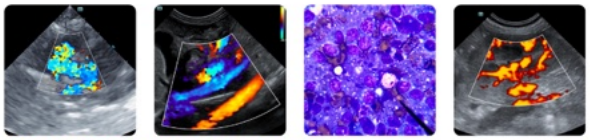

PATIENT

Gracie Harrod

SPECIES

Canine

BREED

Pomeranian

SEX

Spayed female

AGE

5 years

WEIGHT

8.16 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Emilia Monachino

HOSPITAL NAME

Finger Lakes AH Vetcor

REFERRING VET

Dr. Monachino

INVOICE

75237

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5/5/26

PRESENTING CLINICAL SIGNS

History: - PPHx: Seizures (on Zonisamide), Alopecia X, Presumptive GERD (on Metoclopramide), dental disease
- Second opinion evaluation & tumor staging. Cystotomy performed (notes say incision was made ventrally) elsewhere on 4/15/26 to remove bladder calculi. Calculi analysis = calcium oxalate
- Surgery notes state a large, friable nonresectable bladder mass evident during cystotomy extending into urethra. Fragments of mass submitted for histopathology came back as "most consistent with TCC"
- Patient was initiated on Piroxicam 1mg PO SID one week ago and has been doing well
Abnormal PE/Chem/CBC/UA Results: Preop CBC/ CHEM 10 were normal. Ionized calcium is pending. Urine culture & sensitivity pending. Thoracic radiographs = no pulmonary metastasis; Abdominal rads = mineralization of the urinary bladder (dystrophic mineralization and/or a cystic calculus.) and nephrolithiasis (versus dystrophic mineralization).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended. The urinary bladder wall is thin and smooth. The urine is turbid, containing suspended mineral sediment and cystic calculi. At the level of the bladder neck extending into the proximal urethra, there is an approximately 0.88×0.41 cm intraluminal soft tissue proliferation within the proximal urethral lumen. Based on its location and sonographic appearance, this finding is not strongly suggestive of postoperative mural scarring, as no adjacent mural inflammatory change or visible suture material is identified. The lesion appears to represent soft tissue protruding into the proximal urethral lumen, although definitive characterization is not possible sonographically.

The mineral opacity previously described radiographically within the urinary bladder region appears to predominantly correspond to mobile intraluminal mineral sediment, as displacement of the mineral material is observed dynamically within the bladder lumen.

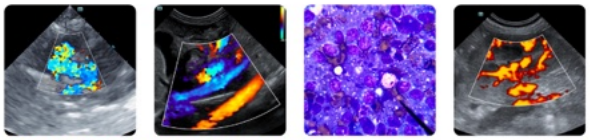
The left kidney is normal in shape and size, measuring 2.79×1.81 cm. Cortical thickness measures 0.26 cm in the sagittal plane. Extensive nephrolithiasis is present throughout the renal pelvic/caliceal region. No pyelectasia or hydronephrosis is identified.

The right kidney is normal in shape and size, measuring 3.14×1.78 cm. Cortical thickness measures 0.30 cm in the sagittal plane. Mild nephrolithiasis is present. Mild right pyelectasia measuring 2.68 mm is identified without evidence of hydroureter.

Both kidneys demonstrate normal corticomedullary ratio and preserved corticomedullary distinction. The renal cortices are isoechoic relative to the hepatic parenchyma. Color Doppler evaluation demonstrates a subjectively normal vascular pattern.

Adrenal Glands

Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.34 cm at the cranial pole and 0.41 cm at the caudal pole. The right adrenal gland measures 0.62 cm at the cranial pole and 0.34 cm at the caudal pole.



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Spleen

Splenic thickness is 0.95 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

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.

The gallbladder is moderately distended. The gallbladder wall is thin and regular. The contents are predominantly anechoic with a very small amount of biliary sludge. Mild dilation of the cystic duct and proximal common bile duct is identified.

Gastrointestinal System

The stomach is empty and folded. Gastric wall thickness measures 1.54 mm with preserved mural layering. The pyloric wall measures 3.16 mm. Duodenal wall thickness measures 3.06 mm. Jejunal wall thickness measures 2.11 mm. Intestinal wall layering is preserved throughout the evaluated segments. No evidence of focal gastrointestinal inflammation, obstructive ileus, or foreign material is identified. Colonic wall thickness measures 1.37 mm, with small amounts of formed fecal material present within the descending colon.

Pancreas

The evaluated pancreatic regions 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

- Intraluminal soft tissue proliferation within the proximal urethra/bladder neck region measuring approximately 0.88×0.41 cm.
- Marked left nephrolithiasis and mild right nephrolithiasis.
- Mild right pyelectasia (2.68 mm) without hydroureter.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A small focal intraluminal soft tissue proliferation is identified at the bladder neck/proximal urethral

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region. Given the recent histopathologic diagnosis most consistent with transitional/urothelial cell carcinoma, this finding is considered highly suspicious for residual neoplastic tissue involvement of the proximal urethra/bladder neck region. Although recent surgical intervention may contribute to some local tissue alteration, the location and sonographic appearance are not strongly suggestive of simple postoperative mural scar tissue alone. Definitive differentiation between residual neoplasia and postoperative reactive tissue change cannot be established sonographically with complete certainty.

No sonographic evidence of regional abdominal metastatic disease, ureteral obstruction, hydroureter, or abdominal effusion is identified at this time.

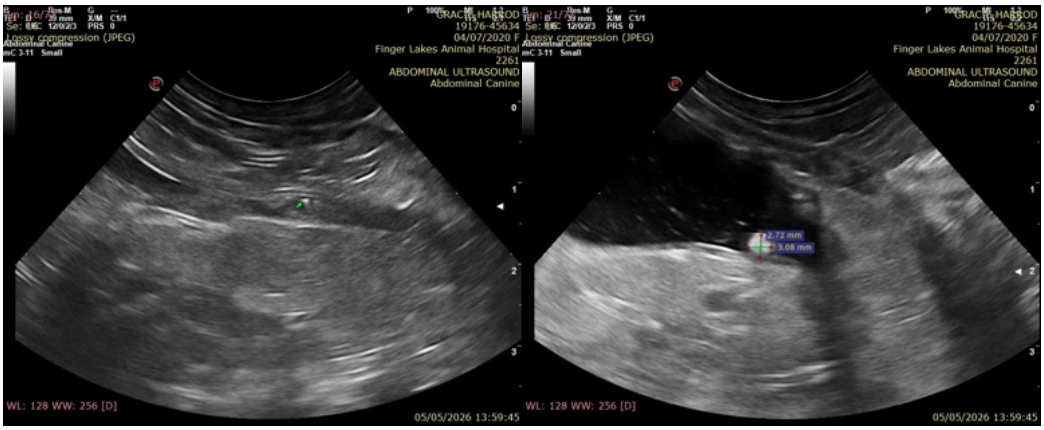
Marked left-sided nephrolithiasis and lesser right nephrolithiasis are present, with mild right pyelectasia likely reflecting partial urinary outflow disturbance or chronic renal pelvic irritation. No current sonographic evidence of clinically significant obstructive nephropathy is identified.

The mild biliary ductal dilation is nonspecific and may be incidental or related to chronic medical management/fasting status. No concurrent ultrasonographic evidence of obstructive hepatobiliary disease or pancreatitis is identified.

Recommendations

- Continued oncologic management and monitoring for progression of urethral/trigonal disease is recommended.
- Follow-up ultrasonographic monitoring of the proximal urethral lesion and upper urinary tract is advised to assess progression or development of obstructive changes.
- Cystoscopic evaluation could be considered if additional characterization of the proximal urethral lesion would alter therapeutic planning, particularly for assessment of urethral extent, repeat tissue sampling, or potential interventional planning.
- Correlation with pending urine culture results is recommended given the concurrent mineral sediment/urolithiasis and recent urinary tract instrumentation.
- Continued monitoring of renal pelvic dilation is recommended, particularly if lower urinary tract signs worsen or azotemia develops.

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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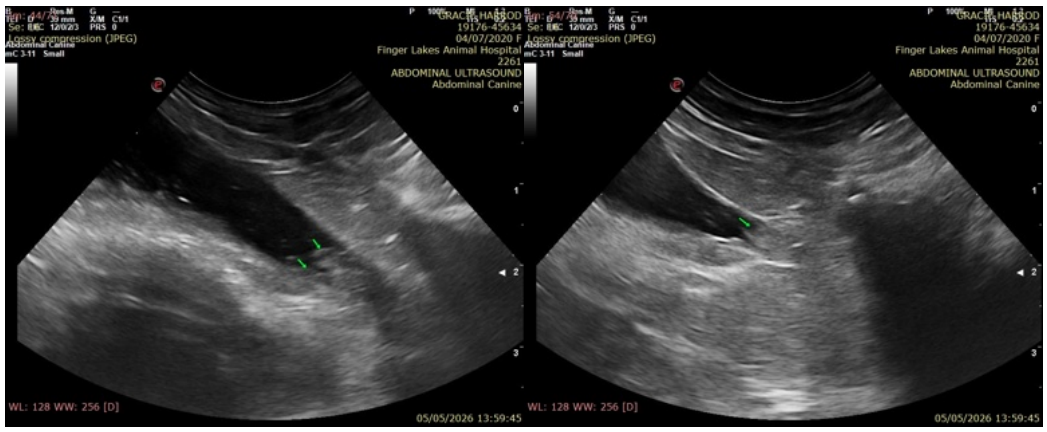

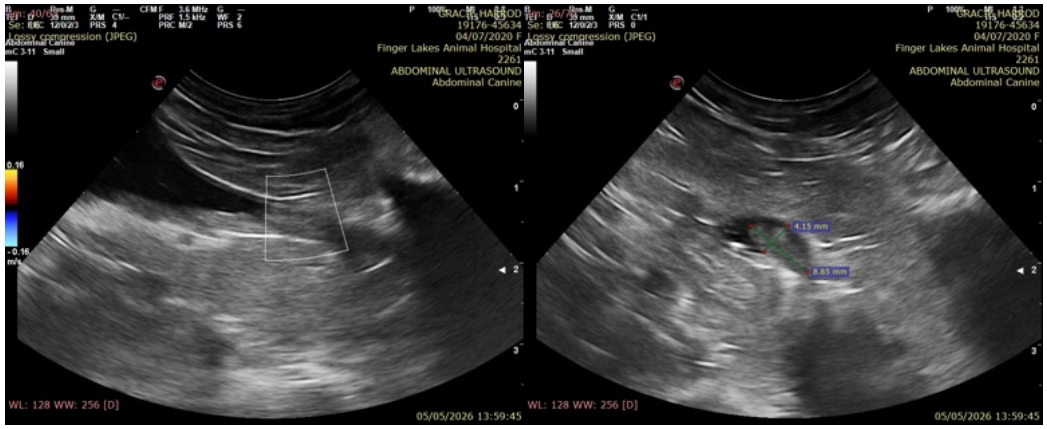

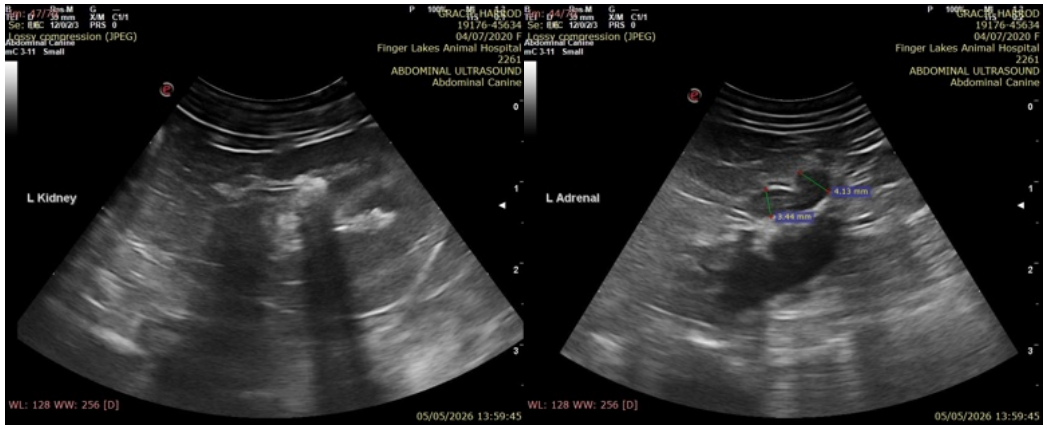

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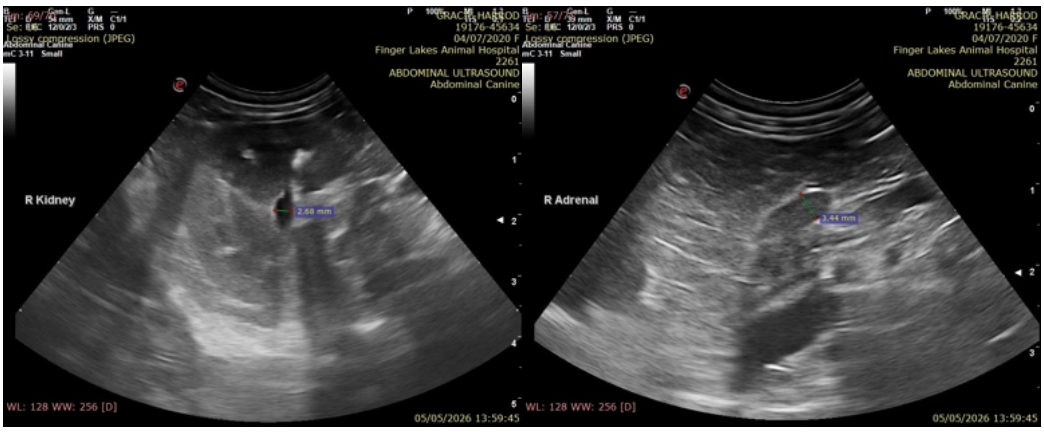

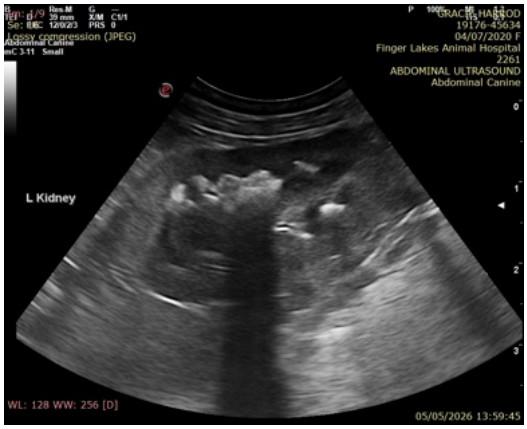

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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