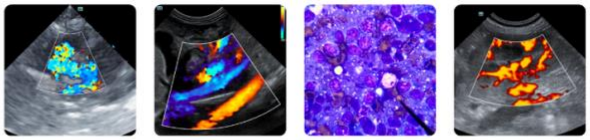


PATIENT

Boots House

SPECIES

Canine

BREED

Mixed

SEX

Neutered Male

AGE

9 Years

WEIGHT

49 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Sophia Riscavage

HOSPITAL NAME

North Winds VS

REFERRING VET

Dr. Maxwell Babinec

INVOICE

36288

DATE

3/19/26

PRESENTING CLINICAL SIGNS

- Presented for blood in urine on 2/18, clinical signs did not improve on Clavacillin, UA did improve when checked in 3/2
- Started Enroquin and Carprofen on 3/2, did not see any improvement on treatment.
- Abnormal PE/Chem/CBC/UA Results: PE unremarkable UA: improved compared to previous, Leu 70, Pro +, pH 8.5, Blo 200, SG 1.010. Sediment Active: WBCs, RBCs, Epithelial cells, apparently normal transitional epithelium cells in clusters/sheets. no crystals appreciated. CBC: mild hemoconcentration, Chem WNL. Radiographs: no overt urinary stones appreciated, remainder unremarkable

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with primarily adequate contents, as well as a moderate amount of suspended echogenic non-shadowing debris. Additionally, there is a large solitary heterogeneous irregular echogenic density/mass lesion in the trigone area, measuring approximately 2.1 cm x 3.1 cm in size. The echogenic density extends into the very proximal urethra which demonstrates a thick irregular wall and is difficult to fully differentiate from residual prostatic tissue. A definitive prostatic mass is not observed but prostatic involvement can't be definitively ruled out.

Left kidney is normal in size (5.57 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. A hyperechoic band parallel to the corticomedullary border is present.

Right kidney is normal in 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. A hyperechoic band parallel to the corticomedullary border is present.

Adrenal Glands

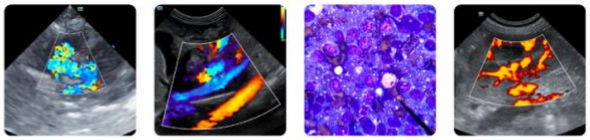
The areas of the adrenal glands are examined without evident adrenal gland pathology.

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 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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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 of the small intestine 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. 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.

The medial iliac 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.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder mass – Urinary bladder wall changes are most concerning for infiltrative neoplasia such as transitional cell carcinoma vs other. Benign inflammatory disease (cystitis) cannot be ruled out but is considered less likely given the location and appearance of the tissue.
- Reactive medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Bilateral medullary rim sign - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

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

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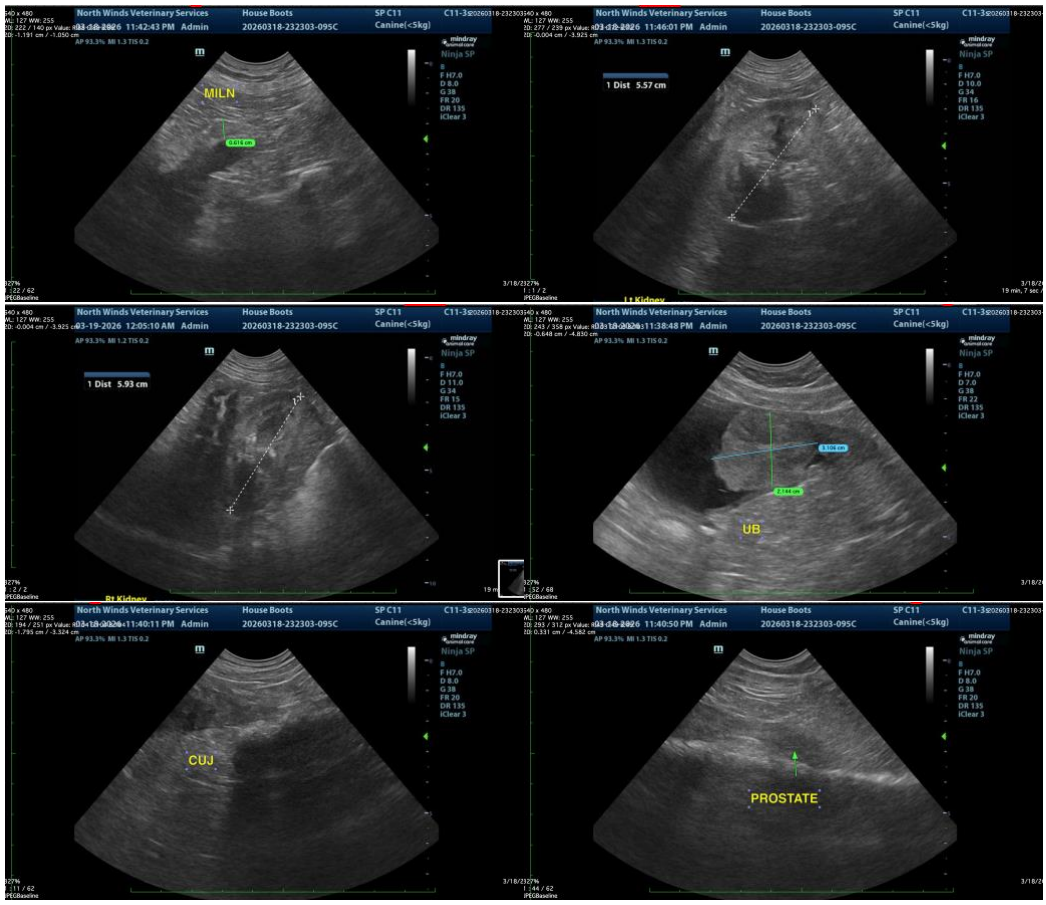
be considered. Other diagnostic options include traumatic catheterization, fine needle aspirate (with small risk of tumor seeding/trailing) or cystoscopy for further sampling. In the meantime, empirical therapy with a broad-spectrum antibiotic (or ideally an antibiotic based on culture and sensitivity 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.

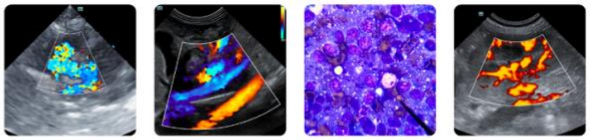
Further evaluation of the mildly enlarged medial iliac lymph nodes is largely dependent on results of above. While their appearance is more consistent with reactive nodes, early metastatic disease can't be definitively ruled out.



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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