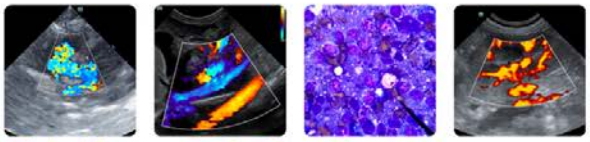


PATIENT

Mia McKee

SPECIES

Canine

BREED

Pit Bull

SEX

Spayed Female

AGE

14 Years 6 Months

WEIGHT

25.76 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

East Bradford Veterinary Hospital

REFERRING VET

Meghan McGrath, DVM

INVOICE

72610

DATE

1/29/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate chronic hematuria, history of proteinuria, and elevated ALP. Previous AUS performed 7/10/25. December 2025 presented for recurrent urinary tract infection with severe hematuria and dysuria. Previous treatment with Clavamox 100mg for 10 days provided temporary resolution, but signs returned 4 days after discontinuation. Current examination reveals thickened bladder wall with no stones or obvious masses on imaging. Plan includes extended antibiotic therapy with Clavamox 375mg for 21 days with urine recheck on day 19. December 2025 O described, severe dysuria, could only produce few drops of urine tinged with blood- Multiple attempts to urinate (went in and out 8 times)- Vocalization during urination attempts- Client observed chunks of blood in urine during previous episode.

Meds: Clavamox 375mg, Enalapril 10mg, Pregabalin 100mg, Amantadine 100mg

Abnormal PE/Chem/CBC/UA Results: 1/14 recheck UA: USG 1.025, pH 5.5, Pro 2+, inactive sediment. (Dec UA showed USG 1.032, Bld 2+, RBC 21-50/hpf, Pro3+, no bact) - UC: no growth Dec 2025: - BRAF mutation testing: Undetected - Lat rad: no cystoliths 10/2025 recheck UPC: < 0.4 (Prev 1.5 H) - CBC: Hct 52%, Plts 275-n - Chem: Alb 4.0-n, ALP 459 H, ALT 53-n, BUN 43H, Cr 1.6-n, SDMA 11.2-n July 2025 AUS (Sonopath): Normal urinary bladder. • Heterogeneous liver – diffuse hepatic changes are non-specific and could be consistent w/vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, EMH, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. • Age related changes visualized associated with both kidneys, as well as right-sided pyelectasia.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

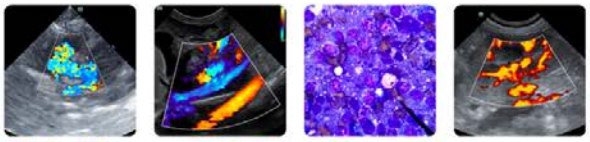
Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.32 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measures 5.28 cm. An approximately 0.67 cm in diameter cortical cyst is noted in the caudal pole of the left kidney. The right kidney measures 5.98 cm. Multiple small cortical cysts are noted in the right kidney.

Adrenal Glands

The right adrenal gland is normal in size (1.1 cm at cranial pole and 0.70 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.49 cm at cranial pole and 0.69 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.



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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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.

Liver

Liver is relatively normal in size and contour. Parenchyma is mildly heterogenous and coarse with mild likely age-related parenchymal remodeling noted. 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 with some echogenic debris noted. 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 mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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 observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. 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

- Very mild/subtle chronic cystitis - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.
- Otherwise, this is a largely unremarkable/normal structural senior abdomen with age related hepatobiliary, kidney and pancreatic changes.

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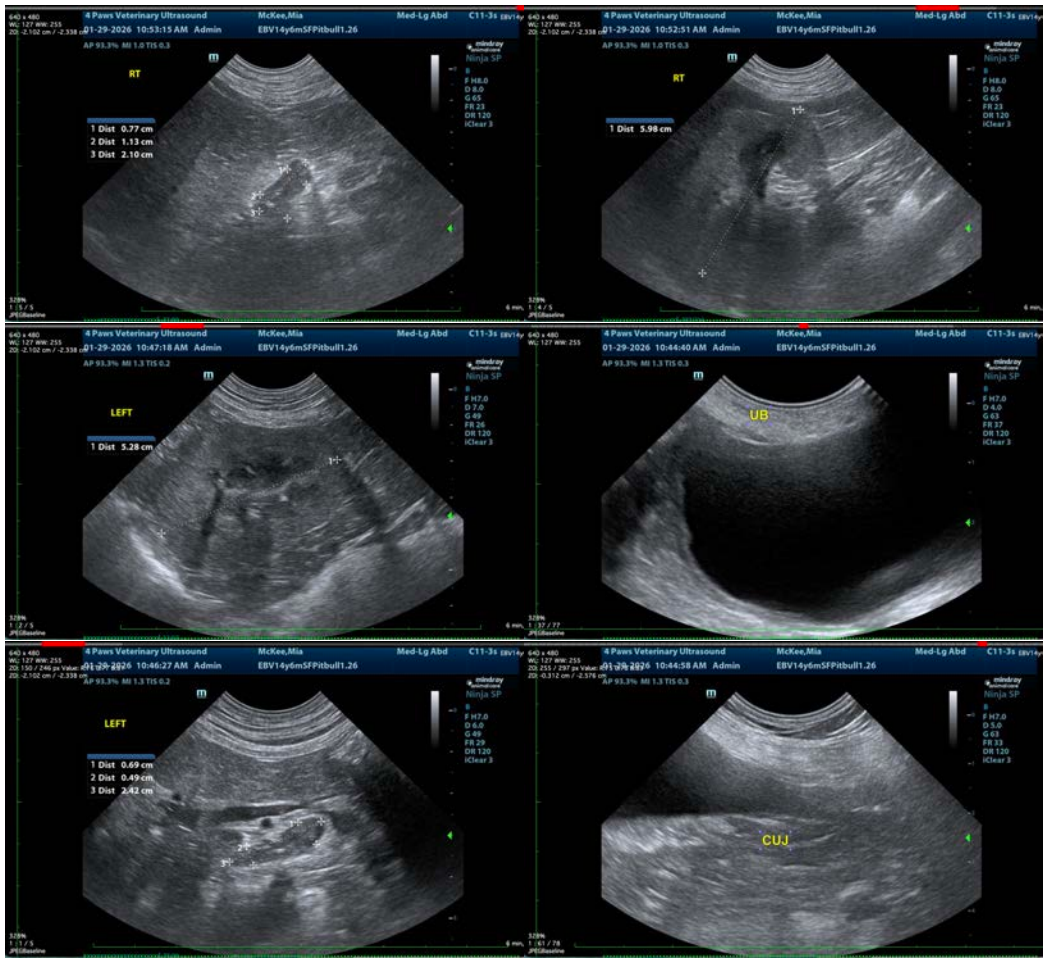
- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

As is reportedly planned, management of the suspected urinary tract infection based on culture and sensitivity results, if possible, as a complicated urinary tract infection including mid treatment cultures and a follow up culture a week to 10 days after finishing antibiotics is recommended. If infections recur following management of a possible persistent urinary tract infection, advanced imaging of the urinary tract including possible cystoscopy could be considered.



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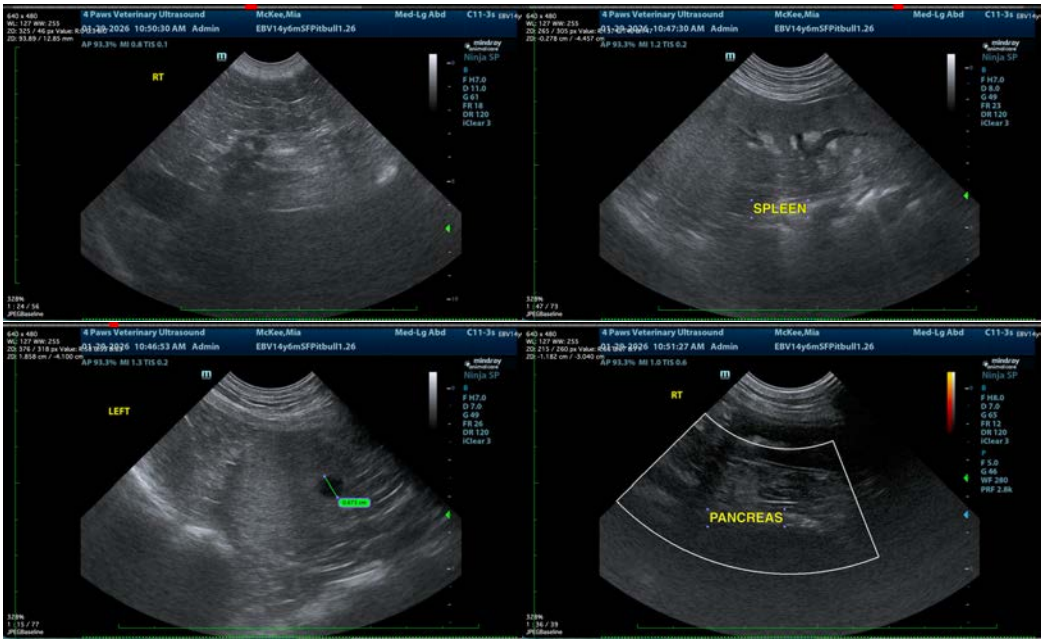

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com