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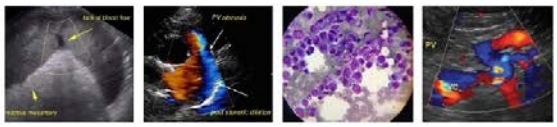


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Iggy Wilson

SPECIES

Canine

BREED

Husky

SEX

Intact Male

AGE

1 Year

WEIGHT

37 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Norwich Vet Clinic

REFERRING VET

Dr. Saturno

INVOICE

24877

DATE

8/24/21

PRESENTING CLINICAL SIGNS

BCS 1/9, wasted with weight loss Bilateral cryptorchid. Benign prostatic hyperplasia suspected. Struggling with BMs, almost prolapsing while straining. Very tense on palpation but can feel that caudal abdomen is full, suspect from prostate. Very reactive to palpation. Suspect malabsorption disorder? Has unusual skin masses also. Has been on Clindamycin without improvement.
Abnormal PE/Chem/CBC/UA Results: IDX TLI, B12, Folate normal Previous CBC, Chem, Fecal all normal/neg in July Blood glucose slightly high and very mild elevation in SDMA. Albumin was one point below normal range. T4 normal. Mild eosinophilia. U/A normal Sp Grav, some RBCs and a few Struvite crystals but was collected by owner at home.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm 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 were noted.

The prostate exhibited mild prominent size, yet not overtly enlarged given the intact status of the patient. The prostate measured 3.0 cm x 2.2 cm. 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.

Normal size and margination were present in the left kidney. 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 6.7 cm.

The right kidney was indistinctly visualized owing to patient conformation, body condition, and minor regional omental artifact. The right kidney measured 5.4 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.34 cm at the cranial pole and 0.32 cm at the caudal pole. The right adrenal gland measured 0.73 cm at the cranial pole and 0.45 cm at the caudal pole.

Spleen

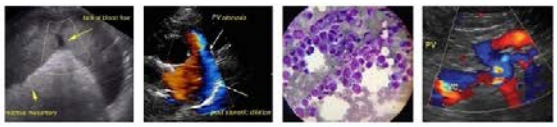
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver

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.

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. The jejunum exhibited mild segmental to generalized mucosal speckling. No overt evidence of loss of intestinal wall layering or overt small intestinal mural pathology such as intussusception. Jejunum wall measured 0.36 cm.

The colon walls presented intact yet prominent wall layering with mild thickened to echogenic submucosa, primarily in the descending to distal colon and colorectum. Generalized colonic distention noted with formed to shadowing feces. Distal descending to colorectal wall measured 0.28-0.37 cm in width.

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

Multiple, mildly prominent to enlarged mid abdominal mesenteric nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). Example measured 0.53 cm.

Subjectively cellular peritoneal free fluid was present.

The retained testicles in this patient were not definitively visualized.

ULTRASONOGRAPHIC FINDINGS

- Generalized colonic distention with formed to shadowing feces
- Thickened descending to distal colon/colorectum
- Mildly prominent to uniformly echogenic prostate
- Intact small bowel wall layering with mild jejunal mucosal speckling
- Mesenteric lymphadenopathy – immunologic immaturity, lymphoid hyperplasia, or minor reactive lymphadenitis likely.
- Mild peritoneal free fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of the patient's difficulty defecating appears to most likely be associated with the descending to distal colon and colorectum, exhibiting mild asymmetrical mural hypertrophy. This may indicate non-specific, potentially chronic colitis, while the possibility of descending to distal infiltrative neoplasia or other pathology are less likely, although possible. Given the size of the prostate, tenesmus associated with prostatomegaly is unlikely.

Concurrently, non-specific enteropathy given the patient's decreased body condition is suspected. Endoscopic or surgical enterocolic biopsies are recommended for further clarification. The etiology of the mild peritoneal free fluid is unclear assuming current normal albumin levels. Empirically, medical therapy for colitis along with empirical deworming (Panacur 50 mg/kg PO SID for 5 consecutive days with potential repeat protocol in 3 weeks) suggested, even with negative fecal testing.

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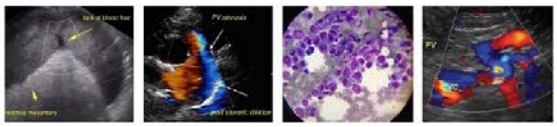

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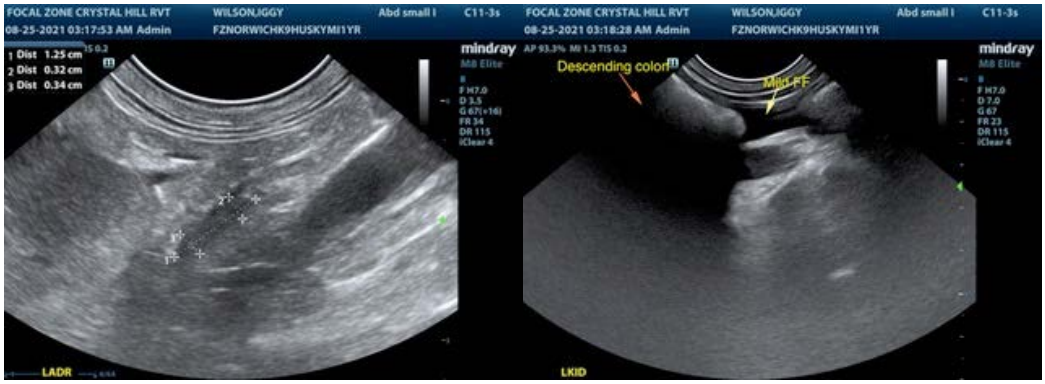

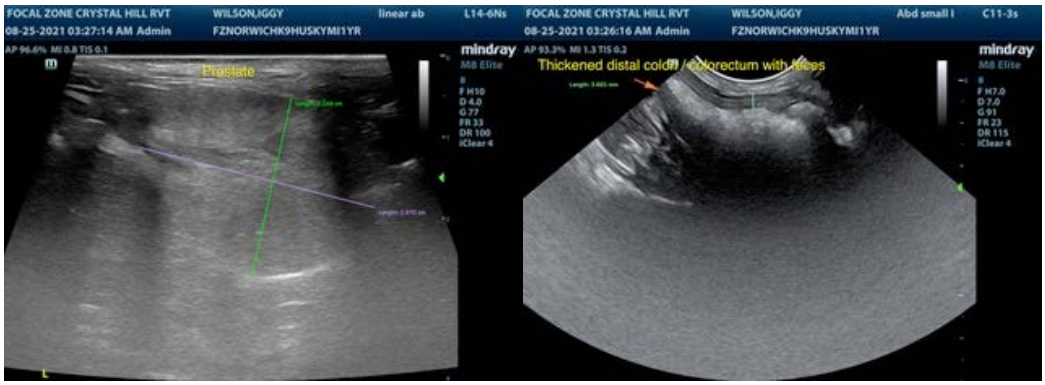

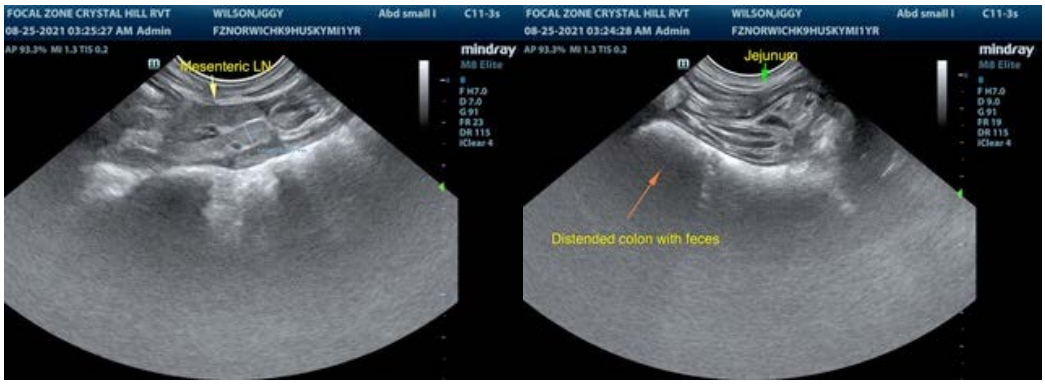

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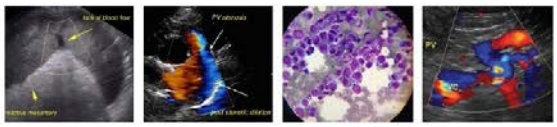

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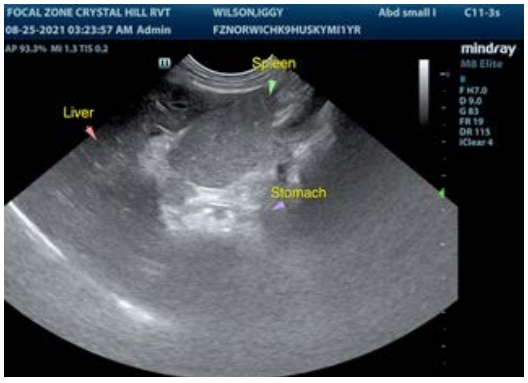

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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