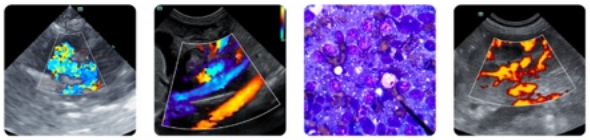


PATIENT

Mila Vaughn

SPECIES

Canine

BREED

Lagotto

SEX

Spayed female

AGE

11 years

WEIGHT

20.7 kg

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Patrick Hennigan, DVM

HOSPITAL NAME

Mattydale AH

REFERRING VET

Dr. Hennigan

INVOICE

78795

DATE

6/17/26

PRESENTING CLINICAL SIGNS

History: Presented originally April 28th with associate DVM for urinary accidents in the house and increased frequency of urination. U/A at that time had USG 1.039 and was quiet.
Re-presented May 11th for continued clinical signs of UTI to this DVM. Radiographs revealed no visible stones but hepatomegaly.
Bloodwork revealed normal CBC, normal TT4, increased ALP and PSL. U/A revealed USG 1.046, no bacteria or crystals seen but increased WBC at 4-10/hpf. Amoxicillin x7days Rx but no change in increased urination.
Abnormal PE/Chem/CBC/UA Results: Chem-increased ALP (715)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder is predominantly thin and smooth. A focal soft tissue thickening/mass-like lesion measuring approximately 1.13-1.66 cm is identified arising from the cranial to craniodorsal aspect of the urinary bladder wall. The lesion appears predominantly associated with the outer mural layers and demonstrates mainly extraluminal extension, although a mural origin involving deeper layers of the bladder wall cannot be definitively excluded. The urine is anechoic. The trigone and proximal urethra have a normal ultrasonographic appearance. No calculi are identified.

The left kidney is normal in shape and size, measuring 5.91×3.01 cm, with a cortical thickness of 0.48 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 6.13×3.08 cm, with a cortical thickness of 0.51 cm in the sagittal plane.

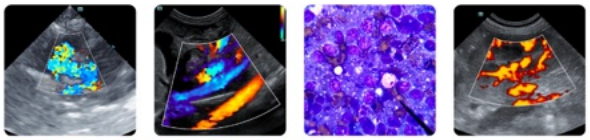
Both kidneys demonstrate normal cortical echogenicity. Corticomedullary distinction and corticomedullary ratio are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler interrogation demonstrates a normal vascular pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.53 cm at the cranial pole and 0.50 cm at the caudal pole. The right adrenal gland measures 0.49 cm at the cranial pole and 0.56 cm at the caudal pole.

Spleen

Splenic thickness is 2.24 cm. The splenic parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture. A solitary hyperechoic splenic nodule measuring 5.11×7.72 mm is identified. The splenic capsule is smooth and regular.



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Liver

The liver is subjectively enlarged, with rounded margins and a regular contour. The hepatic parenchyma is homogeneous and isoechoic relative to the surrounding falciform fat, with a normal echotexture. A focal hypoechoic hepatic nodule measuring 2.16×2.55 cm is identified. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is thin and smooth, and the contents are predominantly anechoic. No dilation of the cystic duct or common bile duct is identified.

Gastrointestinal tract

The stomach is empty and folded. Gastric wall thickness measures 2.29 mm with preserved wall layering. The pylorus measures 5.56 mm. The duodenum measures 5.25 mm. The jejunum measures 4.11-4.38 mm with preserved wall layering. No evidence of gastrointestinal obstruction, focal mural masses, ileus, or foreign material is identified. The colon measures 1.07 mm in wall thickness and contains formed fecal material within the descending segment.

Pancreas

The pancreas measures approximately 0.94 cm in thickness. Pancreatic parenchyma is isoechoic to the adjacent mesenteric fat. No focal pancreatic lesions are identified. No ultrasonographic evidence of active peripancreatic inflammation is observed.

Free Abdomen

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

PRIMARY FINDINGS

- Focal 1.13-1.66 cm mass-like thickening associated with the cranial/craniodorsal urinary bladder wall, demonstrating predominantly extraluminal extension.
- Mild hepatomegaly.
- Solitary 2.16×2.55 cm hypoechoic hepatic nodule.

SECONDARY FINDINGS

- Small hyperechoic splenic nodule measuring 5.11×7.72 mm.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most clinically significant finding is a focal thickening associated with the cranial to craniodorsal urinary bladder wall. The lesion appears to arise from the outer mural layers and extends predominantly extraluminally, although involvement of the deeper bladder wall layers cannot be excluded. Given the

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patient's persistent lower urinary tract signs and lack of response to antimicrobial therapy, a focal neoplastic or inflammatory mural process is considered more likely than uncomplicated cystitis. Differential considerations include focal mesenchymal neoplasia (such as leiomyoma or leiomyosarcoma), atypically located urothelial carcinoma, granulomatous/inflammatory disease, or a lesion arising from the urachal region.

Mild hepatomegaly and a solitary hypoechoic hepatic nodule are identified. Given the marked ALP elevation, diffuse hepatomegaly, and otherwise relatively homogeneous hepatic parenchyma, the findings may be compatible with diffuse vacuolar hepatopathy accompanied by a focal area of nodular hyperplasia or regeneration. The hepatic nodule is nonspecific ultrasonographically but benign age-related nodular hepatopathy is considered more likely than aggressive hepatic neoplasia.

The small hyperechoic splenic nodule is most consistent with an incidental benign lesion such as nodular hyperplasia, fibrosis, lipomatous change, or myelolipoma.

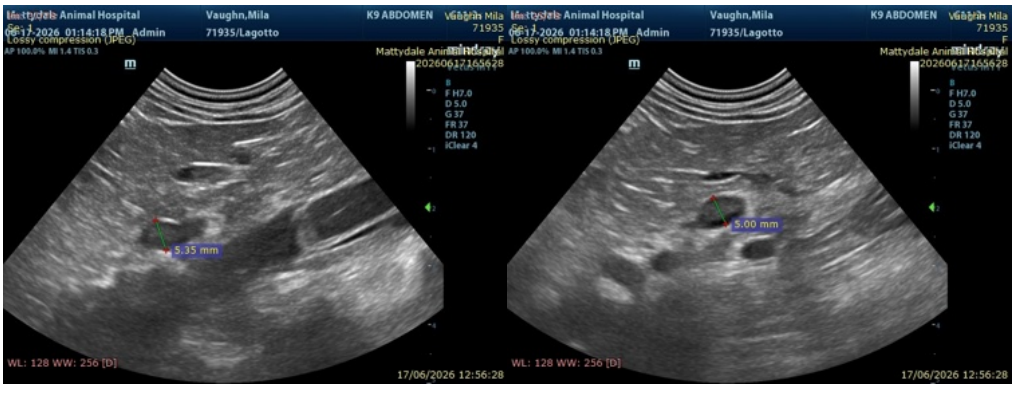
No ultrasonographic evidence of active pancreatitis is identified despite the reported PSL elevation.

The adrenal glands are within normal limits, and there is no convincing ultrasonographic evidence of hyperadrenocorticism.

Recommendations

- Further characterization of the urinary bladder lesion is recommended, as this is the finding most likely to explain the patient's persistent urinary signs.
- Monitor the hepatic nodule with repeat abdominal ultrasound, or consider cytologic/histopathologic evaluation if there is evidence of growth or progressive clinicopathologic abnormalities.
- Continue monitoring liver enzyme activities and clinical signs.
- Correlate the elevated PSL with clinical findings; additional pancreatic diagnostics may be considered if gastrointestinal signs develop or persist.

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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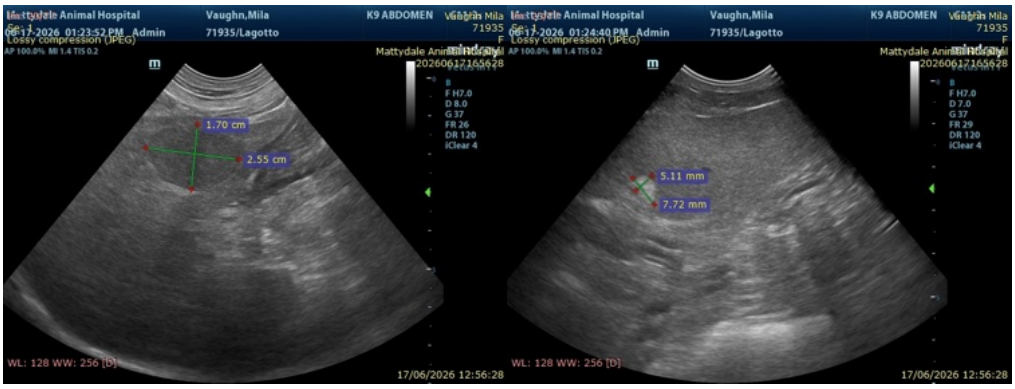

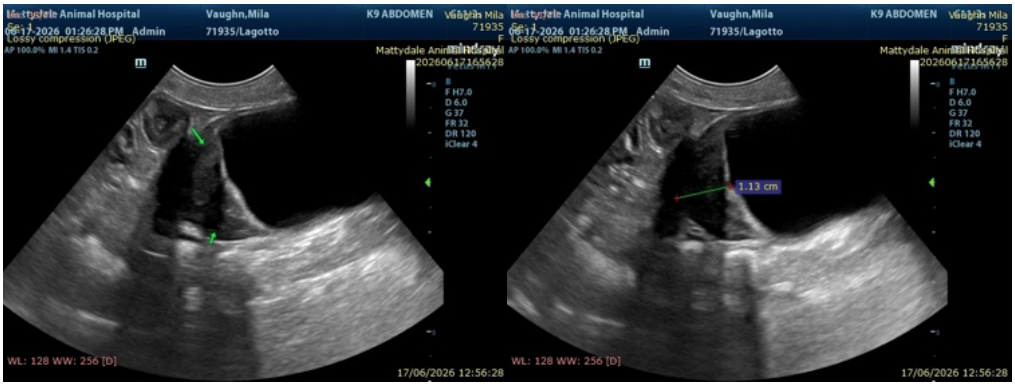

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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