



PATIENT

Olivia Tessitore

SPECIES

Canine

BREED

Terrier Mix

SEX

Spayed Female

AGE

10 Years

WEIGHT

11 pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Julia Bakker DVM

HOSPITAL NAME

Orange Blossom
Veterinary Imaging

REFERRING VET

Dr. Molly Caldwell
DVM

INVOICE

13933

DATE

02/23/26

PRESENTING CLINICAL SIGNS

- Patient has been taking a long time to urinate and straining to urinate.
- *Assessment* Previous x-rays showed some mineralization at the neck of the bladder. This could be neoplasia but also maybe could be chronic inflammation, bladder stones, a polyp, reproductive area, open dx.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents as well as a small amount of echogenic suspended urinary bladder debris. In the trigone is a curvilinear 0.7 cm in size mineral density right at what appears to be the left ureteral papilla. The left ureter at that area is dilated measuring 0.31 cm dilated and appears to contain within the ureter, some mineral debris as well as in some views, echogenic irregular suspect tissue density. The urethra for 2.0+ cm (as far as it can be visualized) measures approximately 0.5 cm thick with a heterogeneous irregular echogenic largely mineralized appearance. The mineral appears to be within tissue. Having said that, a very large amount of intraluminal mineral debris versus mineralized tissue can't be definitively ruled out.

A thin rim of renal cortex is the only tissue present in the left kidney, surrounding a markedly fluid dilated renal pelvis/collecting system. Narrow bands of hyperechoic tissue extend from the capsule towards the hilus. The left kidney measured 4.4 cm in size.

The right kidney is 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. The right kidney measures 4.2 cm in size.

Adrenal Glands

Left adrenal gland is normal in size (0.67 cm at cranial pole and 0.43 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.65 cm at cranial pole and 0.53 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.



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Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. Pyloric outflow tract appears patent.

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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.

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

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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.

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Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

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ULTRASONOGRAPHIC FINDINGS

- The suspected mineralized tissue within the urinary bladder, trigone, urethra and potentially extending even into the left ureter is concerning for infiltrative ureter epithelial neoplasia versus other infiltrative neoplasia although a marked but benign inflammatory response with a large amount of intraluminal mineral debris and 1.7 cm in diameter cystolith can't be ruled out without additional information.
- Suspected left ureteral obstruction and concurrent left hydronephrosis due to urinary bladder pathology described above.
- Moderately heterogenous liver- These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- Moderate gallbladder debris- Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

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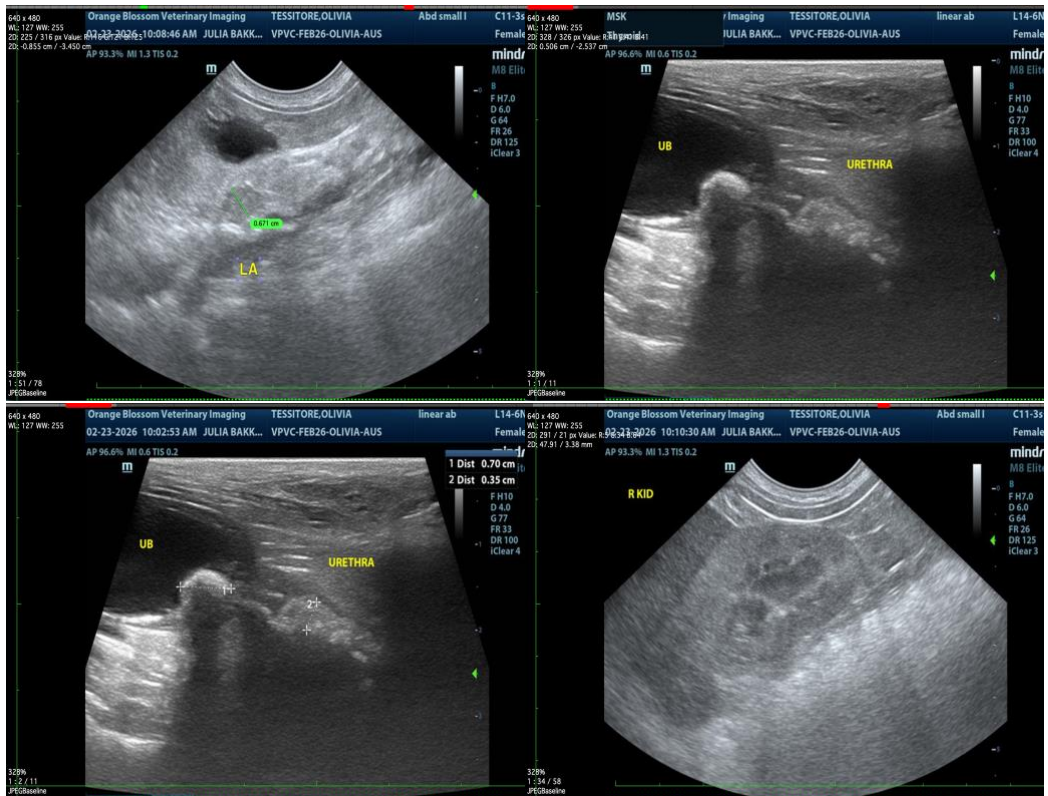
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Pending results of above, 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.

Additionally if not recently evaluated, a full general metabolic health screen is recommended to also include CBC, chemistry panel and electrolytes.





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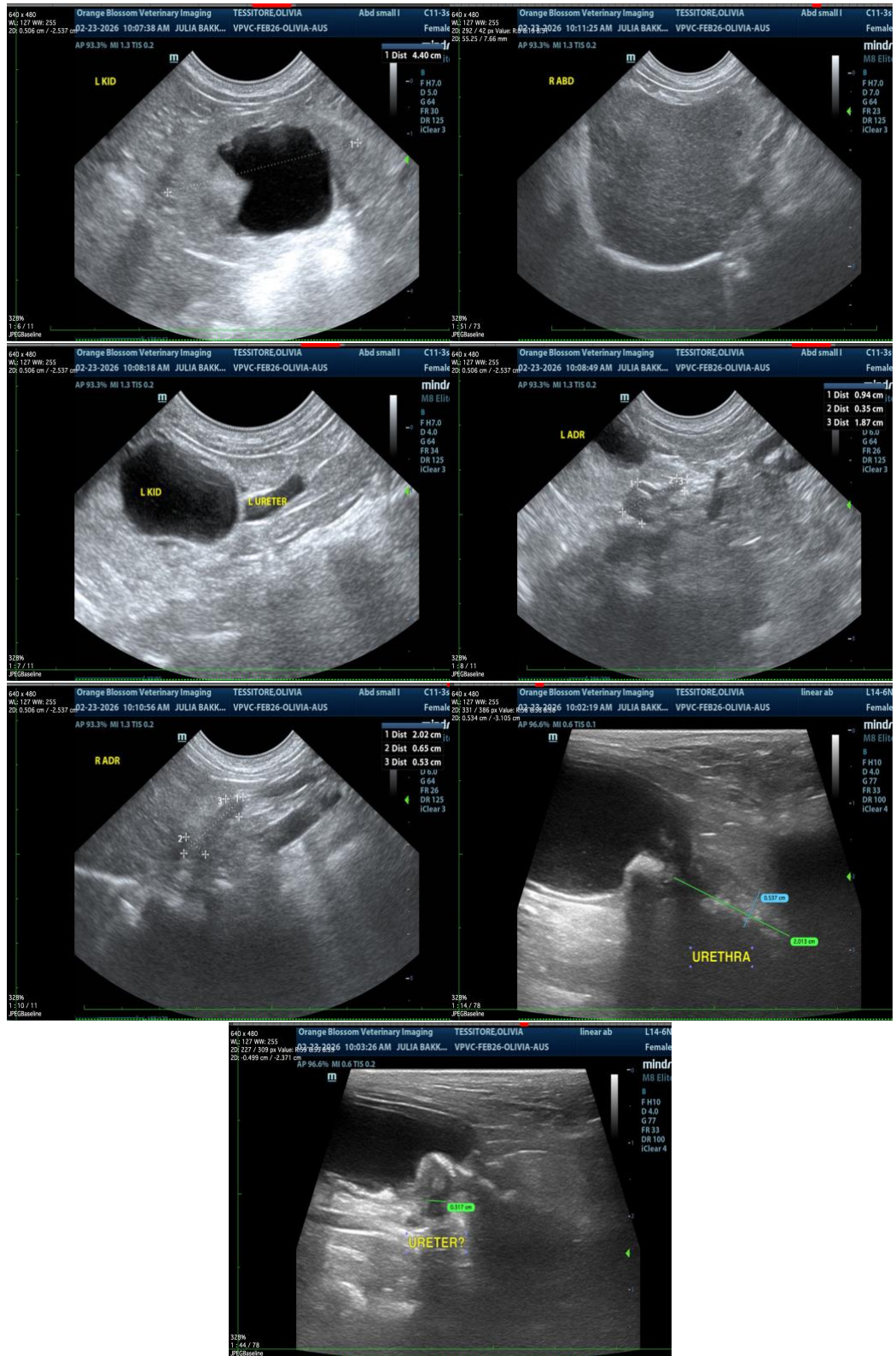
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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