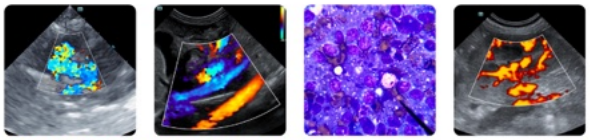


PATIENT

Captain Smith

SPECIES

Canine

BREED

Australian Shepehrd

SEX

Neutered male

AGE

12 years

WEIGHT

28 kg

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Catherine Alexander, LVT

HOSPITAL NAME

NorthStar VS

REFERRING VET

Dr. Kaiser

INVOICE

69507

DATE

12/10/25

PRESENTING CLINICAL SIGNS

History: Prostatic Mass, Braf+ Vinblastine 11/26/25

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder measures 2.62 mm and appears smooth. Due to underdistension, wall thickness may be overestimated. The urine is anechoic. Normal appearance of the proximal urethra and vesicoureteral junction. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 6.70x3.05 cm, and the cortical thickness is 0.51 cm in the sagittal plane. The cortex is isoechogenic compared to the liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis.

The right kidney is normal in shape and size: 6.32x2.87 cm, and the cortical thickness is 0.60 cm in the sagittal plane. The cortex is isoechogenic compared to the liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis.

Enlarged prostate: 4.06x3.3 cm approx. The prostatic parenchyma is heterogeneous, containing a 2.46x1.60 cm structure with a thin wall and anechoic fluid that appears turbid. The surrounding prostatic parenchyma appears hyperechoic.

Adrenal Glands

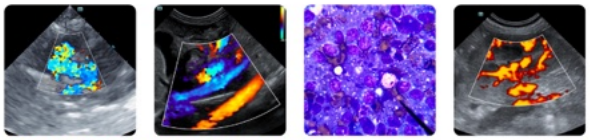
Both adrenal glands show normal shape and echogenicity. The left adrenal gland measures 0.64 cm at the cranial pole and 0.51 cm at the caudal pole. The right adrenal gland measures 0.67 cm at the cranial pole and 0.65 cm at the caudal pole.

Spleen

Splenic thickness is 2.70 cm. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture, with a few focal parenchymal abnormalities: 0.55x0.91 cm, 0.65x0.80 cm, 0.65x0.84 cm hypoechoic foci. A 1.42x1.36 cm hypoechoic area is present at the splenic tail. The splenic capsule is smooth and regular, and splenic vasculature appears normal.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The parenchyma is uniform and isoechoic compared to the falciform fat, with normal echotexture. No hepatic lymphadenopathy is observed.



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The gallbladder lumen is normally distended. The wall is thin, and the contents are primarily anechoic with a small amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and folded, with a gas pattern, mural thickness of 3.12 mm, and preserved wall layering. The pylorus measures 4.63 mm.

Duodenum: 4.44 mm. Jejunum: 4.8 mm with normal wall layering. The ileocecal junction was not visualized. No signs of inflammation, ileus, or foreign material are identified.

Colon: mm (measurement not provided), with formed feces in the descending segment.

Pancreas

The right limb, body, and left limb appear normal. The pancreatic parenchyma is isoechoic to the adjacent omental fat. The diameter of the pancreatic duct is mm (measurement not provided). No signs of active inflammation or neoplastic disease are evident.

Peritoneal Cavity

No abdominal effusion or peritonitis is observed. Cranial mesenteric lymph nodes and ileocecal lymph nodes are not visualized, but the surrounding regions appear unremarkable. The iliac trifurcation is normal.

Right medial iliac lymph node: 5.28 mm, with normal shape and echogenicity.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Heterogeneous prostate with a 2.46x1.60 cm cystic/necrotic structure.

SECONDARY FINDINGS

- Multiple small hypoechoic splenic nodules (0.55–0.91 cm) and a 1.42x1.36 cm hypoechoic lesion in the splenic tail.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The abdominal ultrasound reveals a markedly heterogeneous prostate, containing a well-defined 2.46x1.60 cm fluid-containing structure with a thin capsule and turbid anechoic content. The surrounding prostatic parenchyma appears hyperechoic, consistent with chronic inflammatory or degenerative change, but in the context of a BRAF-positive test, these findings are most compatible

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with a carcinoma of urothelial origin (prostatic or urethral TCC). The presence of a cystic or necrotic region within the prostate may represent tumoral cavitation, cystic degeneration, or necrosis, all of which are possible in neoplastic prostates, particularly under chemotherapy.

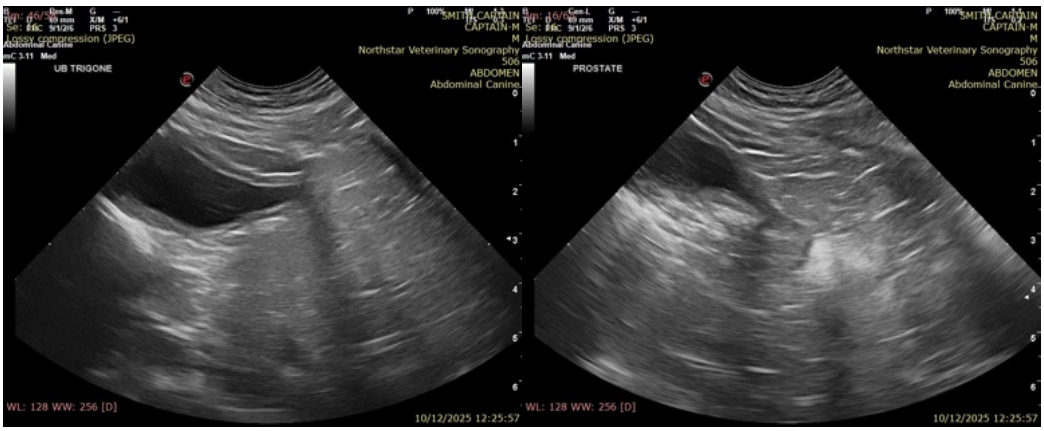
No abdominal lymphadenopathy is detected, including normal-appearing right medial iliac lymph nodes, and neither the cranial mesenteric nor ileocecal nodes are visualized—an expected finding when they are not enlarged. The absence of detectable nodal enlargement does not fully exclude microscopic metastasis, but it is reassuring in the context of staging or treatment monitoring.

The small hypoechoic splenic nodules and the mild increase in splenic size are most consistent with benign processes such as extramedullary hematopoiesis, nodular hyperplasia, or reactive change. Metastatic involvement is considered unlikely, as the spleen is not a common metastatic target for prostatic carcinoma, and the ultrasonographic appearance does not suggest malignant behavior.

The bladder contents and wall are normal, and no intraluminal masses or focal thickening are seen; however, early mucosal TCC can occasionally evade detection on ultrasound, especially when flat or confined to the trigone. In this study, the vesicoureteral junctions are normal, and no secondary signs such as hydroureter or hydronephrosis are present, indicating that ureteral outflow is currently uncompromised.

Recommendations

- Continue monitoring the prostate with periodic ultrasound to assess response to vinblastine and detect progression.
- Consider thoracic imaging (CT or radiographs) to evaluate for pulmonary or mediastinal metastasis, common in prostatic/urothelial carcinoma.
- Monitor urinary function closely, as TCC can progress toward bladder neck or urethra even without early ultrasonographic changes.
- Cytology of urine (if not already performed) may help detect exfoliating urothelial carcinoma cells.
- Consider spinal imaging (lumbar/sacral radiographs or CT/MRI) to evaluate for possible metastatic involvement of adjacent vertebrae (L6–L7, sacrum, pelvis), as prostatic carcinoma may spread via the vertebral venous plexus.



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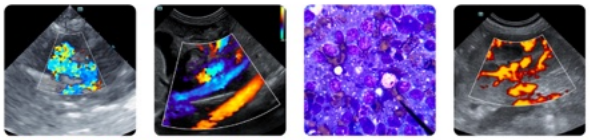

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SonoPath.com | info@sonopath.com | 1.800.838.4268

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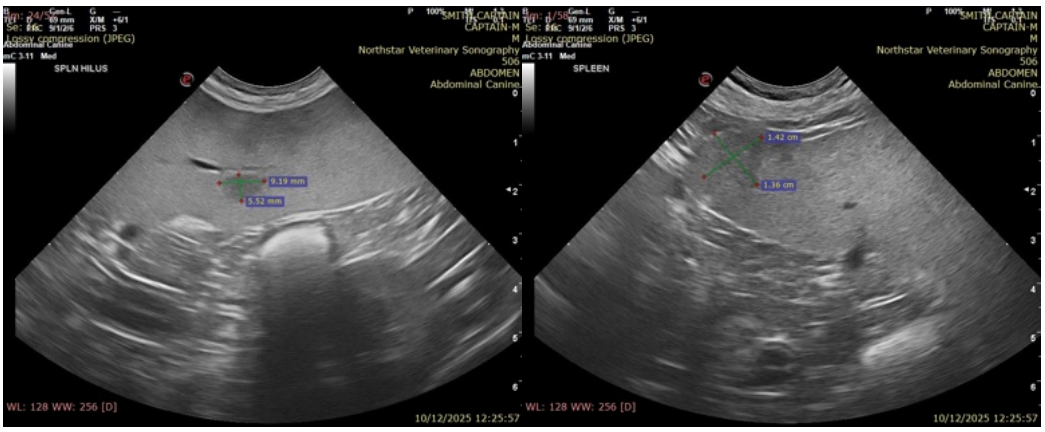

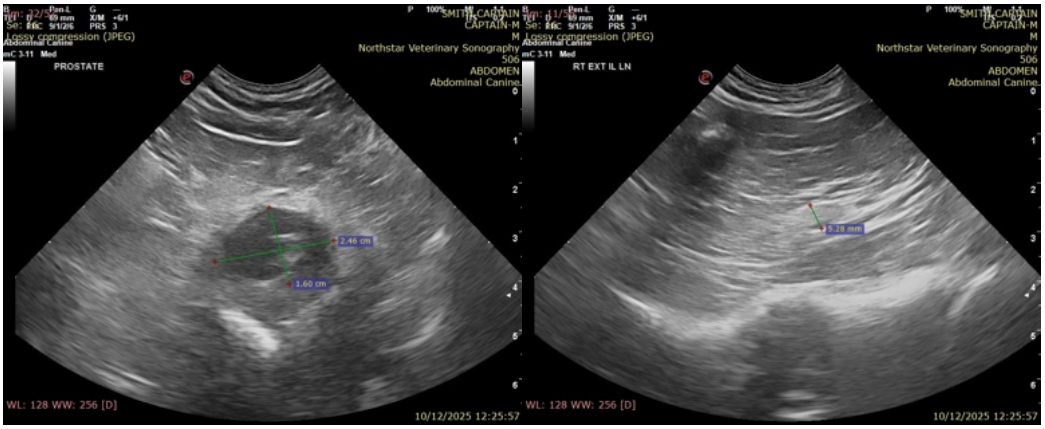

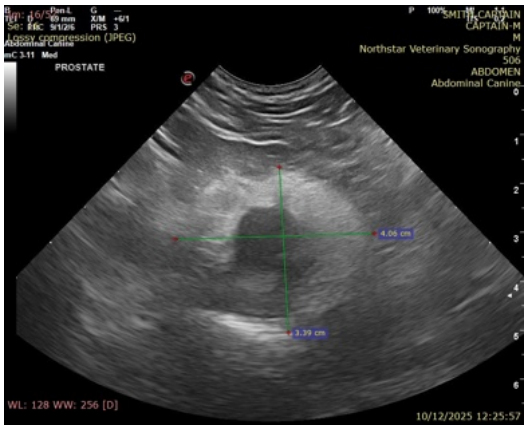

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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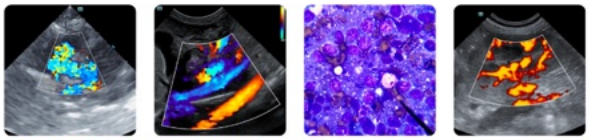

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