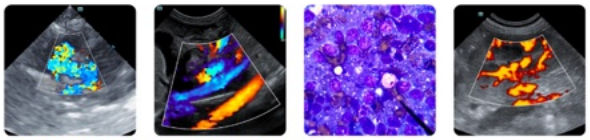


PATIENT

Bandit Luker

SPECIES

Canine

BREED

Dachshund

SEX

Neutered male

AGE

15 years

WEIGHT

13.8 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Devon Papa, CVT

HOSPITAL NAME

Valley VS

REFERRING VET

Dr. Riddlebaugh

INVOICE

73472

DATE

3/16/26

PRESENTING CLINICAL SIGNS

- Presented for routine visit 12/1/25. Bloodwork showed elevated BUN and ALT. Started Denamarin and repeated chemistries 2mo later.
- Repeat labwork stable. Continued Denamarin. Rec. checking urine. Owner dropped urine sample off next day. Dispensed Clavamox for UTI.
- Repeat UA post abx. Still showing signs of UTI. Came back for sterile cysto and sent out culture.
- No growth on culture. Rec. imaging.
- OA patient, takes Carprofen.
- 12/1/25: MCV 57.3 (61.6-73.5) PLT 485 (148-484) PDW 8.8 (9.1-19.4) PCT 0.49 (0.14-0.46) BUN 51 (7-27) ALT 422 (10-125) 2/16/26 BUN 46 (7-27) ALT 337 (10-125) 2/17/26 UA WBC >50/HPF RBC 33/HPF Rods (suspect presence) Unclassified Crystals <1/HPF Squamous Epithelial Cells <1/HPF Non-Squamous >10/HPF 3/3/26 UA WBC >50/HPF RBC >50/HPF Bacteria Rods (suspect presence) Non-Squamous >10/HPF

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly underdistended. The cranial portion of the bladder appears normal. At the level of the bladder neck, proximal urethra, and prostate, there is marked wall thickening with highly irregular margins and multiple intramural mineralized foci. The urine is anechoic, and no uroliths are identified.

The left kidney is normal in shape and size, measuring 3.89×1.95 cm, with a cortical thickness of 0.30 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler shows a normal vascular pattern.

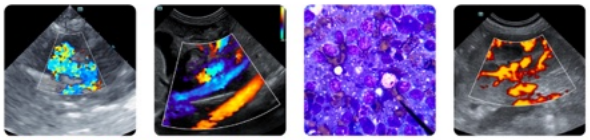
The right kidney is normal in shape and size, measuring 3.93×2.08 cm. Cortical thickness is not provided. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler shows a normal vascular pattern.

Adrenal Glands

Dorsoventral diameters measured in the sagittal plane: the left adrenal gland measures 0.40 cm at the cranial pole and 0.48 cm at the caudal pole. The right adrenal gland is not visualized.

Spleen

Splenic thickness is 0.79 cm. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture without focal abnormalities. The splenic capsule is smooth and regular.



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Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The parenchyma is overall isoechoic compared to the falciform fat but heterogeneous, with multiple hypoechoic nodular areas. The largest measures 2.07×2.90 cm and contains internal cystic regions. No hepatic lymphadenopathy is observed.

The gallbladder lumen is markedly distended. The wall is thin, and the contents consist of a large amount of organized biliary sludge. No ultrasonographic evidence of mucocele formation is observed. No dilation of the cystic duct or common bile duct is identified.

Gastrointestinal

The stomach is distended with ingesta. Gastric wall thickness is 1.86 mm with preserved layering. The pylorus measurement is not provided. The duodenum measures 4.00 mm.

The jejunum measures 2.97 mm, with preserved layering. No ultrasonographic signs of inflammation, ileus, or foreign material are identified.

The colon measures 1.36 mm and contains a small amount of semi-formed feces in the descending segment.

Pancreas

The evaluated pancreatic regions do not show ultrasonographic evidence of overt inflammation or neoplastic disease.

Peritoneal Cavity

No ultrasonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is unremarkable.

ULTRASONOGRAPHIC FINDINGS

- Marked irregular thickening of bladder neck/proximal urethra/prostate with mineralization.
- Several hepatic nodules (largest 2.07×2.90 cm, partially cystic).
- Markedly distended gallbladder with organized sludge.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most clinically significant finding is marked, irregular thickening of the bladder neck, proximal urethra, and prostatic region with intramural mineralization, which is highly suspicious for neoplasia, most consistent with transitional cell carcinoma (urothelial carcinoma). The distribution (trigone/neck/proximal urethra), irregular margins, and presence of mineralization strongly favor a neoplastic process over inflammatory disease. This provides a coherent explanation for the persistent hematuria, pyuria, and bacteriuria on urinalysis despite negative culture, as well as the lack of response to antimicrobial therapy.

Renal architecture is preserved, with no evidence of pyelectasia or changes to suggest ascending infection or pyelonephritis at this time.

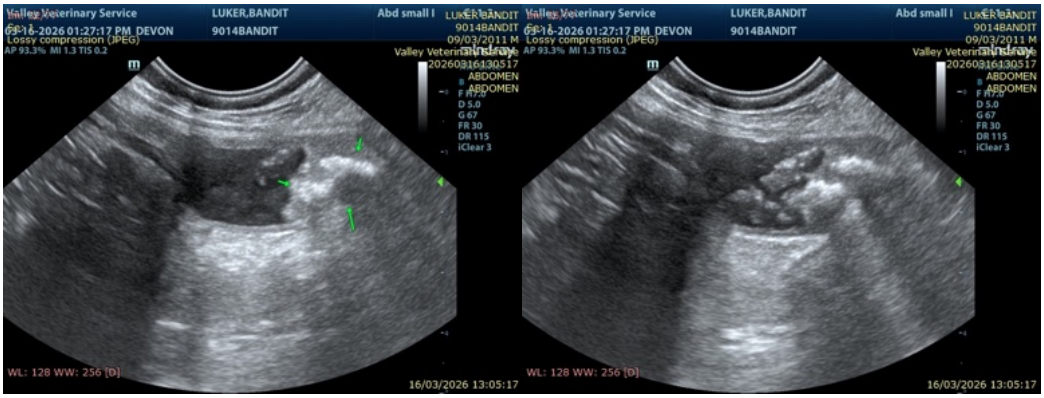
The liver shows heterogeneous parenchyma with multiple hypoechoic nodules, including one lesion with cystic components (2.07×2.90 cm). These findings are nonspecific and may represent nodular hyperplasia, cystic change, or, less likely, neoplasia. However, given the concurrent urinary tract findings, metastatic disease cannot be completely excluded. The gallbladder is markedly distended with organized sludge, a common incidental finding in geriatric patients, without evidence of biliary obstruction or mucocele.

Overall, findings are most consistent with a neoplastic process affecting the lower urinary tract (most likely transitional cell carcinoma), with concurrent hepatic nodular changes of uncertain significance, requiring further characterization.

Recommendations

- Consider BRAF testing (urine) to support the diagnosis of urothelial carcinoma.
- If results are negative, recommend cytologic or histologic sampling of the urethral/bladder neck lesion for definitive diagnosis.
- Consider further characterization of hepatic nodules (FNA) if it will impact clinical decision-making.
- Consider thoracic imaging for staging, if not already performed.

Recommendations are provided as guidance and should be carried out at the discretion of the attending veterinarian.



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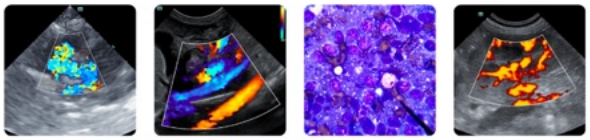

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Educational Teleconsultation Services™

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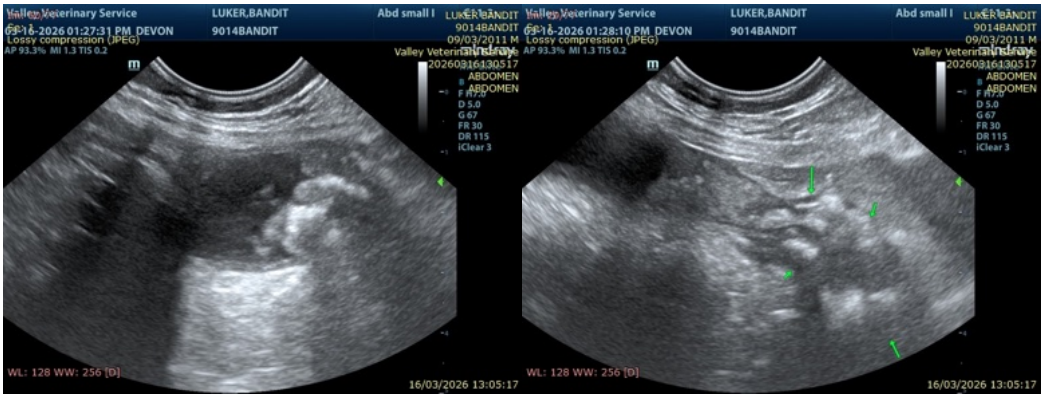

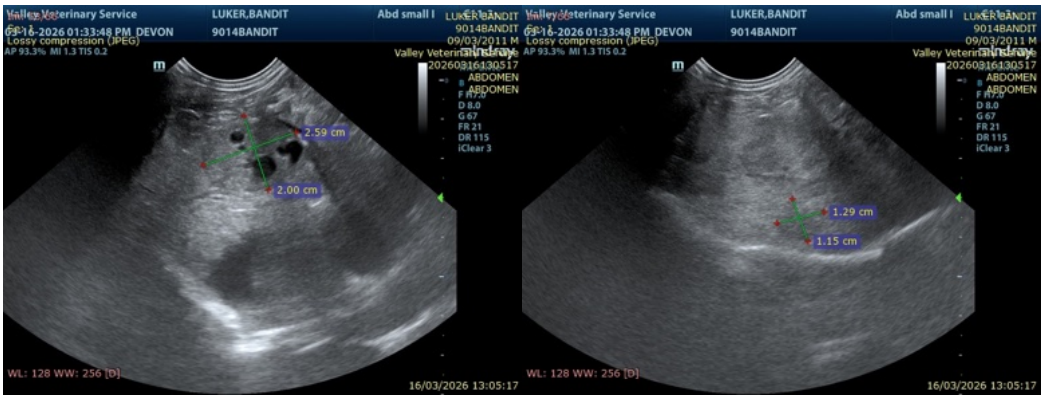

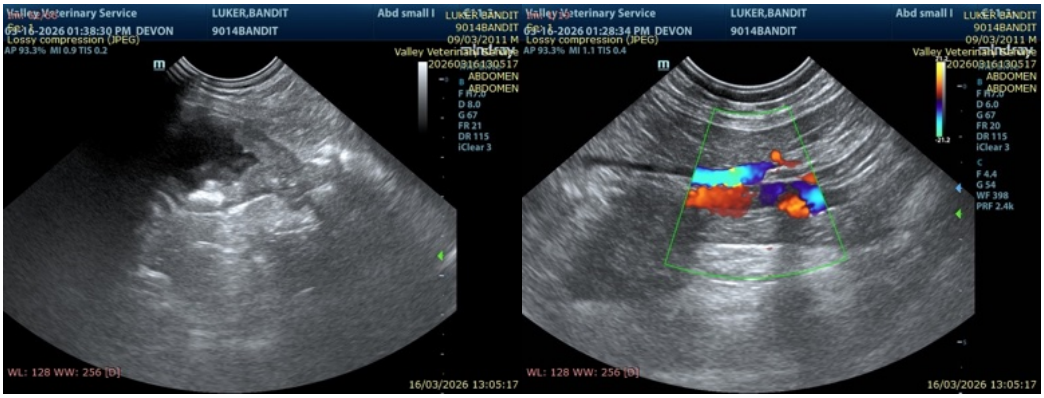

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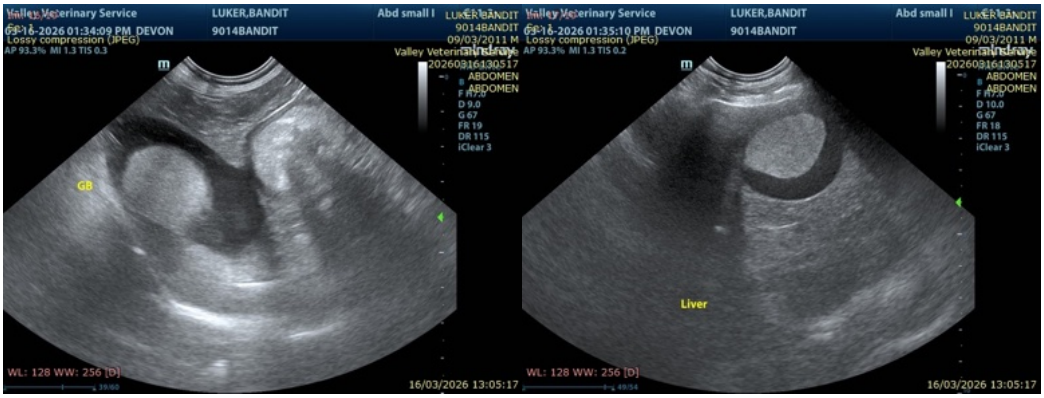

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

info@SonoPath.com