



PATIENT

London Berar

SPECIES

Canine

BREED

Min Schnauzer

SEX

Male Intact

AGE

10 years

WEIGHT

8.18 kg

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. Sarah Barthelemy

HOSPITAL NAME

Calgary Holistic Vet
Clinic

REFERRING VET

Dr. Qi

INVOICE

15320

DATE

11/1/22

PRESENTING CLINICAL SIGNS

Chronic hx of proteinuria. Has been on benazepril. BP systolic 126 mmHg. Intact Male. Previous concerns dysuria and hematuria.

Abnormal PE/Chem/CBC/UA Results: Chronic elevated UPCR 3.2.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

The prostate was enlarged in size with an intact, primarily symmetrical capsule contour. The margins of the gland were intact and able to be differentiated from the surrounding tissue. The prostatic parenchyma was heterogeneous with a mixed pattern of varying echogenicity without evidence of parenchymal mineralization. The prostate measured 3.9 cm x 2.7 cm.

Solitary mildly prominent medial iliac lymph node was present. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). The lymph node measured 1.0 cm x 0.3 cm. The lymph node was not consistent with inflammatory or neoplastic criteria and likely incidental.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pyelectasia was present. Pinpoint areas of medullary mineralization were noted. The left kidney measured 5.1 cm in length. The right kidney measured 5.1 cm in length.

Adrenal Glands

The bilateral adrenal glands were mildly prominent in size based on caudal pole width measurement and in light of patient body weight. This is nonspecific and may indicate minor benign hyperplasia or minor adenomatous change without overt evidence of neoplastic criteria. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.57 cm width in the cranial pole and 0.69 cm width in the caudal pole. The right adrenal gland measured 0.53 cm width in the cranial pole and 0.67 cm width in the caudal pole.

Spleen

The spleen was overall normal in size and contour with mild generalized parenchyma heterogeneity. A solitary, mildly expansive, nonhomogeneous, possibly focally cystic nodule was noted in the cranial spleen measuring 2.4 cm in diameter. The nodule mildly distorted the caudal splenic capsule, yet without evidence of parenchymal escape.

Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to



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benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size containing mild, nondependent, mildly echogenic, nonorganized gallbladder debris. No evidence of gallbladder or peripheral gallbladder inflammatory criteria was noted. 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 echogenic, nonshadowing ingesta without signs of obstruction or foreign material. This is likely consistent with recent meal ingestion. The stomach was otherwise normal.

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 pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia. This is likely consistent with age-related pancreatic changes and incidental. Minor remodeling owing to previously inflammatory episode or less likely chronic pancreatitis are possible.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Prostatomegaly exhibiting nonhomogeneous parenchyma - benign prostatic hyperplasia or prostatitis possible, neoplastic criteria considered unlikely
- Sonographically unremarkable urinary bladder
- Bilateral nonspecific mild chronic renal changes
- Subjective mild prominent adrenal glands - nonspecific
- Mildly expansive nonhomogeneous caudal splenic nodule - hyperplasia, hematopoiesis, focal splenitis, less likely emerging neoplasia all potentials
- Mild heterogeneous pancreas - likely incidental
- Subjective mild prominent adrenal glands

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sonographic monitoring of the splenic nodule for evidence of progression with an initial recheck in 4-6 weeks would be reasonable. Screening FNA cytology of the nodule could also be considered using a 25-gauge needle and assuming normal clotting status.



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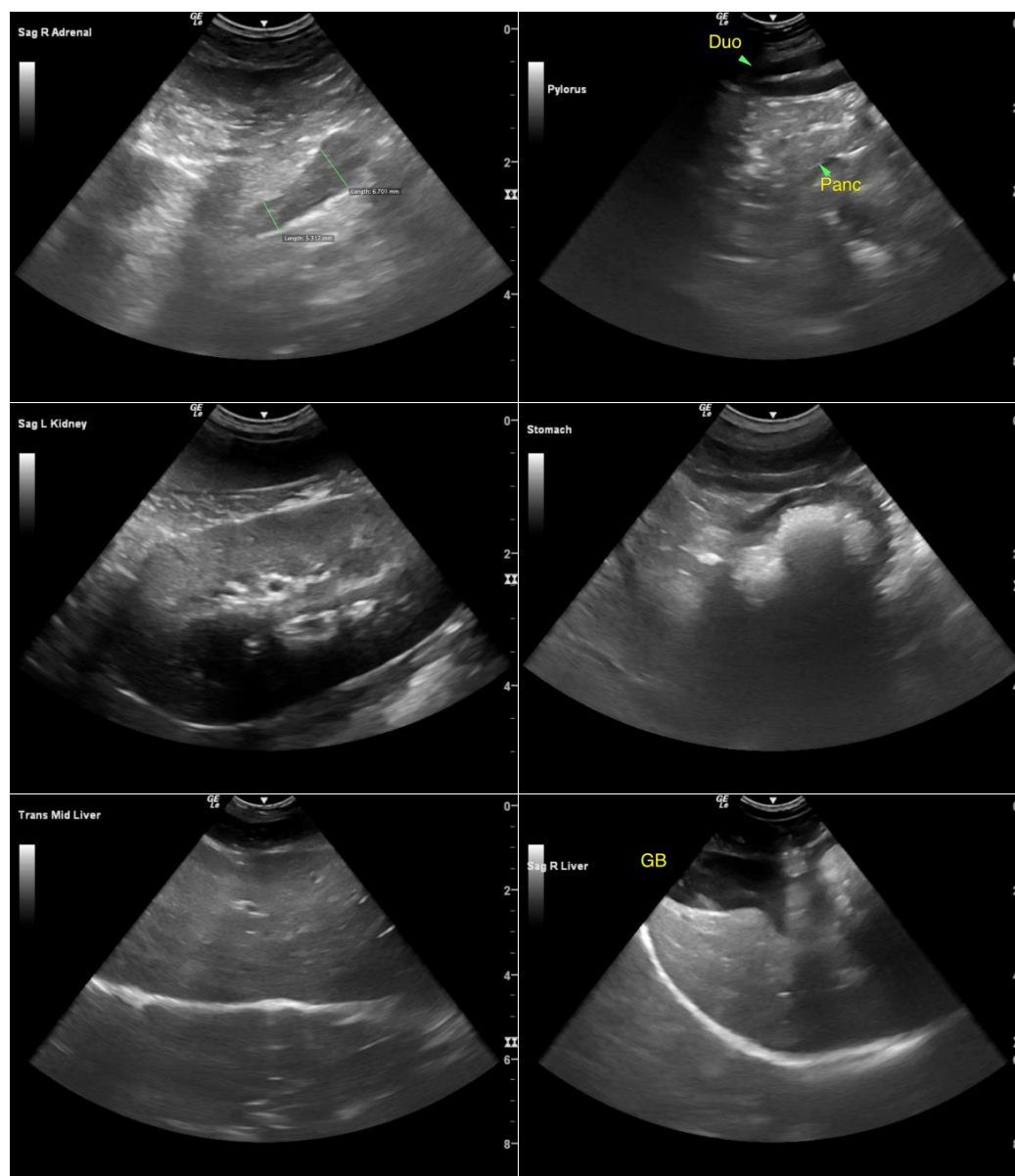
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Continued PLN therapy would be appropriate if persistent to chronic UPC elevation on ideally cystocentesis urine sample to minimize potential influence of inflammatory cells associated with the prostate on free catch urine sample if clinically applicable. A reduced protein renal diet could prove beneficial.

Hepatosupportive medications including Denamarin and Ursodiol may prove beneficial if evidence of cholestasis.

Prostatic sampling either via ultrasound-guided FNA or prostatic wash for cytology is required for further assessment.





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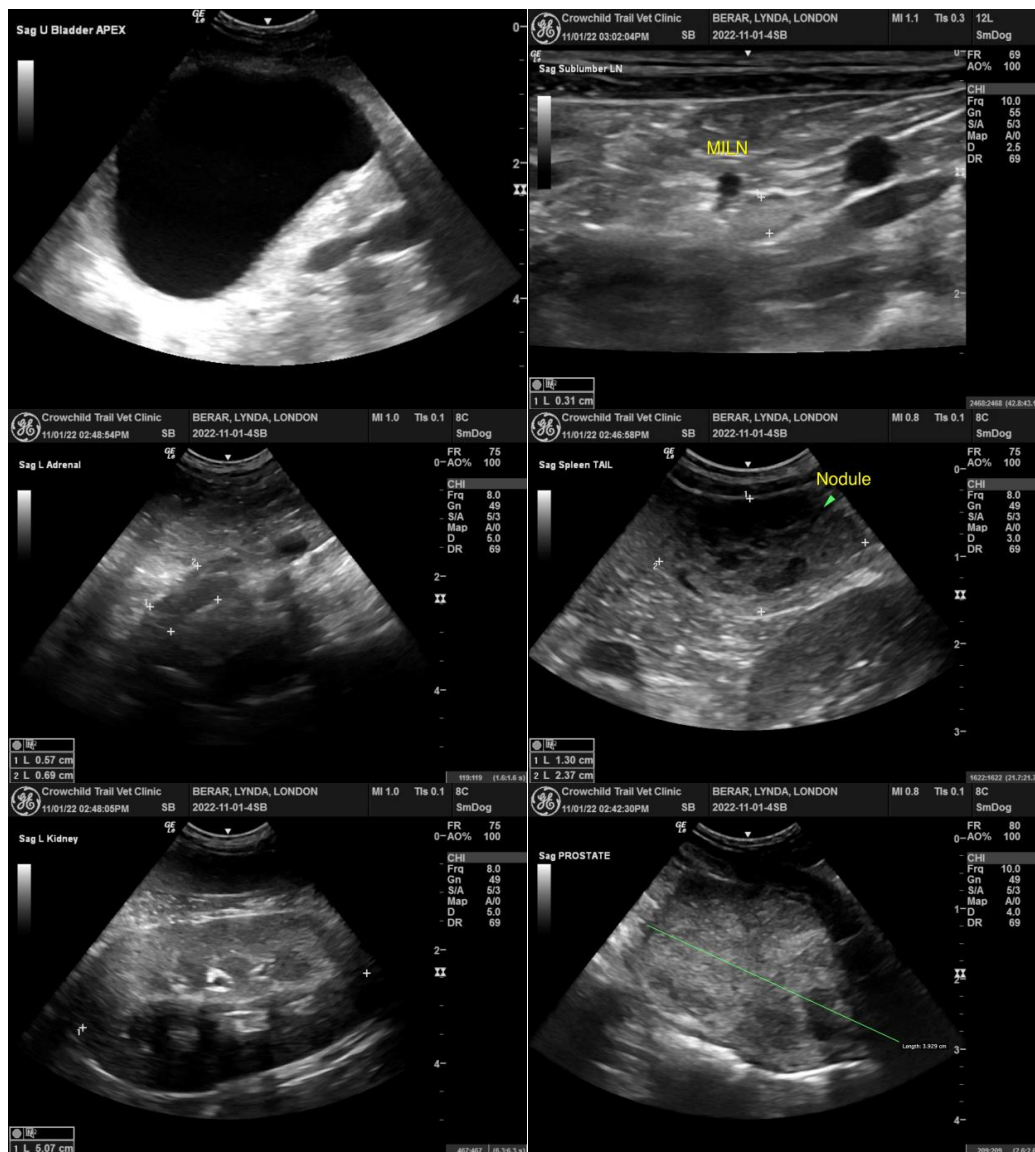
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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