



PATIENT

Deacon Torres

SPECIES

Canine

BREED

Bulldog

SEX

Neutered Male

AGE

10.5 Years

WEIGHT

31.6 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores VEC

REFERRING VET

Dr. Julia Kerr

INVOICE

35378

DATE

1/13/26

PRESENTING CLINICAL SIGNS

History: *Presents for abdominal ultrasound. For 5 weeks owner has been noting intermittent blood in urine and straining. weight loss but had been on reduced calories for weight loss. was seen at rdvm and at another ER (12/5). two weeks ago at ER radiographs showed enlarged prostate. was started on amoxicillin, carprofen, and enrofloxacin. For about 2 weeks he has not been eating any dog food, owner has been cooking for him. for 2-3 days has been lethargic. did not want to eat yesterday. history of arthritis, tenesmus, colitis, hematuria, enlarged prostate, stranguria, azotemia (noted 1/6/26). *concern for UTI, idiopathic cystitis, crystalluria, cystic calculi, neoplasia, primary renal disease, prostatitis, other.

Abnormal PE/Chem/CBC/UA Results: PE: arthritis, hyperkeratosis, otherwise unremarkable 12/5/25 Hershey ER radiograph: no obvious cystolithiasis, gas in colon, enlarged prostate 12/5 u/a: marked debris, numerous wbc's, gross hematuria, significant rod-shaped bacteriuria 1/6/26 rdvm: BUN 61, creatinine 4.4, phosphorus 7.4 hw/lyme/ehrlichia/anaplasma: negative x4 1/13/26 Shores u/s: urine light yellow color and clear, protein 1+ (30), pH 5.0, blood 3+ (250, hemolyzed), usg 1.014; sediment: wbc <5/hpf, rbc <5/hpf, bacteria none to rare, crystals calcium oxalate and struvite <1/hpf, other epithelial cells <1/hpf.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The area of the prostate presents as an ill-defined, heterogenous, irregular mass-like lesion of mixed echogenicity with subtle punctate mineralization and multifocal, echogenic fluid appearing areas throughout it. The area measures approximately 4.3 cm x 5.3 cm in size.

Left kidney is normal in size (6.2 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of mineral or infarcts observed. Marked pyelectasia approaching hydronephrosis is noted, measuring 3.2 cm transverse view.

Right kidney is normal in size (7.6 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of mineral or infarcts observed. Marked (but less severe than the left side) pyelectasia is noted, measuring 1.3 cm transverse view.

Adrenal Glands

The adrenal glands are unable to be visualized in these images.

Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver



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Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- The prostatic changes are concerning for infiltrative neoplasia, such as uroepithelial neoplasia versus other. Having said that, a benign bacterial, fungal, other prostatitis, can't be ruled out without additional information.
- The marked pyelectasia is likely secondary to at least partial lower urinary tract obstruction from the enlarged prostate, although concurrent ascending infection versus other is also possible.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urinalysis and urine culture, if indicated based on urinalysis results, are recommended. Submission of urine to look for BRAF gene mutation, which is associated with urinary bladder/prostate cancer, could be considered. Other diagnostic options include traumatic catheterization, fine needle aspirate (with small risk of tumor seeding/trailing) or cystoscopy for further sampling. In the meantime, empirical therapy with a broad-spectrum antibiotic (or ideally an antibiotic based on culture and sensitivity results) as well as an anti-inflammatory (unless otherwise contraindicated based on patient co-morbidities) may begin to help alleviate clinical signs.



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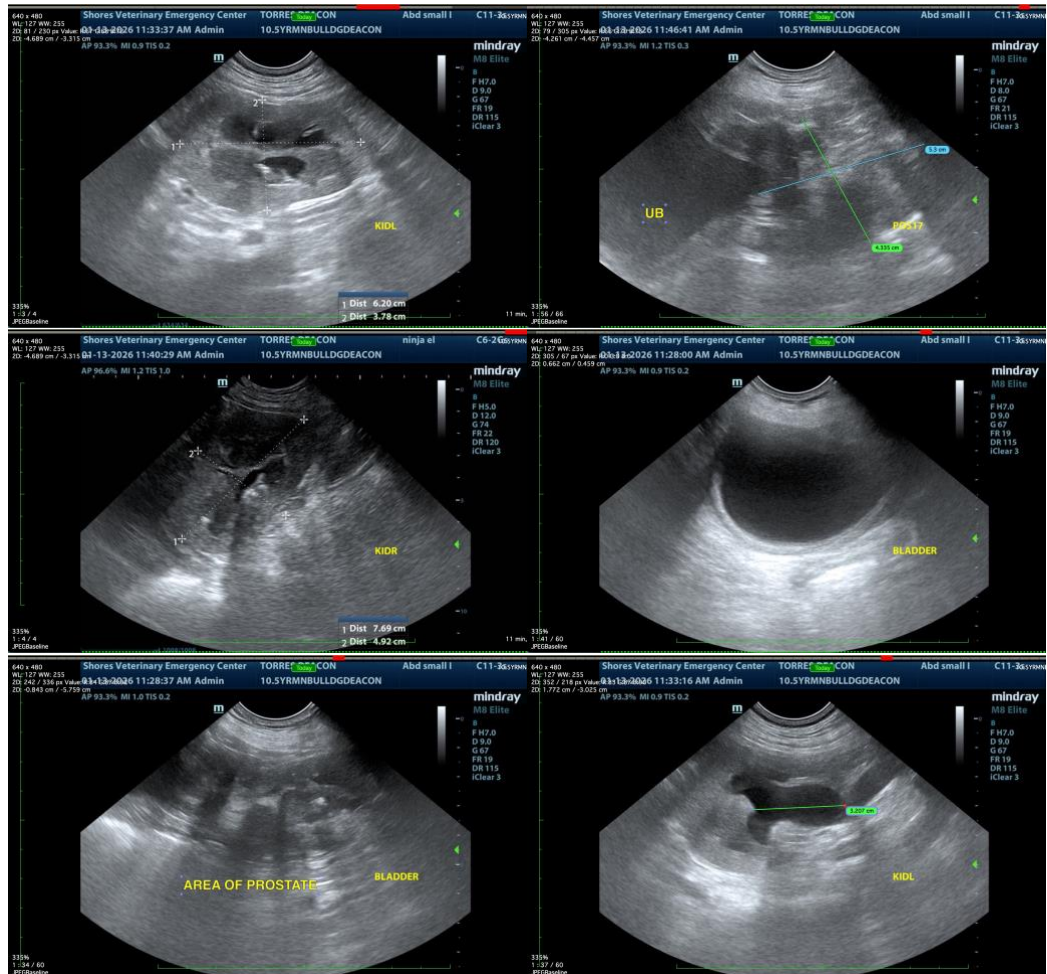
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Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.



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.

Beth Johnson, DVM DACVIM

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