

PATIENT

Bumi Reed

SPECIES

Canine

BREED

Staffordshire

SEX

Male, neutered

AGE

7 Yrs.

WEIGHT

75.2 lbs.

INTERPRETED BY

Andrea Nicastro, DVM,
 Diplomate ACVIM
 (Small Animal Internal
 Medicine)

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Santa Clara AH

REFERRING VET

Dr. Malec

INVOICE

13422

DATE

1/26/26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings:

- Increased difficulty defecating, stools are normal but pt is having frequent small BM's throughout the day. Overall quieter, still wants high value treats and puppy food from new dog in the house but less interested in his own food.
- UTI diagnosed in October 2025 and treated, per o pt still seems to urinate more frequently and longer despite treatment and that never resolved.
- O notes that he feels pt's joints are getting slightly swollen but is unsure if he is trying to find something wrong

ABNORMAL Labwork Values- Monocytes (1.148), Platelets (423), Cystatin B (606), TP (7.7), Albumin (2.5), Globulin (5.2), ALT (16), CK (245) Urine protein 3+ with WBC >100/HPF and RBC 20-30/HPF and 4+ epithelial cells

Current Medications- Galliprant, gabapentin, and Clavamox

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone is normal.

The prostate is enlarged (4.1 cm in width) with irregular peripheral contours and a mass effect. The parenchyma is heterogeneous with hyperechoic to mineralized foci. The mass effect appears to extend into the proximal urethra. Surrounding mesentery is hyperechoic.

The left kidney is normal in size (7.70 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

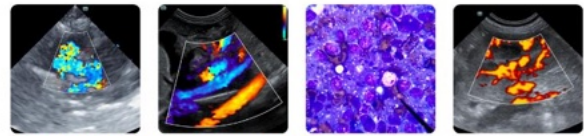
The right kidney is normal in size (7.57 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.65 cm at cranial pole) (0.80 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (1.30 cm at cranial pole) (0.70 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen



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A 5.8 x 4.3 cm heterogeneous, expansile mass is visualized approximately mid-spleen. In the remainder of the spleen, the margins are curvilinear and the parenchyma is homogeneous. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly distended with ingesta and irregular shadowing material. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Lymph nodes

A 2.79 x 0.63 cm medial iliac lymph node is visualized.

Free Abdomen

There is no obvious evidence of free fluid.

Other

A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window.

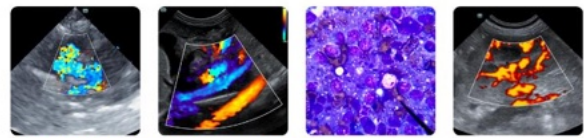
ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Prostatic mass with suspected extension into the proximal urethra. Neoplasia (i.e., adenocarcinoma, transitional cell carcinoma) is strongly suspected with a lower possibility of inflammation, hyperplasia or other pathology. Mild adjacent retroperitonitis is present.
- The prominent medial iliac lymph node could be consistent with reactive change or early metastatic disease.
- Splenic mass. Neoplasia (i.e., sarcoma, round cell tumor) is suspected with a lower possibility of a benign process (i.e., lymphoid hyperplasia or similar).

Secondary Findings:

- Bilateral nonspecific, age-related renal changes
- Urinary bladder debris
- Minor retained gastric ingesta. The shadowing material within the gastric lumen may represent normal ingesta and/or foreign material.



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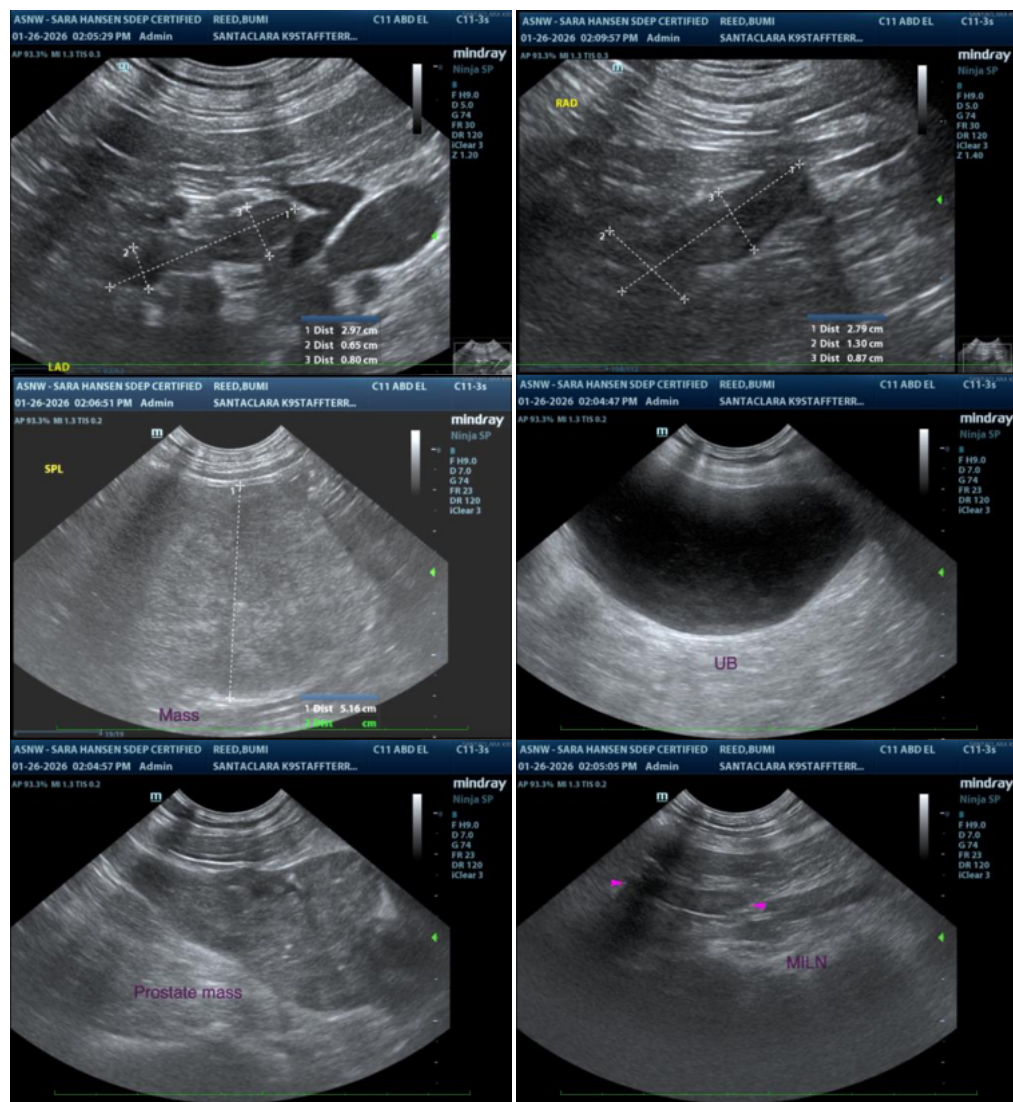
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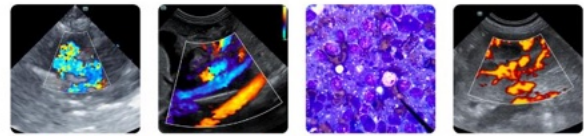
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
2. Regarding the prostate mass, consider a urine BRAF test to further evaluate for neoplasia. It should be noted that a positive test confirms neoplasia, however a negative test does not rule out the possibility of cancer and further evaluation (i.e., tissue sampling) may be necessary to get a definitive diagnosis.
3. Regarding the splenic mass, consider fine needle aspiration (assuming normal clotting status). A 25-gauge needle should be used. Depending on results, consultation with a board-certified oncologist and/or surgeon may be indicated.





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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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com