



## PATIENT

Linnay Smith

## SPECIES

Canine

## BREED

Pitbull Mix

## SEX

Spayed female

## AGE

12 years

## WEIGHT

64 lbs

## INTERPRETED BY

Alicia Angosto  
Guerrero, DMV,  
PgDip, MSc.

## IMAGING PERFORMED BY

Jonathan Moss

## HOSPITAL NAME

Harvest Hills VH

## REFERRING VET

Dr. Moss

## INVOICE

75219

## DATE

5/5/26

## PRESENTING CLINICAL SIGNS

History: Pt presented for urinary issues. BW indicated Cushing's was possible, but LDDS test was not indicative of Cushing's. Pt urinated in kennel, which is very unlike her, so rec'd sending out urine culture but found suspected mass.

Abnormal PE/Chem/CBC/UA Results: attached, pending urine cytology on catheterized sample

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder lumen is incompletely distended. Urinary bladder wall thickness measures 3.32 mm, mildly prominent for the degree of distension. The urine is anechoic, without evidence of mineral sediment or cystolithiasis. At the level of the bladder neck and proximal urethra, there is an irregular broad-based soft tissue mass arising from the dorsal urinary bladder wall, measuring at least 3.65×1.27 cm.

The left kidney is normal in shape and size, measuring 5.91×3.03 cm. Cortical thickness measures 0.54 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 6.35×3.32 cm. Cortical thickness measures 0.61 cm in the sagittal plane. Both kidneys demonstrate normal corticomedullary ratio and preserved corticomedullary definition. The renal cortices are isoechoic relative to the hepatic parenchyma. No pyelectasia, hydronephrosis, or nephrolithiasis is identified. Color Doppler evaluation demonstrates a subjectively normal vascular pattern.

### Adrenal Glands

Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.61 cm at the cranial pole and 0.78 cm at the caudal pole. The right adrenal gland is not visualized.

### Spleen

The spleen measures 1.71 cm in thickness. The splenic parenchyma demonstrates normal echogenicity and homogeneous fine echotexture. A small, well-defined hyperechoic splenic nodule measuring 0.68×0.72 cm is identified, compatible with a benign myelolipoma-like change. 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 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.



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## *Gastrointestinal*

The stomach is mildly distended with ingesta. Gastric wall thickness measures 3.77 mm with preserved mural layering. Duodenal wall thickness measures 4.18 mm. Jejunal wall thickness measures 3.20 mm. Intestinal wall layering is preserved throughout the evaluated segments. No evidence of obstructive ileus, focal intestinal inflammation, or foreign material is identified. The colon measures 1.31 mm in wall thickness and contains formed fecal material throughout the evaluated segments.

## *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

- Irregular broad-based mass associated with the dorsal urinary bladder wall/bladder neck and proximal urethra, measuring at least 3.65×1.27 cm.
- Subtle urinary bladder wall thickening for degree of distension.
- Mild enlargement of the left adrenal caudal pole (0.78 cm).

## SECONDARY FINDINGS

- Small amount of biliary sludge.
- Small incidental hyperechoic splenic myelolipoma-like nodule.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The dominant ultrasonographic abnormality is an irregular broad-based mass centered at the bladder neck/proximal urethral region. Given the location, morphology, and mural attachment, transitional/urothelial carcinoma is considered the primary differential diagnosis. Polypoid cystitis or other inflammatory proliferative lesions are less likely with this degree of irregular mural proliferation and trigonal/proximal urethral involvement. Ultrasound alone cannot definitively distinguish neoplastic from severe inflammatory proliferative disease.

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

The mild enlargement of the left adrenal caudal pole is nonspecific. In dogs, caudal pole thickness greater than approximately 0.74 cm may be mildly enlarged depending on body size and imaging plane; however, isolated mild unilateral enlargement without corroborating LDDS findings does not specifically support functional hyperadrenocorticism. Adrenal incidental hyperplasia or age-related



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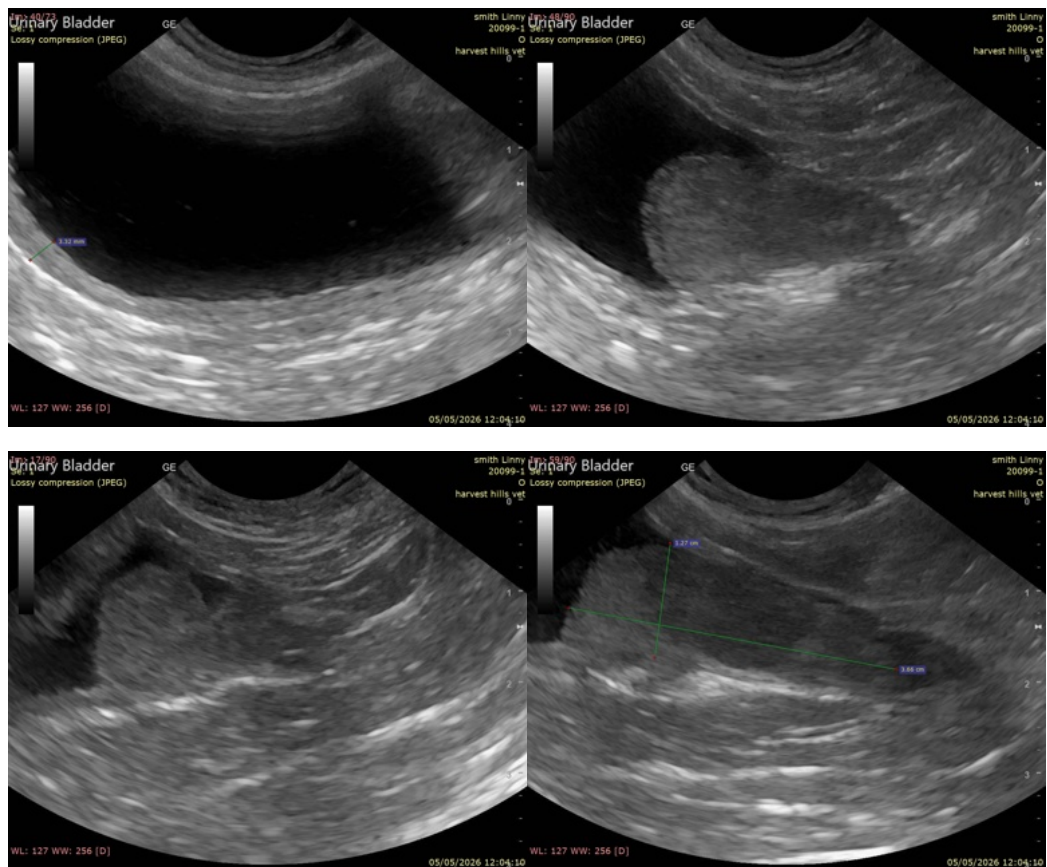
change are possible considerations.

Incidental mild biliary sludge accumulation and a small benign-appearing splenic myelolipoma-like lesion are identified.

Recommendations

- Correlation with pending urine cytology is recommended, recognizing the limited sensitivity of cytology for urothelial carcinoma.
- Consider traumatic catheterization sampling and/or cystoscopic-guided biopsy for definitive characterization if clinically appropriate.
- If urothelial carcinoma remains a primary concern, further staging could include thoracic imaging and continued surveillance of regional lymph nodes and upper urinary tract.
- BRAF testing may be clinically useful if transitional cell carcinoma is suspected and sampling is available.

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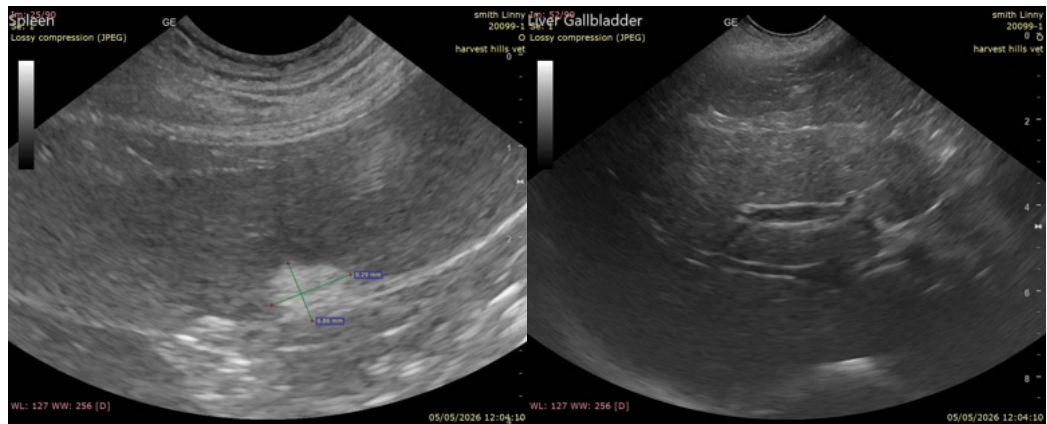
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.



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[info@SonoPath.com](mailto:info@SonoPath.com)

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