


**PATIENT**

 Cash Oregon Coast  
 Humane Society

**SPECIES**

Canine

**BREED**

Terrier X

**SEX**

Intact Male

**AGE**

10 Years

**WEIGHT**

10.4 kg

**INTERPRETED BY**

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

**IMAGING  
 PERFORMED BY**

Patti Mayfield, DVM

**HOSPITAL NAME**

 Emergency Vet  
 Hospital

**REFERRING VET**

Patti Mayfield, DVM

**INVOICE**

38883

**DATE**

6/19/22

**PRESENTING CLINICAL SIGNS**

Cash is a recently acquired patient from the OR Coast Humane Society-- he presented to EVH today due to concerns for hematuria (urine appeared diluted with blood)-- dripping out, hematochezia (uncertain if bloody diarrhea vs soft stools with blood clot) and ecchymosis on the ventral abdomen. He didn't eat well yesterday. Has been increasingly lethargic x 2 days. Uncertain if he vomited-- he was kenneled with 3 other seniors. Vaccinations on 5/24/22: DHLPP Bordatella Vacc on 6/2/22 Rabies PPH: Rectal mass; 1/2 cm ulcerated on rectum, ~ 6 o'clock Cryptorchid Severe POD TREATMENTS: 3 pm: Buprenex 0.13 mg IV TID 7 pm: IV fluids; Norm R @ 25 mL/hr 7 pm: Cerenia 1 mg/kg (10 mg) IV 6/19/22: 1 am: Enrofloxacin 10 mg/kg (104 mg) IV Carprofen 2.2 mg/kg (23 mg) SQ

Abnormal PE/Chem/CBC/UA Results: Physical Exam: -- Borderline pyrexia, 102.9 F -- Lenticular sclerosis OU -- ~ 6% dehydration -- Severe periodontal disease -- Mild abdominal pain; overweight, no palpable masses or FB's. Rectal reveals moderate prostatomegaly, with mild pain, R>L. ~ 5 mm crusting lesion on the anus, at ~ 6 o'clock. -- Unilateral cryptorchid, no lesions noted on the penis, however mild hematuria appreciated with manipulation. -- Hypopectia diffusely. ~ 5 cm region of ecchymosis at the L cranialateral region of the prepuce. -- Dull and obtunded. No obvious neuro deficits. Blood work: 6/11/2022 via Walnut Valley Animal Hosp: TP: 9.2 g/dL GLOB: 5.8 g/dl ALP: 227 U/L (5-131) CHOL: 379 U/L (92-324) PSL: 333 U/L (24-140) WBC: 16,100/uL (4000-15,500) PMN: 13,202/uL (2060-10,600) T4: < 0.5 ug/dL (0.8-3.5) CBC: HCT= 54% (wnl) WBC = 16.1K/uL (4000-15,500) PLTS = 386,000/uL (170-400) BLOOD WORK AT EVH 6/18/2022: 1.) CBC: -- HCT: 36.3% (37-61) -- RETIG: 20.1 pg (22.3-29.6) -- Leucocytosis; 42,080/uL (5050-16,760) -- PMN: 35,740/uL (2950-11,640) -- MONO: 1960/uL (160-1120) -- PLT wnl @ 192,000/uL (148-484) 2.) CHEM: -- Cl: 105 mmol/L (109-122) -- TP: 9.2 g/dL (5.2-8.2) -- GLOB: 6.5 g/dL (2.5-4.5) -- ALT: 196 U/L (10-125) -- ALP: 403 U/L (23-212) -- CHOL: 379 mg/dL (110-320) 3.) PT: 12 sec (11-17) 4.) PTT: 103 sec (72-102) 5.) Saline agglutination: NEG 6.) Platelet count (manual): 156,000/uL 7.) 4DX snap: NEG 8.) LAT/VD THORACIC RADS: --- Normal cardiac silhouette with no abnormalities noted of the airways and trachea. No abnormalities of the skeletal structures. Mild bronchointerstitial pattern, but no overt patchy infiltrates that suggest pneumonia, nor nodular changes that suggest metastatic lesions. No obvious pleural effusion or pericardial effusion. 9.) LAT/VD ABDOMINAL RADS: --- Stomach has normal axis, no noted ingesta with only mild gas and no noted FB/obstruction. Loops of SI are empty, with no noted FB or obstruction. No noted ascites, nor organomegaly. Subtle prostatitis noted. 10.) AUS-- pending 11.) Passed sterile red rubber U catheter to collect urine. 12.) UA-- dark yellow, USG: 1.038, pH: 7; 500 proteinuria, hematuria (250 RBC/uL); Pyuria, 500 WBC/uL; Further assessment will require dilution-- pending \* Additional urine held for potential C/S \*

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**
**Urinary System**

The urinary bladder was normal in size and tone with overtly normal urinary bladder walls. Primarily anechoic urine present with moderate non-dependent particulate urinary bladder sediment.

The prostate was enlarged in size with areas of mild prostatic capsule asymmetry. Non-homogeneous, hypoechoic parenchyma. Minimal cystic parenchymal changes present. No overt evidence of parenchymal mineralization. The prostate measured 5.6 cm in diameter. Regional periprostatic inflammation noted without evidence of periprostatic free fluid.

The area of the aortic trifurcation was free of pathology. No 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 dilation was present. The left kidney measured 5.2 cm. The right kidney measured 4.7 cm.



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**Adrenal Glands**

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.44 cm at the cranial pole and 0.51 cm at the caudal pole. The right adrenal gland measured 0.56 cm at the caudal pole.

**Spleen**

The spleen was overall normal in size and contour. Small, well demarcated, uniform hypoechoic non-disruptive nodule noted in the cranial spleen measuring 0.80 cm in diameter. A separate, mildly expansive, mixed echogenic nodule was noted in the caudomedial spleen, measuring 2.2 cm in diameter. This nodule appeared to mildly distort the medial splenic capsule contour.

**Liver**

The liver was overall normal in size subjective size. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. A solitary, well demarcated, mildly hyperechoic intraparenchymal nodule was noted in the mid liver measuring 1.0 cm diameter. 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. Moderate, non-dependent yet mobile, mildly hyperechoic gallbladder debris was present. No evidence of gallbladder or peripheral gallbladder inflammation. Hypoechoic areas within the gallbladder debris, suggestive of entrapped mucus, were present. 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 was empty with no signs of ileus, obstruction or foreign material.

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.

**Free Abdomen**

No overt lymphadenopathy or peritoneal effusion was present.

The reported retained testicle was not definitively visualized.

**ULTRASONOGRAPHIC FINDINGS**

- UB sediment - cellular debris / protein given the UA suspected
- Moderate prostatitis with regional periprostatic inflammation - possible suppurative prostatitis, potential neoplasia possible yet thought less likely
- Mild chronic kidneys with minor medullary mineral
- Nonspecific mildly expansive splenic nodules
- Vacuolar Hepatopathy pattern with solitary probable benign lipogranuloma / nodular hyperplasia – subjectively benign.



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- Moderate yet mobile GB debris (non mucocele)
- Mild heterogeneous pancreas - age related / patient variant, minor remodeling owing to previous inflammation, or low grade / chronic pancreatitis (not suggestive of significant inflammation).

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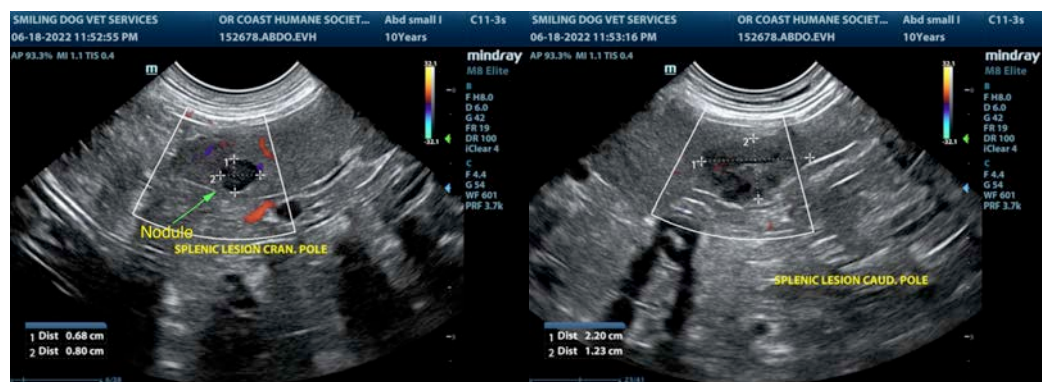
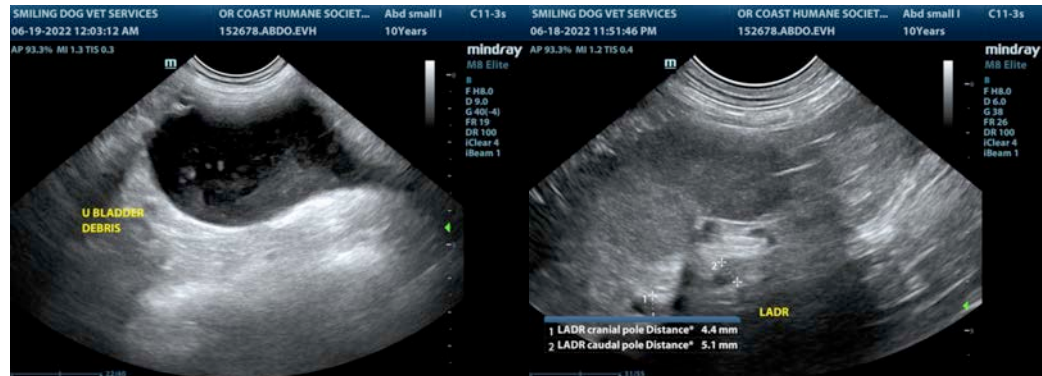
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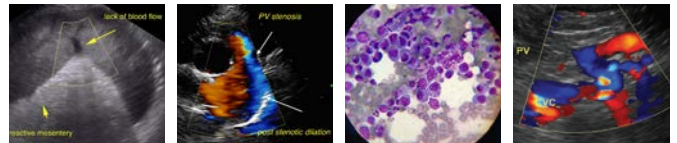
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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Prostatic sampling ie FNA or wash with cytology and C/S indicated. Neutering likely ideal. Concurrent urine C/S is recommended. Enrofloxacin pending sampling, Urine C/S with monitoring warranted. Potential etiologies for the splenic nodules may include benign processes such as nodular hyperplasia, extramedullary hematopoiesis, hematoma, infection, infarction, or neoplasia. Ultrasound guided FNA of the nodule using 25-gauge needle and assuming normal coagulation parameters may be considered. Otherwise, sonographic monitoring of the splenic nodules for any changes in size or appearance with initial recheck in 4 weeks would be a more conservative approach. Hepatic and GI support as needed is suggested.





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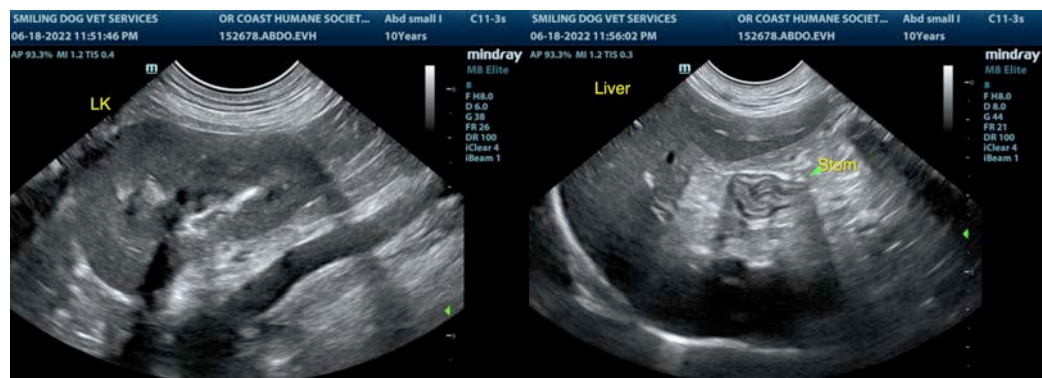
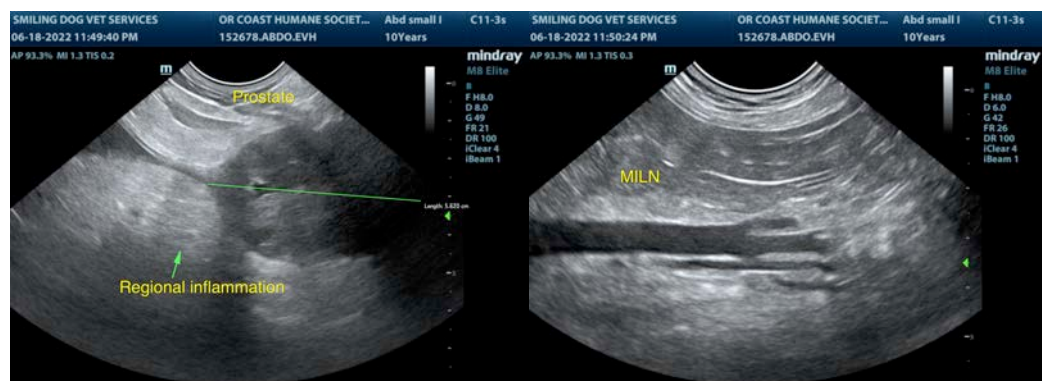
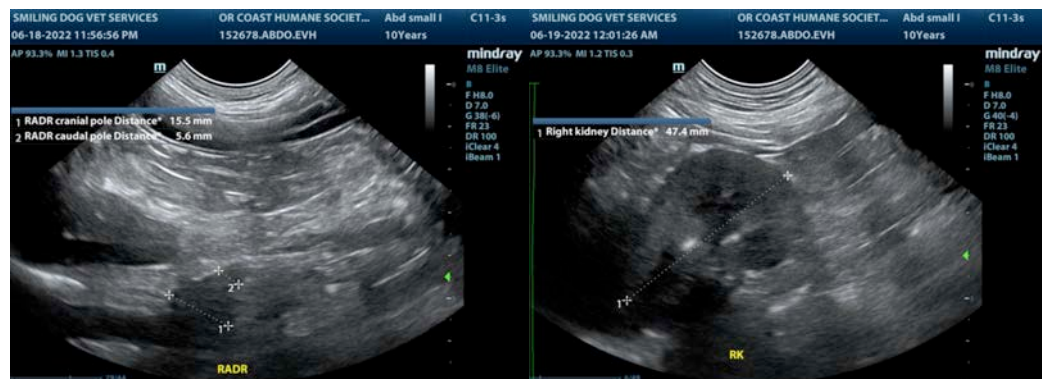
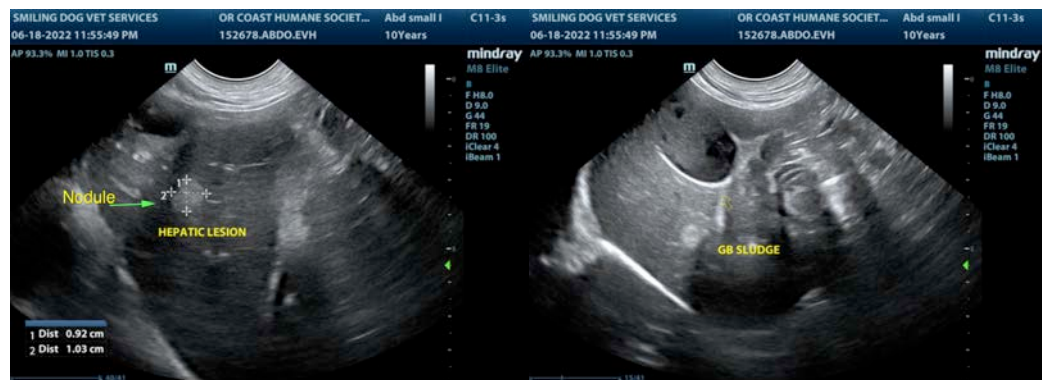
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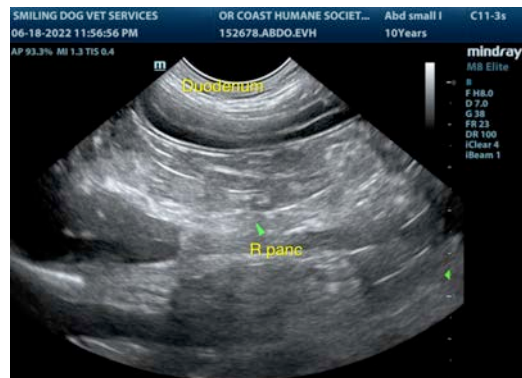
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)**

info@SonoPath.com

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