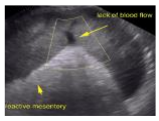
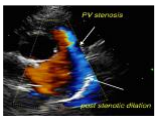
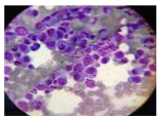
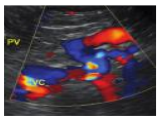





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Brooklyn McFayden

SPECIES

Canine

BREED

Yorkshire terrier

SEX

MN

AGE

12 years

WEIGHT

14 #

INTERPRETED BY

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM

IMAGING PERFORMED BY

Sonya Myers, DVM

HOSPITAL NAME

Oviedo Veterinary Care and Emergency

REFERRING VET

Dr Shoeppner

INVOICE

303152

DATE

7/27/22

PRESENTING CLINICAL SIGNS

History: Partial urinary obstruction due to prostamegaly.

Physical Examination: N/A.

Urinalysis: N/A.

CBC: N/A.

Serum Biochemistry: Azotemia and pancreatitis.

Radiographic Findings: N/A.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Full urinary bladder with a normal thickness and appearance of the wall. Small amount of floating hyperechogenic sediment. No uroliths evident. Foley urinary catheter present.

Irregular and thickened appearance of the trigone area. Thickened (1.5 cm) and irregular appearance of the proximal urethra. Normal iliac blood vessels.

Iliac lymphadenomegaly (left 0.8 x 1.9 cm, right 0.5 x 1.1 cm) with normal shape and echogenic appearance. Ureters not visualized.

Normal renal size (left 5.3 cm, right 5.5 cm) with increased echogenic appearance, some loss of cortico-medullary differentiation, and normal pelvis and capsule. Focal cortical cyst (0.9 cm) in the caudal pole of the left kidney.

Reproductive System

Irregular prostamegaly (3.2 x 5.5 cm) with a mottled echogenic and cavitatory appearance and areas of mineralization. FNA taken with no obvious post aspirate hemorrhage.

Adrenal Glands

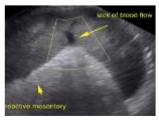
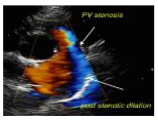
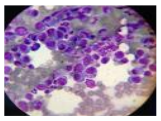
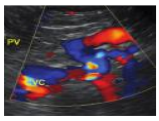
Normal shape, echogenic appearance, size, and position. Left 0.67/0.71 cm, right 0.67/0.69 cm.

Spleen

Normal size (2.3 cm) and echogenic appearance. Smooth homogenous parenchyma, regular curvilinear capsule, and normal vasculature. No evidence of inflammatory, neoplastic, infarction, or infiltrative changes noted.

Liver

Normal size, with a diffuse hypoechogenic and nodular appearance, some loss of portal markings, and regular curvilinear capsule. Nodules are parenchymal, faint, and hypoechogenic. No masses evident. Full gall bladder containing small amount of hyperechogenic sediment. Normal thickness and appearance of the gall bladder wall. Normal bile duct (0.2 cm).

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Gastrointestinal

Normal appearance of the stomach, ileo-cecal junction, and colon with no loss of layering, normal wall thickness (stomach 0.43 cm) and peristaltic activity, and no distension of the lumen. Thickening of the duodenum (0.54 cm) and small intestine (0.54 cm) with no loss of layering or distension of the lumen and normal peristalsis.

Pancreas

Enlarged (1.6 cm) with a diffuse mottled echogenic appearance and irregular capsule. Hyperechogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Normal mesenteric lymph nodes (2.9 cm).
Small amount of ascites
Hyperechogenic appearance of the mesentery.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Prostatic neoplasia with extension into the trigone and proximal urethra.
- Pancreatitis.
- Nodular hepatopathy.
- Enteropathy.
- Mesenteric inflammation.
- Iliac lymphadenomegaly.

Secondary Findings:

- Age-related renal changes.
- Urinary and gall bladder sediment.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

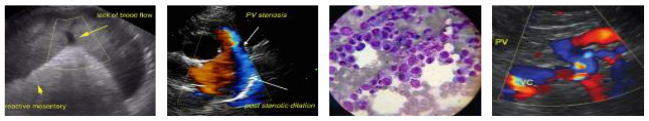
Etiologies for the pancreas would be resolving acute pancreatitis, chronic-active pancreatitis, and emerging neoplasia.

Etiologies for the nodular hepatopathy would be secondary to the pancreatitis, reactive, vacuolar, metabolic, nodular regeneration, early cirrhosis, chronic hepatitis, infiltrative neoplasia.

Etiologies for the enteropathy would be secondary to the pancreatitis, non-specific enteritis (viral, bacterial, protozoal, helminths, toxins, dietary indiscretion), inflammatory bowel disease, and dietary hypersensitivity.

The mesenteric inflammation can be ascribed to the pancreatitis.

The most likely etiology for the Iliac lymphadenomegaly would be reactive with lymphadenitis and infiltrative neoplasia, differential diagnoses.



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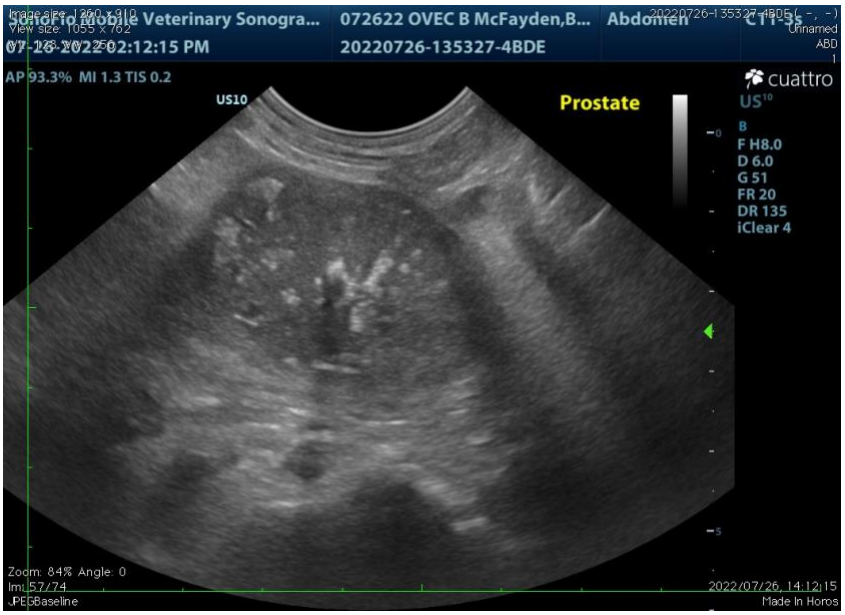
With the appearance of the prostate, bladder trigone, and proximal urethra, further assessment (urine and fecal analyses, cPL/PSL assay, FNA cytology of the liver, iliac lymph nodes and pancreas, and endoscopy of the upper GI tract with biopsies) would not be indicated.

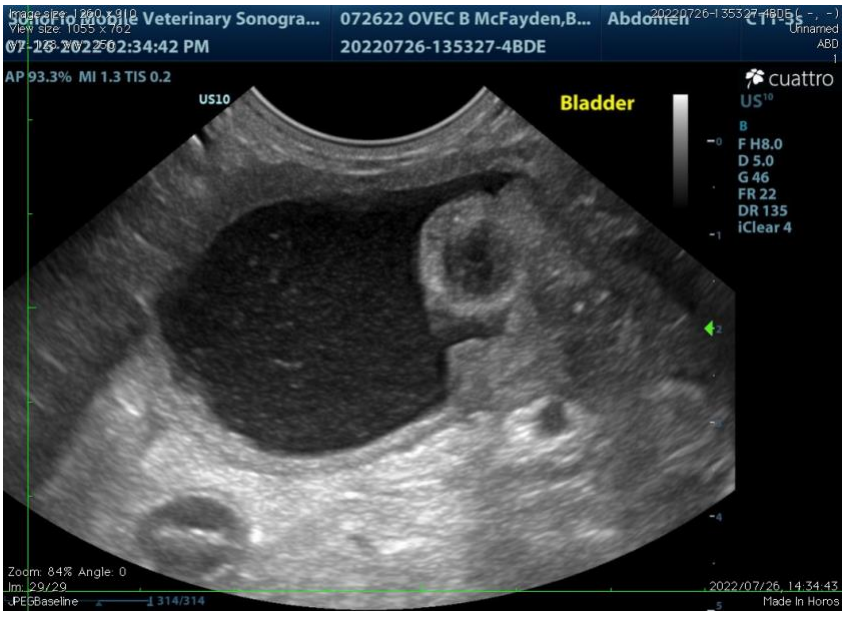
Management would be palliative urethral stenting and NSAIDs.

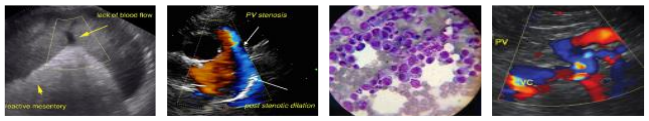
IMAGES

Prostate



Urinary bladder





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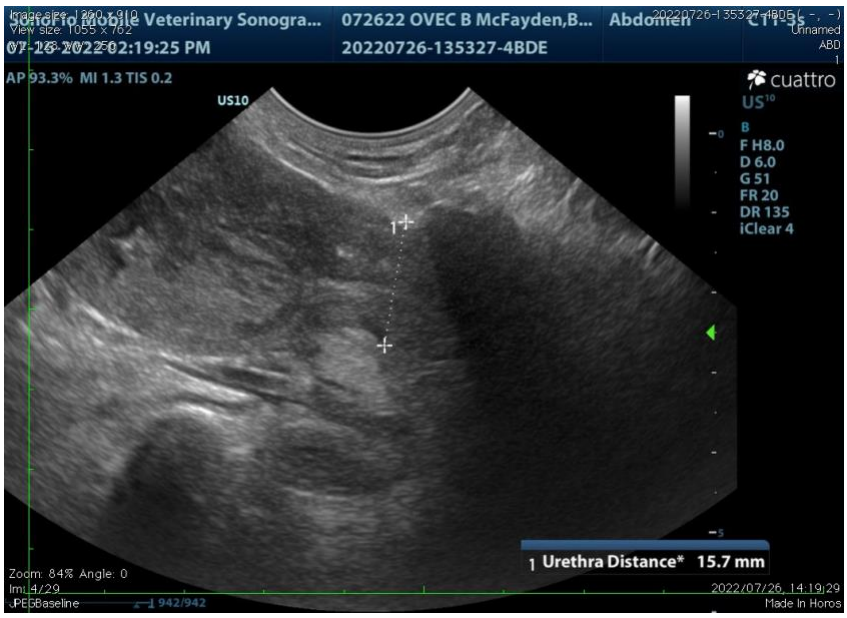
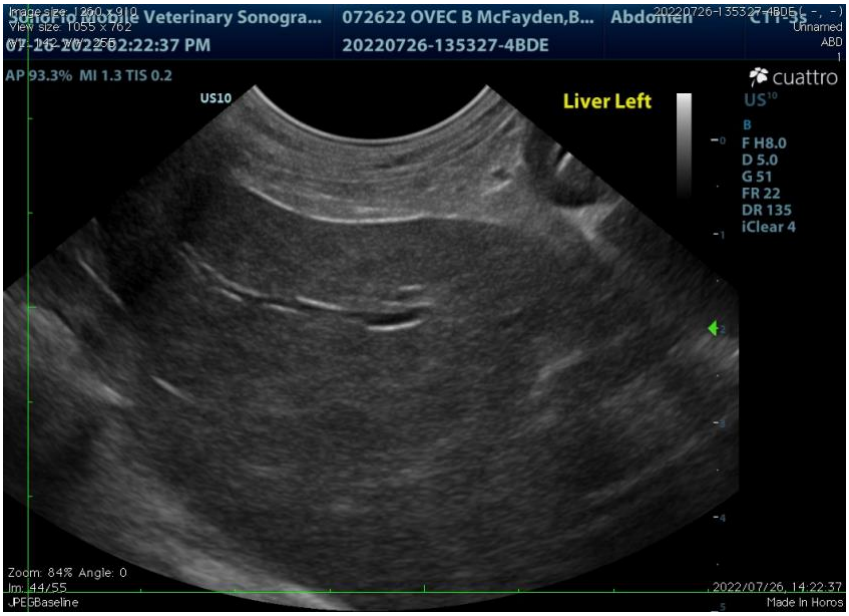
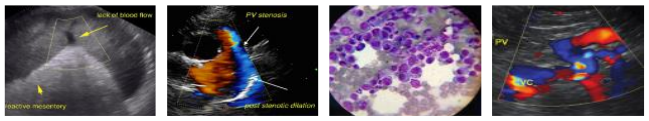
Urethra



Liver





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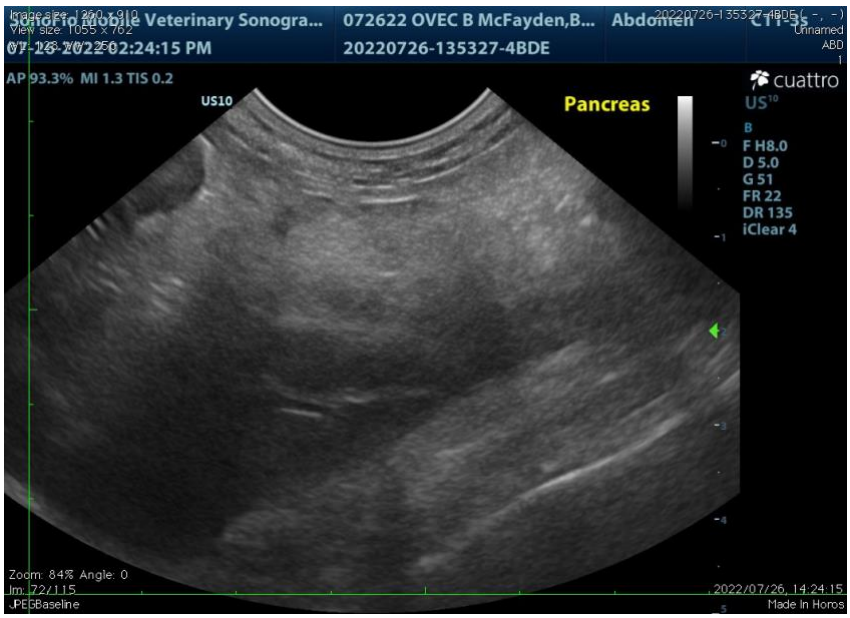
Pancreas



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.

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)
rlobetti@mweb.co.za