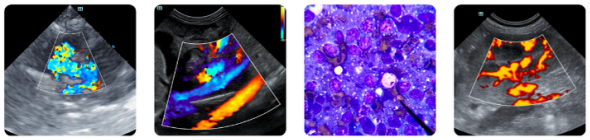

PATIENT

Brick Hofstede

SPECIES

Canine

BREED

Bulldog

SEX

MN

AGE

10 years

WEIGHT

26.8 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Michelle DeMelo, RVT

HOSPITAL NAME

Woodstock Veterinary Hospital

REFERRING VET

Dr. Tamara Hofstede

INVOICE

11330

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PRESENTING CLINICAL SIGNS

- Follow up to 16862, July 19/25. 11 yr old MN 27 kg bulldog. Neutered at 3 yrs. First presented with hematuria/E. coli UTI June/25. Bacteriuria/pyuria resolved with 2 wks of FQ. Hematuria continued, UTI in Sept/25. Bacteriuria/pyuria resolved with 6 wks of FQ. Hematuria persisted, rads and a brief ultrasound to Imagepet Oct25, NSF. Hematuria not affected by 2 mo enalapril (Nov/Dec/25). Hematuria worse in last 6 weeks. Patient is anemic,BAR. UAs showed no evidence of UTI until last month when WBC counts increased. Small (<1 kg) wt loss in last 6 weeks. Significant pyuria was found on UA today. Goal is to see if a cause for the hematuria can be found. Current meds: acetaminophen 250 mg q12 hrs, Metacam 25 kg dose q24 hrs, doxy250 mg PO q24 hrs (indolent ulcer), apoquel 16 mg q24 hours, Gabapentin PRN, omeprazole 20 mg q24-48 hrs, Thyroid supp 0.1 mg q12hours. Is in middle of T4 range

Abnormal PE/Chem/CBC/UA Results: See above.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The 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. In these images of the urinary bladder, not visible previously, is a 0.3 cm in diameter mineral density/cystolith.

Prostate is mildly enlarged (1.1 cm thick in sagittal view). Parenchyma is diffusely homogenous and relatively hyperechoic. Normal distinct margins and symmetrical bilobed shape are maintained. This finding is likely normal patient variant, especially if patient was neutered as an adult; however, if patient was neutered as a puppy, prostatitis or, less likely, infiltrative neoplasia cannot be ruled out. This finding should be interpreted in combination with clinical signs, urinalysis results, etc. and either further investigated or monitored, as indicated.

The right kidney is normal is size (4.9 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 (5.1 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.

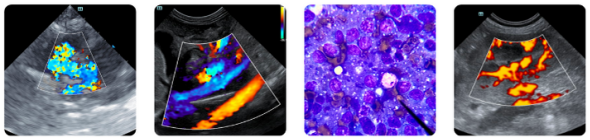
Adrenal Glands

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

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



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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.

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 stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

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

- Mild prostatomegaly as described above.
- Suspect a small cystolith.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations are unchanged from the previous exam, except for, given the new mineral, retrieval for analysis is recommended. It may be small enough to pass with an anesthetized bladder flush/voiding urohydropropulsion.

If patient's previous urinary tract infections have resolved and an infection is not believed to be the cause, assessment of patient's coagulation status is recommended. A blood pressure is recommended if not recently evaluated. Ultimately, cystoscopy could be considered for further visual evaluation of

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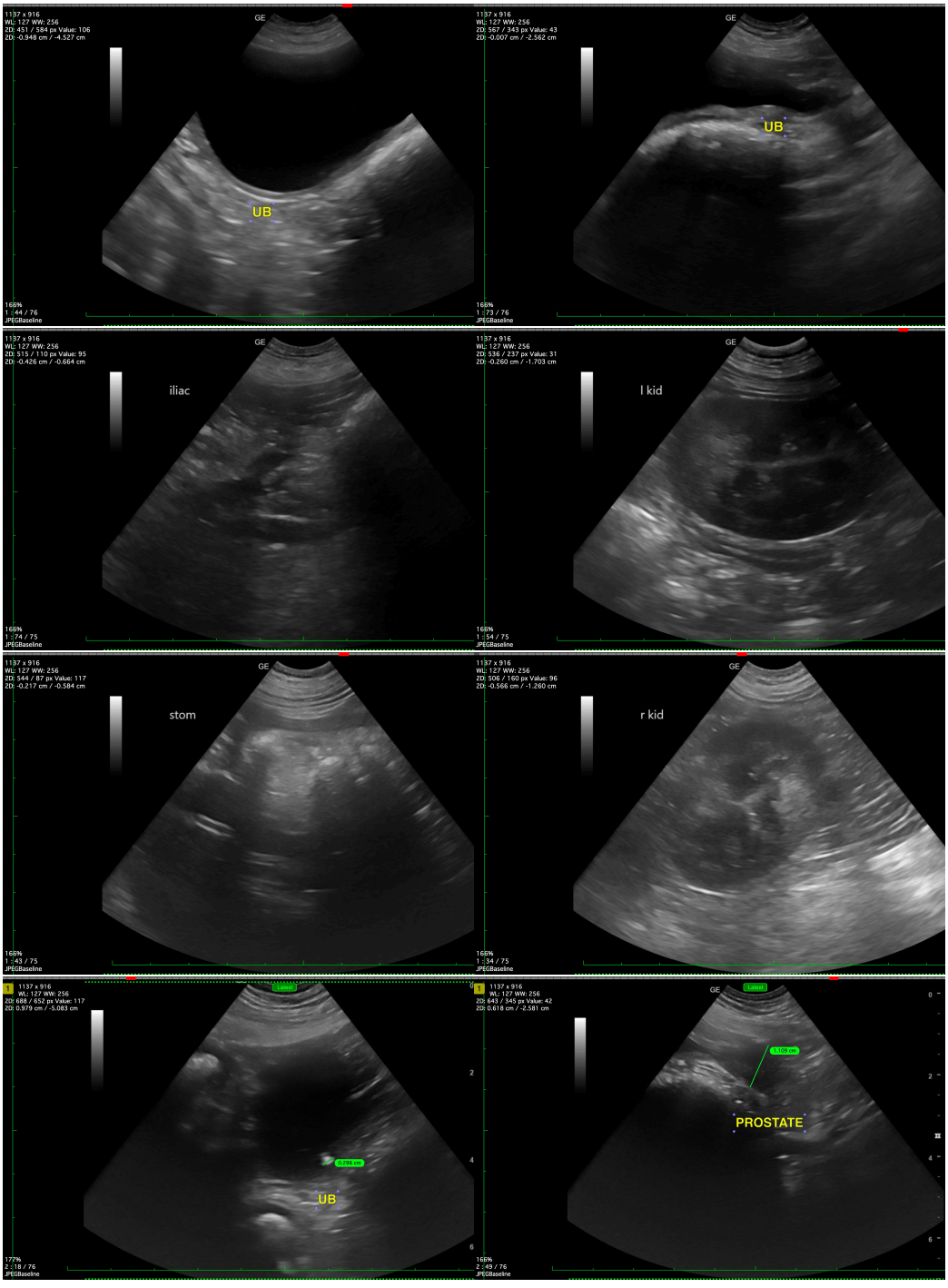
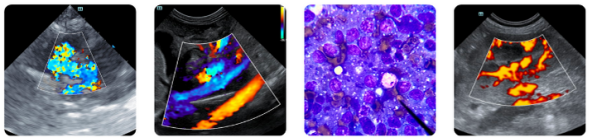
things like potentially renal hematuria, as well as sampling for histopathology and deep culture, and sensitivity of the urinary bladder.



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



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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