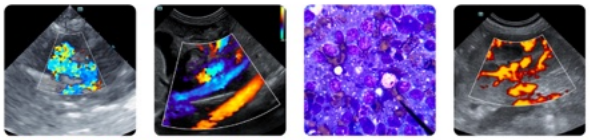


PATIENT

Ellie VanBlargan

SPECIES

Canine

BREED

German Shepherd Mix

SEX

Spayed Female

AGE

9 years

WEIGHT

65.5 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Jocelyn Smith CVT

HOSPITAL NAME

Annville Cleona VA

REFERRING VET

Dr. Pinamonti

INVOICE

74691

DATE

4/21/26

PRESENTING CLINICAL SIGNS

History: 01/2026: Hematuria and suspected urinary incontinence since . Recessed Vulva, hind end covered in urine. Licking at hind end a lot, urine work-up declined, anal glands expressed.
02/2026: Urinalysis, culture (neg), wellness bloodwork
Recommended Proin : declined
04/2026: Licking continued , started Apoquel and NSAIDS - no improvement
Abnormal PE/Chem/CBC/UA Results: Hematuria

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended. The bladder wall is markedly thickened and irregular, measuring 8.77–9.46 mm (normal in a distended dog is typically ~1–2 mm), indicating severe mural thickening. The lumen contains a large amount of heterogeneous, hyperechoic material, most consistent with sediment and/or blood clots. No discrete, well-defined mass arising from the bladder wall is identified on this study. The bladder neck appears unremarkable. The proximal urethra is not clearly visualized. No uroliths are identified. Color Doppler evaluation of the intraluminal material/lesion was not performed.

The left kidney is normal in shape and size, measuring 6.26×3.46 cm, with a cortical thickness of 0.70 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 6.12×3.53 cm, with a cortical thickness of 0.52 cm. In both kidneys, the cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

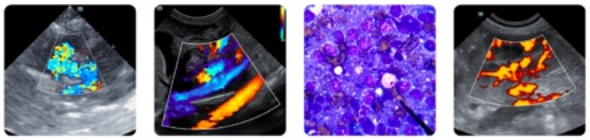
Not confidently visualized.

Spleen

Splenic thickness is 2.26 cm. The splenic parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture, with two small hyperechoic foci, most consistent with benign changes such as myelolipomas or areas of fibrosis. The splenic capsule is smooth and regular. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a 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 very small amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach contains a small amount of ingesta, with a mural thickness of 3.61 mm and preserved wall layering. The pylorus measures 4.83 mm. The duodenum measures 4.00 mm, and the jejunum measures 4.46 mm, both within normal limits (<5 mm), with preserved wall layering. No signs of inflammation, ileus, or foreign material are identified. The colon measures 1.18 mm, with formed feces in the descending segment.

Pancreas

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

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Marked diffuse urinary bladder wall thickening (8.77–9.46 mm) with irregular margins
- Organized heterogeneous hyperechoic intraluminal material.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The urinary bladder demonstrates severe diffuse wall thickening with irregularity, far exceeding normal values for a distended bladder. This degree of thickening is most consistent with severe cystitis, likely chronic and/or hemorrhagic in nature, particularly given the presence of abundant intraluminal echogenic material compatible with blood clots or/and inflammatory debris. The intraluminal material appears heterogeneous, hyperechoic, and amorphous, without a clearly defined point of attachment or broad-based origin from the bladder wall. These features favor organized intraluminal material such as blood clots or inflammatory debris rather than true mural mass. However, the marked diffuse bladder wall thickening and irregularity creates significant ultrasonographic overlap between severe inflammatory disease and infiltrative neoplasia, particularly transitional cell carcinoma. Infiltrative forms of urothelial carcinoma can present with more diffuse mural changes and cannot be excluded based on ultrasound alone, especially in the setting of persistent hematuria and intraluminal clots.

Recommendations
This is a case where imaging findings strongly support significant lower urinary tract disease, but definitive differentiation between severe inflammation and neoplasia requires further diagnostic investigation.

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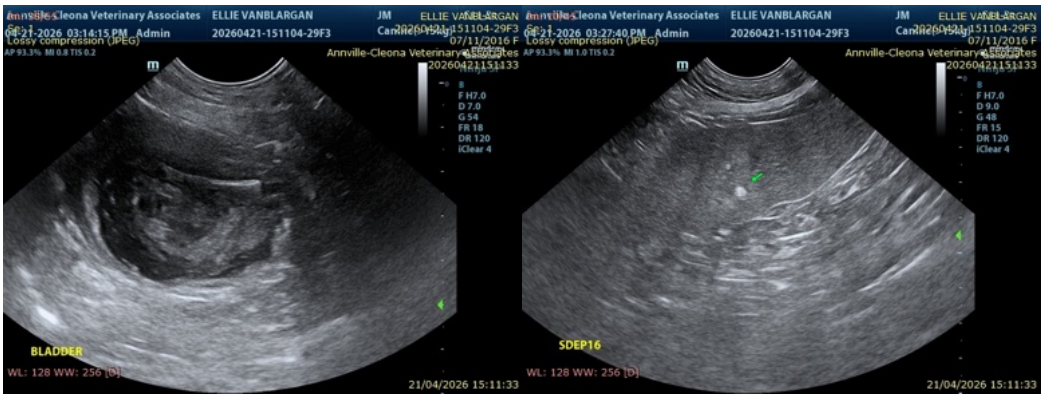
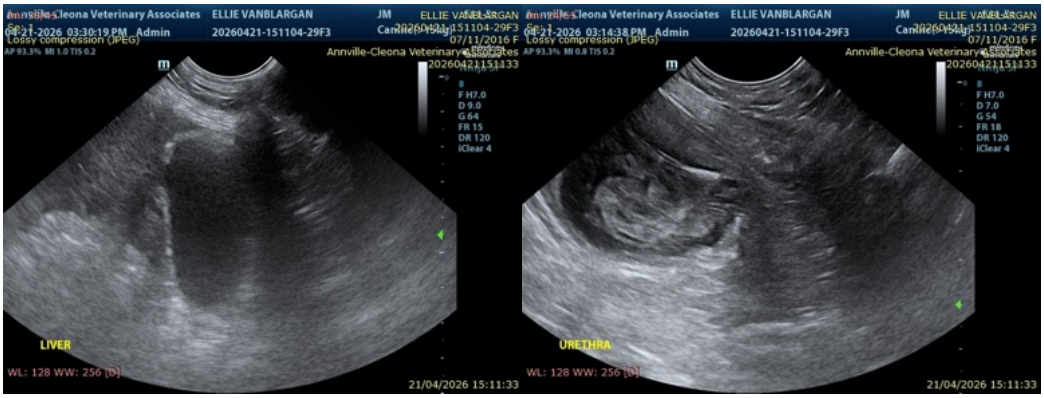
- Urine cytology and/or traumatic catheterization sample may help identify neoplastic cells, although sensitivity is limited.
- In cases where intraluminal material is present, bladder catheterization with gentle flushing may be considered, as mobile material (sediment or blood clots) may disperse or reposition, whereas true mural lesions remain fixed. Improved bladder distension during this process may also facilitate better evaluation of the bladder wall and help identify any underlying mural abnormalities.
- Urine-based molecular testing (BRAF mutation analysis) may be considered to support the diagnosis of urothelial carcinoma.
- Cystoscopy should be considered for further evaluation, including targeted biopsies.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.





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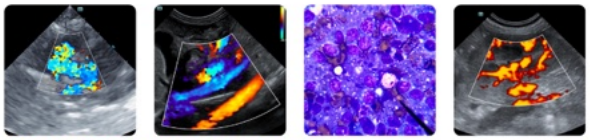

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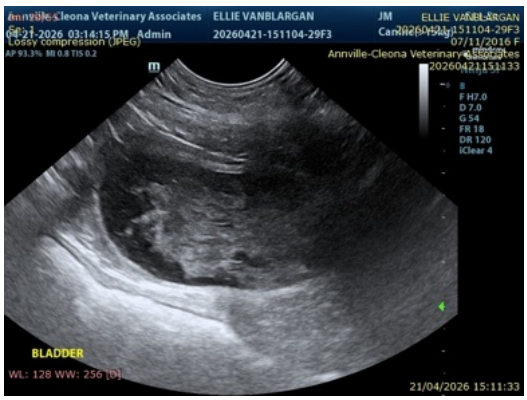

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com