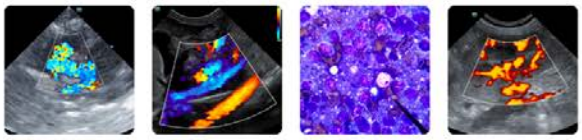


PATIENT

Nala Marine

SPECIES

Canine

BREED

English Golden Doodle

SEX

Spayed Female

AGE

6/22/20

WEIGHT

25.4 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Incline Veterinary Hospital

REFERRING VET

Dr. Ivan Grechanichenko

INVOICE

72590

DATE

12/16/25

PRESENTING CLINICAL SIGNS

Pt presented 12/10/2025 for increased urination with suspected straining for one week. Pt squatting to urinate 5-6 times per walk. No blood noted in urine, and no accidents/leaking in house. Pt otherwise E/D/BM normal. Pt previously examined 4/10/2025 for PU/PD and licking vulva, NSF on exam or UA at that time. Working diagnosis r/o lower urinary tract inflammation, irritation, cystitis, urolithiasis, urinary bladder neoplasia. Carprofen 100mg 1/2 tablet PO BID, Clavamox 375mg 1 tablet PO BID, Any additional information Gabapentin & Trazodone given prior to ultrasound.

Abnormal PE/Chem/CBC/UA Results: Recent UA 12/10/2025: increasing number of WBC, RBC, presence of Protein, no bacteria found

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. The apical wall is mildly thick and irregular, measuring 0.47 cm thick. The trigone, especially the ventral aspect of the trigone, is thick, demonstrating an almost mass-like appearance measuring 1.8 cm long x 0.80 cm thick, with thick, irregular tissue extending into the proximal urethra where the wall measures 0.30 cm thick. No cystoliths are observed. In some views there is a very subtle, tiny anechoic, tubular-like structure running dorsal to the urinary bladder to the proximal urethra that could represent a ureter, but ureter can't be definitively identified/diagnosed, especially in a 5 year old dog where I would expect more dilation from a truly ectopic ureter.

The right kidney is normal is size (6.7 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 pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (6.4 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 pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.50 cm at cranial pole and 0.50 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

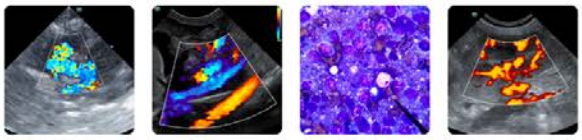
The left adrenal gland is normal in size (0.40 cm at cranial pole and 0.40 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The 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

The 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



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homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The 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 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 is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. The lumen is diffusely mildly distended with soft stool.

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.

Medial iliac and mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

Assessment of heart base images is included when/if a splenic nodule/mass is present (as a complimentary add on). They are also assessed when a specific request is made for assessment of a limited second cavity (heart base and/or thorax) for an additional charge. Images of the heart (and/or) thorax were not assessed for this study. Please contact us if you would like a second cavity.

ULTRASONOGRAPHIC FINDINGS

- The urinary bladder wall thickening in the area of the trigone and urethra could represent a benign inflammatory process/chronic cystitis, although infiltrative neoplasia is also a differential and can't be ruled out without additional information. An ectopic ureter or ureters can't be ruled out but are considered slightly less likely.

- Moderately reactive medial iliac lymphadenopathy and mildly reactive mesenteric lymphadenopathy – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

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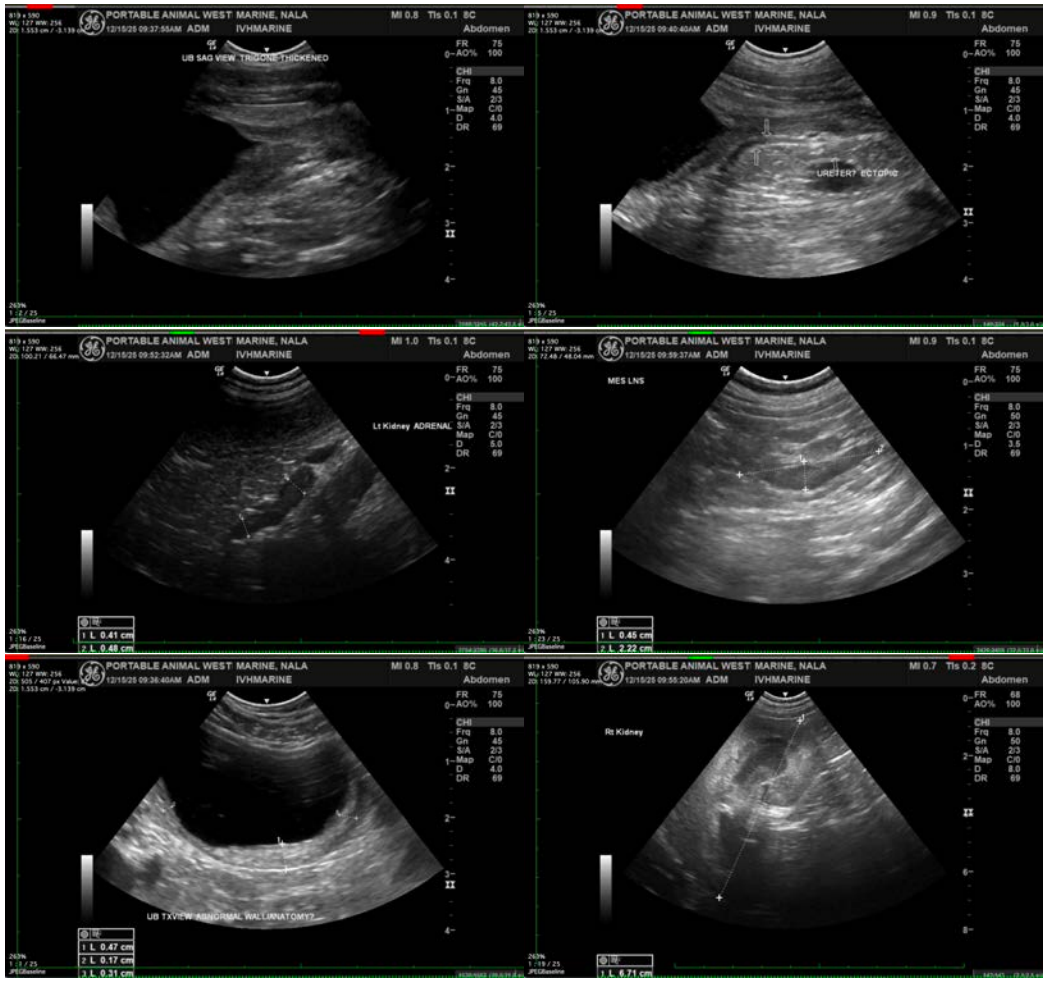
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

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.

If a diagnosis is not obtained, cystoscopy could be considered for further visual evaluation of ureters as well as the urinary bladder as well as sampling of the tissue for histopath, deep culture and sensitivity, etc.



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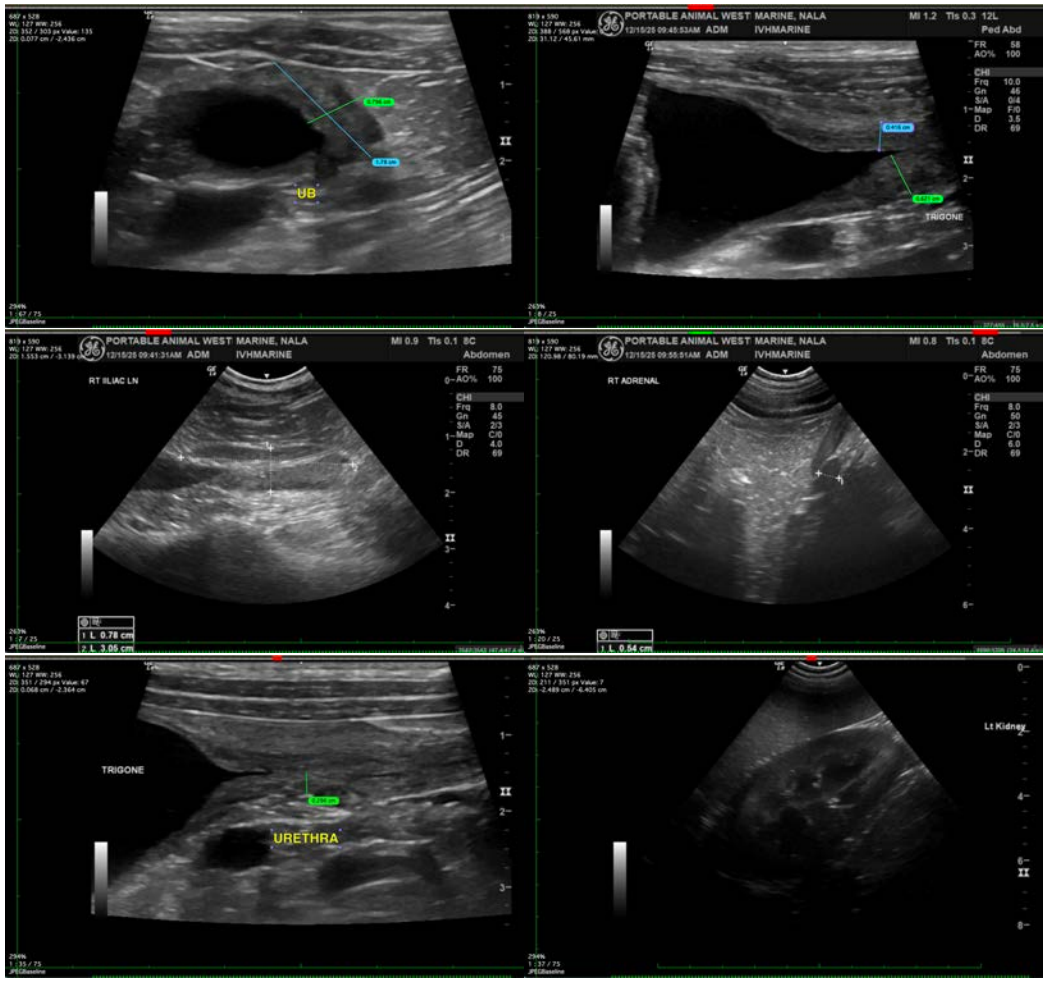

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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