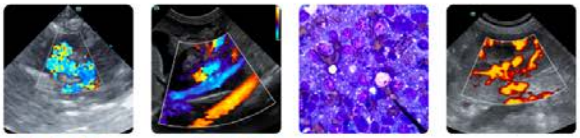


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Finley Lefaivre

SPECIES

Canine

BREED

Shepherd x

SEX

Spayed Female

AGE

11 Years

WEIGHT

25 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Acton VC

REFERRING VET

Dr. Shah

INVOICE

72678

DATE

12/18/25

PRESENTING CLINICAL SIGNS

Findings: -P presented on December 4th for dark urine, which they had now noticed with the snow being on the ground. No other symptoms -Bloodwork was run (unremarkable) and urinalysis showed large amounts of RBC and WBC, when spun down there was debris that resembled bacteria so a culture was sent out -Urine culture came back negative, O reported P getting a bit better but urine still dark -Radiograph taken of bladder, no stones or obvious masses seen Current Medications Clavamox 375mg BID (two more days left

Abnormal PE/Chem/CBC/UA Results: Bloodwork all WNL but will send over, along with the urinalysis and radiograph. Radiographic Findings Radiograph seemed WNL but will send over. Primary Question to Be Answered in This Exam Can anything be seen to explain P's hematuria?

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is only mildly/not fully distended with primarily anechoic contents. The urinary bladder wall is diffusely mildly thick, but likely at least in part due to it not being fully distended. Therefore, the urinary bladder wall is unable to be fully assessed for pathology without further distention. Having said that, beginning in the very distal trigone and extending into the proximal urethra, measuring 3.2 cm long x 1.6 cm wide, is a mildly heterogeneous echogenic mass lesion that des represent true pathology. No mineral is observed.

The right kidney is normal is size (6.48 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 (5.93 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 unable to be well visualized in these images.

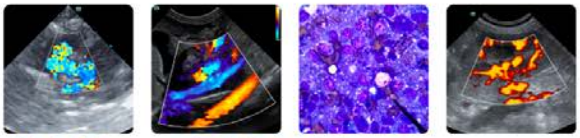
The left adrenal gland is normal in size (0.52 cm at cranial pole and 0.57 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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



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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 is mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. There is no evidence of obstruction, foreign material, or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of moderately thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine contains fluid.

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 proximal urethral mass is most concerning for infiltrative neoplasia such as uroepithelial neoplasia versus other. A benign inflammatory process cannot be ruled out without additional information but is considered slightly less likely.
- Moderate inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.

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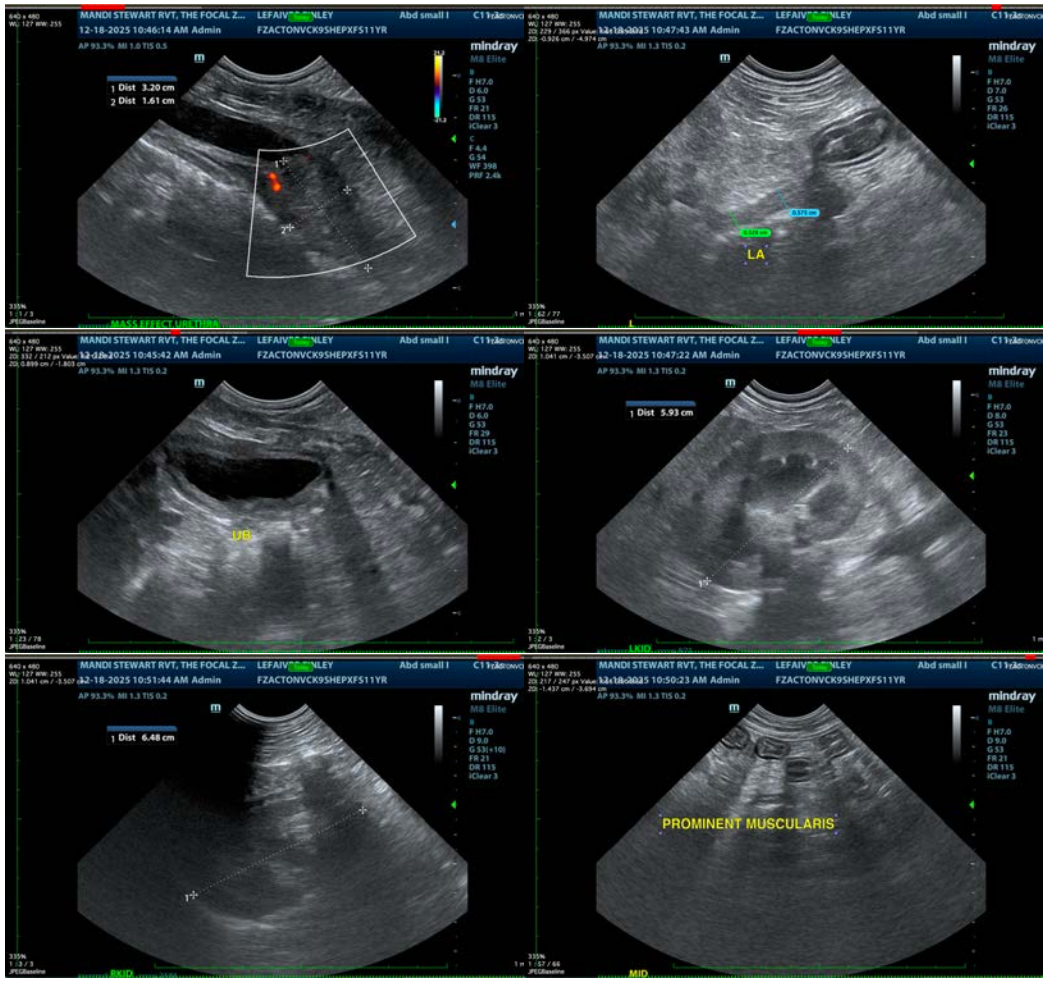
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

The bowel changes may be in part normal patient variant in a senior dog. However, especially given patient's breed and/or if there is any history of gastrointestinal signs i.e., vomiting, diarrhea, unintentional weight loss, etc., further workup may be indicated and could being with:

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.



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