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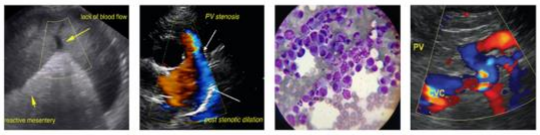


SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Dabo Pace

SPECIES

Canine

BREED

Beagle

SEX

M-

AGE

2015

WEIGHT

30

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebekah Jakum, CVT ARDMS/RVT

HOSPITAL NAME

Stanglein VC

REFERRING VET

Dr. Stanglein

INVOICE

15048

DATE

5/5/22

PRESENTING CLINICAL SIGNS

Blood from penis, diarrhea, distended abdomen, large prostate Amoxicillin

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 intact, symmetrical capsule contour. The margins of the gland were intact and able to be differentiated from the surrounding tissue. The prostatic parenchyma was mildly echogenic to heteroechoic without parenchymal mineralization. The prostate itself measured 5.5 cm x 3.3 cm.

Anechoic, thinly walled parenchyma cysts were present.

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 pyelectasia. The left kidney measured 6.2 cm in length. The right kidney measured 6.3 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.59 cm width at the caudal pole and 0.61 cm width at the cranial pole.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.47 cm width at the caudal pole and 0.43 cm width at the cranial 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.

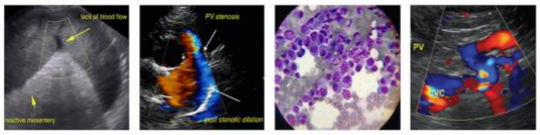
Liver/ Gallbladder

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. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non distended in size with primarily anechoic content with mild luminal debris. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction, or foreign material.



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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 semi-formed to soft feces in lumen, likely consistent with reported diarrhea.

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.

Free Abdomen

A solitary cystic medial iliac lymph node was noted dorsal to the urinary bladder and in the area of the iliac trifurcation, measuring 1.9 cm x 1.0 cm. No other evidence of additional medial iliac, sublumbar or intrabdominal lymphadenopathy.

Scant periprostatic free fluid was present along the cranial ventral aspect of the prostate. No evidence of additional areas of peritoneal free fluid.

ULTRASONOGRAPHIC FINDINGS

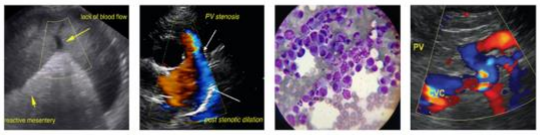
- Moderate prostatomegaly, exhibiting nonhomogeneous to cystic parenchyma, mild regional periprostatic free fluid/inflammation- consistent with probable prostatitis +/- benign prostatic hyperplasia with intraparenchymal cysts. No evidence of prostatic neoplastic criteria, which is considered unlikely
- Sonographically normal urinary bladder
- Normal bilateral kidneys- no evidence of pyelonephritis
- Focal cystic appearing subjectively benign medial iliac lymph node- likely consistent with chronic medial iliac lymphoid reactivity or hyperplasia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the lack of urinary bladder or renal pathology and assuming no evidence of pathology in the area of the penis, the hematuria in this patient is suspected to be secondary to prostatitis. Further assessment may include prostatic sampling, either via prostatic wash or ultrasound guided FNA for cytology, as well as, ideally, culture and sensitivity. Neutering is likely ideal in this patient with sonographic monitoring of prostatic involution as well as empirical therapy for prostatitis with consideration for empirical antibiotic therapy with fluroquinolone.

No overt evidence of gastrointestinal pathology. Dietary indiscretion/food intolerance, dysbiosis, parasitism, low-grade to chronic pancreatitis or inflammatory bowel disease, both of which may present sonographically normal could be considered.

Empirically, a limited antigen or hydrolyzed diet trial with potential long term dietary therapy, prophylactic deworming (Panacur 50 mg/kg SID x 5 consecutive days with repeat protocol in 3 weeks



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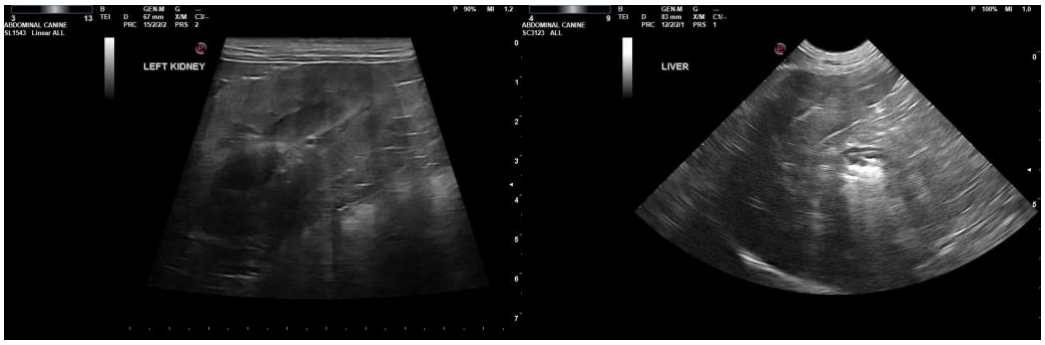
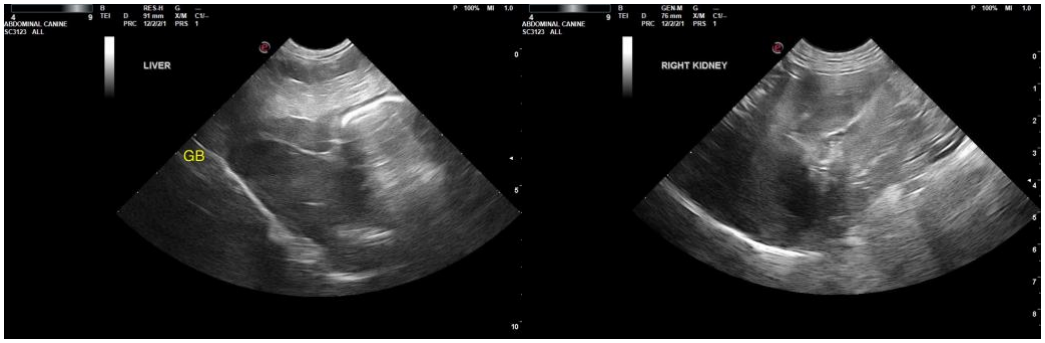
even if fecal testing is negative), high colony count probiotic (Proviable or Visbiome), antibiotic trial and as needed gastrointestinal support with assessment of clinical response may prove beneficial.





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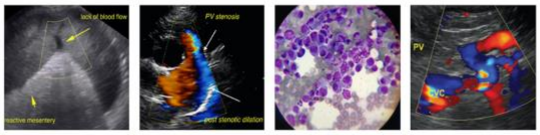

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
mac.daniel@sonopath.com