



**PATIENT**

Cyclone Garcia

**SPECIES**

Canine

**BREED**

German Shepherd

**SEX**

Male Intact

**AGE**

10

**WEIGHT**

82

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Julissa Diaz

**HOSPITAL NAME**

Centro Veterinario  
Del Norte

**REFERRING VET**

Dra, Gabriela Cidre

**INVOICE**

13888

**DATE**

5/17/22

**PRESENTING CLINICAL SIGNS**

Dog presented for evaluation of intermittent episodes of hematuria since early January 2022. Previously evaluated at another veterinarian where radiographs were taken (owner does not have a copy of these at the moment) as well as bloodwork. The veterinarian did not see evidence of uroliths and noted mildly enlarged prostate and was diagnosed with presumptive prostatitis treated with orbifloxacin. The bloodwork was all within normal limits (but did not bring result with him). The dog improved for some time but then started with hematuria again and was treated on two occasions with the same antibiotic but the dog continues with the problem. The dog does not strain to urinate and voids bladder regularly but will have some hematuria from urine dripping intermittently. Dog defecated normally and is otherwise healthy. On presentation today dog is BAR, BC 5/9, normal hydration with pink/moist mucous membranes. TPR within normal limits. Abdomen is not painful on palpation, given the dog's large size prostate is difficult to palpate. Examination of penis is within normal limits, no evidence of trauma. CBC and Chem with SDMA and 4DX were all within normal limits. Urine catheter (8F) was passed through urethra and no obstruction was noted. Dog became uncomfortable when reaching os penis and flexure. Urine sample was taken and sent for UA (given dog is currently receiving antibiotics a culture was not performed). Given long history of problem/age of dog an abdominal US was recommended.

**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, sediment, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic criteria was noted. The visualized proximal urethra exhibited normal structure and tone to a depth of 2.0 cm.

The prostate was enlarged in size with 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 subjectively measured approximately 4.0 cm x 3.6 cm. No overt evidence of periprostatic inflammation was noted.

The area of the aortic trifurcation was free of pathology without evidence of medial iliac or sublumbar lymphadenopathy.

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 pelvic dilatation was present. The left kidney measured 7.2 cm in length. The right kidney measured 7.6 cm in length.

**Adrenal Glands**

No overt pathology was noted in the area of the left or right adrenal glands.

**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



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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.

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**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. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

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**Gastrointestinal**

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The stomach presented intact wall layering with a normal wall layer ratio. Minor progressively shadowing Ingesta was present.

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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.

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**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 were evident.

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**Free Abdomen**

No overt lymphadenopathy or peritoneal effusion was present.

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**ULTRASONOGRAPHIC FINDINGS**

- Moderate prostatomegaly exhibiting mixed echogenic nonmineralized parenchyma
- Sonographically unremarkable urinary bladder and visible proximal urethra
- Mild age-related kidneys - no evidence of pyelonephritis

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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The prostatic presentation may indicate benign prostatic hyperplasia with primary concern for prostatitis, given the sonographic appearance and previous positive response to empirical antibiotics. Minor potential for prostatic neoplasia cannot be excluded yet thought less likely. No obvious evidence of concurrent urinary bladder or urethral pathology was noted. Prostatic sampling either via ultrasound-guided FNA or prostatic was for cytology +/- culture and sensitivity, as well as urine culture and sensitivity on a sterile urine sample, once off antibiotics, would be warranted.

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Given the lack of additional lower urinary tract pathology and assuming no evidence of non-visualized urethral pathology, the prostate is suspected to be the cause of the hematuria potentially secondary to inflammation or mild regional urethritis. Neutering with sonographic monitoring of prostatic involution may be ideal in this patient if possible.



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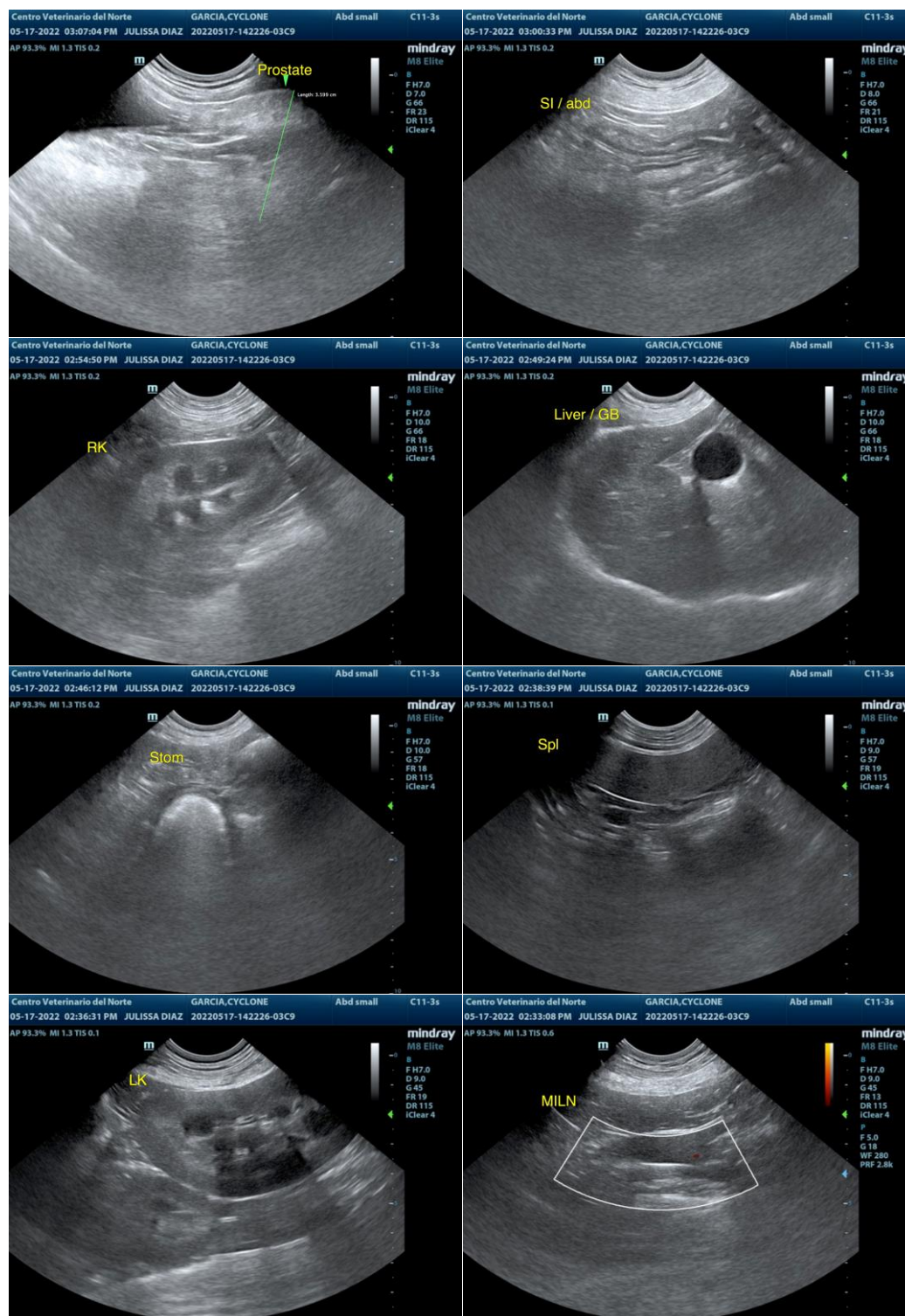
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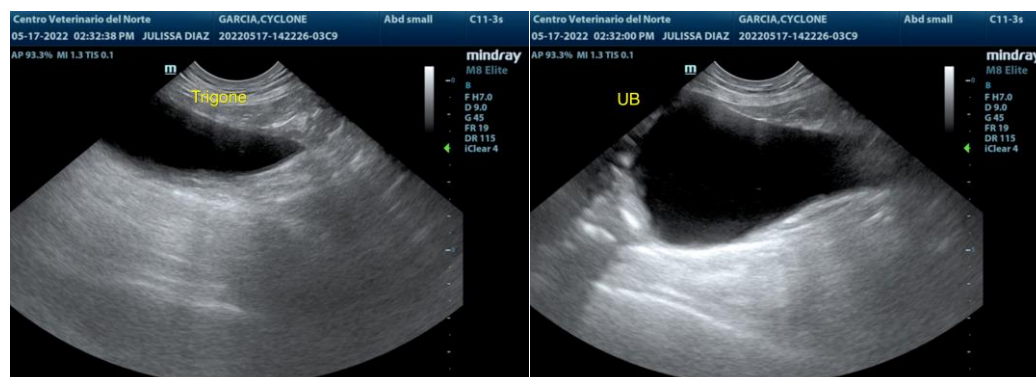
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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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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