenchyma foci. Subtle subjective periprostatic hyperechoic omentum. The post-prostatic urethra was free of overt pathology to a depth of 5 cm.



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Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.45 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.61 cm width at the caudal pole.

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. Normal vascular volume. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild to moderate shadowing ingesta with no signs of obstruction.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine contained mild segmental non-shadowing ingesta with no signs of 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

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Non-distended urinary bladder with mild urine sediment.
- Mildly enlarged non-homogenous hypoechoic residual prostate exhibiting pinpoint hyperechoic parenchyma.
- Normal gastrointestinal tract with shadowing gastric ingesta

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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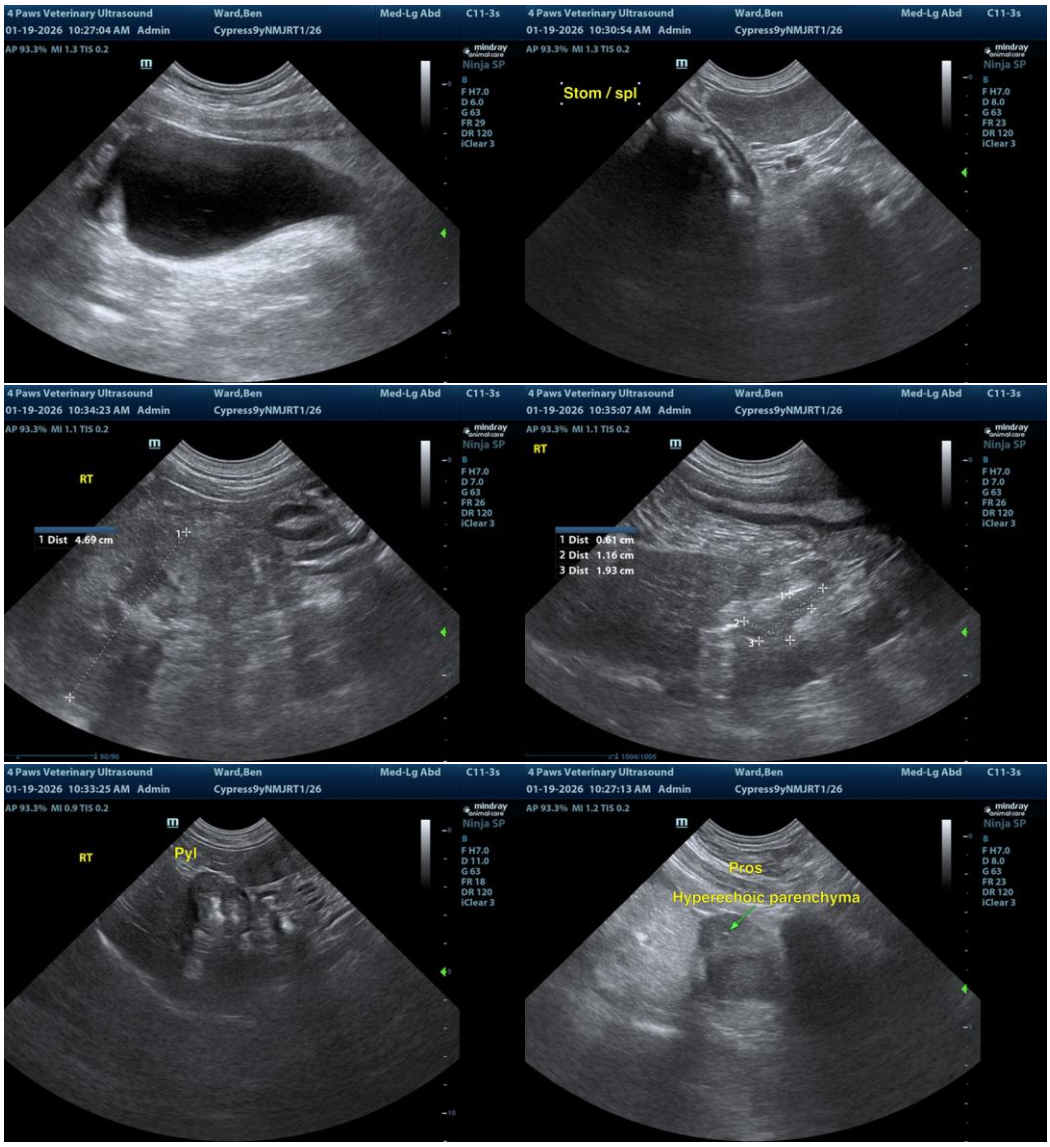
Although potential for residual prostatitis, strong concern for emerging prostatic neoplasia, i.e. transitional cell or prostatic carcinoma, is warranted. The pinpoint prostatic hyperechoic parenchyma is suggestive of pinpoint areas of prostatic mineralization. Further assessment may include a BRAF assay while prostatic sampling for cytology or biopsy is likely required for definitive diagnosis. If neoplastic process is confirmed, no evidence of current regional lymphatic metastasis.

Correlation with most recent meal ingestion recommended. If documented fast, 12 hour NPO with radiographic or sonographic monitoring for gastric emptying is recommended. No evidence of gastrointestinal pathology as a contributing factor.



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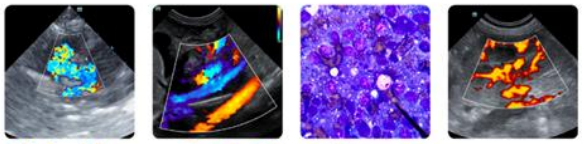

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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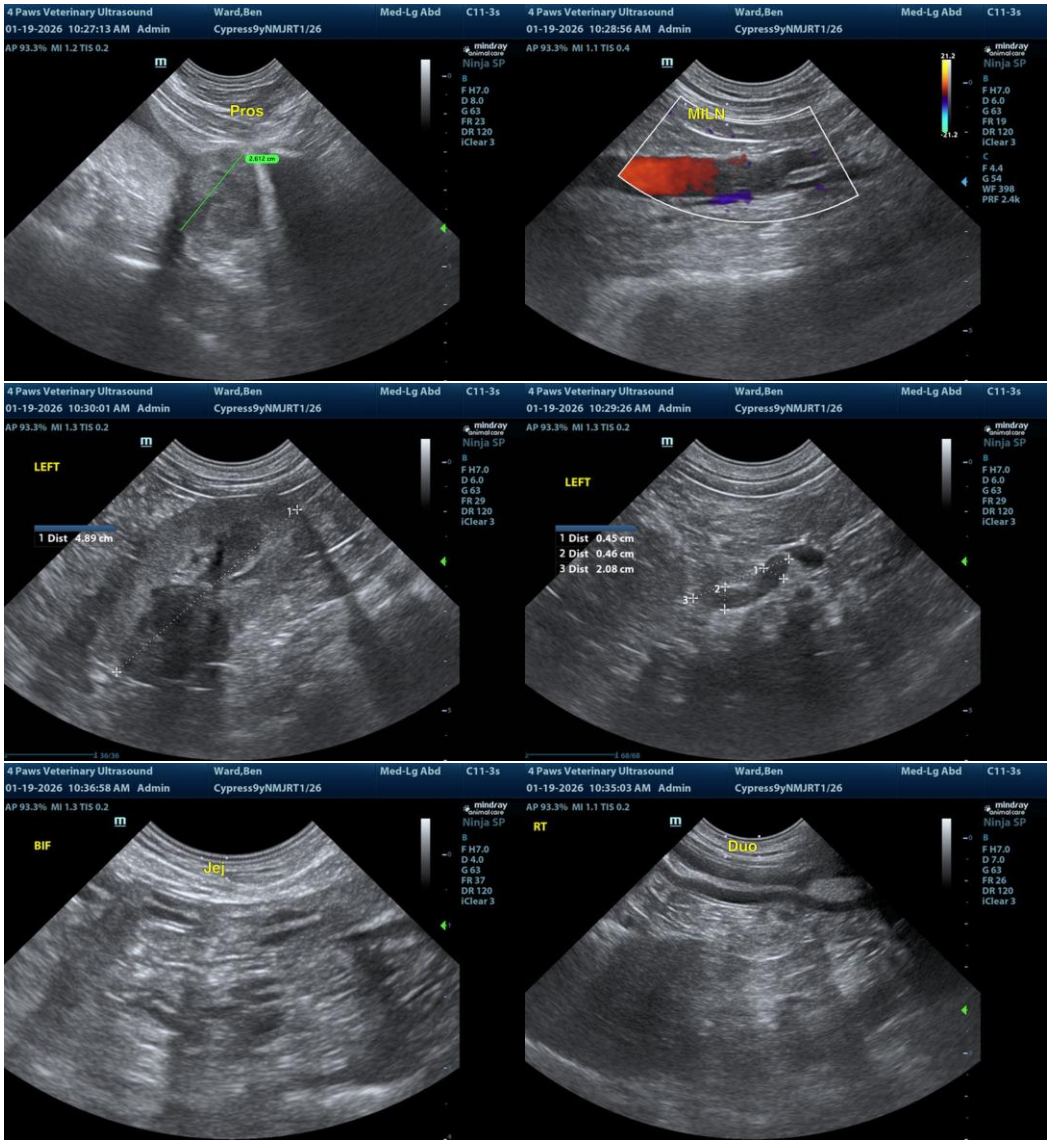

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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