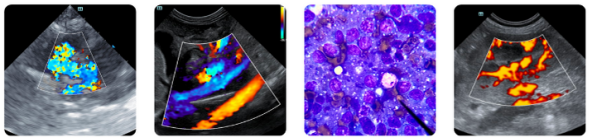

PATIENT

Blue Sakowicz

SPECIES

Canine

BREED

Pitbull

SEX

MN

AGE

11 years 1 month

WEIGHT

71.7 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Julie Kang

HOSPITAL NAME

Sabino Veterinary Care

REFERRING VET

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PRESENTING CLINICAL SIGNS

Investigate ALKP elevation that is trending upwards and urinary tract pathology or neoplastic process.

Abnormal PE/Chem/CBC/UA Results: CBC - thrombocytosis (413). NSAID chem - mod/marked ALKP elevation (1074 <-- 614 in 10/2025 <-- 654 in 6/2025), IRIS stage 1. UA - 1.048, 1+ proteinuria, 11-20/hpf pyuria, 2-3/hpf hematuria, 4-10/hpf transitional epithelia. Path review: The cytologic findings reveal increased urothelial exfoliation with atypia. I am concerned by the atypia demonstrated by this urothelial population, and my concern for a urothelial/transitional cell carcinoma. This patient should be evaluated for the presence of a bladder/urethral mass. Assessment for the presence of the Cadet Braf mutation may also be warranted. I did not encounter the increased numbers of inflammatory leukocytes that were noted by the laboratory technician, to suggest that the atypia represents inflammatory induced dysplasia.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots, as well as dependent mineral “sand” (crystals) debris. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or discrete definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The prostate is large for a neutered dog measuring 3.9 cm in width in the sagittal view with a diffusely heterogenous parenchyma. Cysts and multifocal mineral densities are present. Normal distinct margins and symmetrical bilobed shape, however, are maintained.

Kidneys are 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. Pinpoint non-obstructive mineral densities are noted bilaterally. There is no evidence of pyelectasia or infarcts observed. Left kidney measures 6.93 cm, and the right kidney measures 6.79 cm.

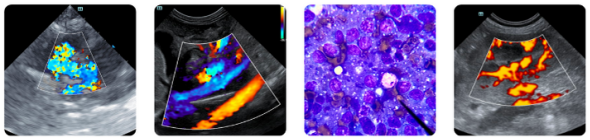
Adrenal Glands

The right adrenal gland is enlarged, primarily at the cranial pole where it measures 1.6 cm x 1.5 cm in size with mild heterogenous parenchymal changes and swollen capsular expansion. The caudal pole is normal to flat measuring 0.39 cm without evident capsular escape or vascular invasion.

The left adrenal gland is small (flattened contour) (0.26 cm at the cranial pole and 0.45 cm at the caudal pole). Corticomedullary structure is unremarkable. 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). Multifocal well-demarcated hyperechoic homogenous nodules are noted.



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Splenic vasculature appears normal. Additionally, near the cranial aspect of the spleen, an approximately 1.4 cm in diameter non-capsular disrupting, hypo to anechoic nodule is noted.

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.

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 empty with 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 empty with 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.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- The prostatic changes could represent a benign process such as chronic bacterial or other infectious prostatitis, although infiltrative neoplasia can't be ruled out without additional information.
- A moderate amount of echogenic urinary bladder mineral/sand debris.
- Right adrenal mass with a flat left gland – most consistent with an adenoma (vs adenocarcinoma) given the concurrent flat contralateral adrenal gland. Hyperplasia secondary to pituitary dependent hyperadrenocorticism is possible but considered less likely. There are no characteristics of malignancy to rank malignancy over benign disease. While considered less likely, pheochromocytoma also cannot be ruled out. Interpret in combination with clinical signs of hyperadrenocorticism or other adrenal disease.

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- Hypo to anechoic splenic nodule – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.

SECONDARY FINDINGS

- Age related kidney changes with pinpoint non-obstructive mineral densities noted bilaterally.
- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the prostate changes, 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.

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.

Given the reported alkaline phosphatase investigation and the adrenal changes, a blood pressure is recommended if not recently evaluated and pending results of above workup, hormone testing could be considered beginning with a low dose dexamethasone suppression test.

Further recommendations, both diagnostic and therapeutic are largely dependent on the results of the above.

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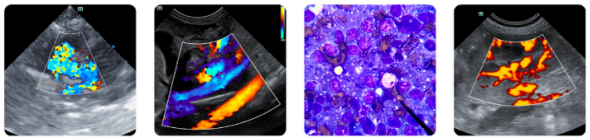

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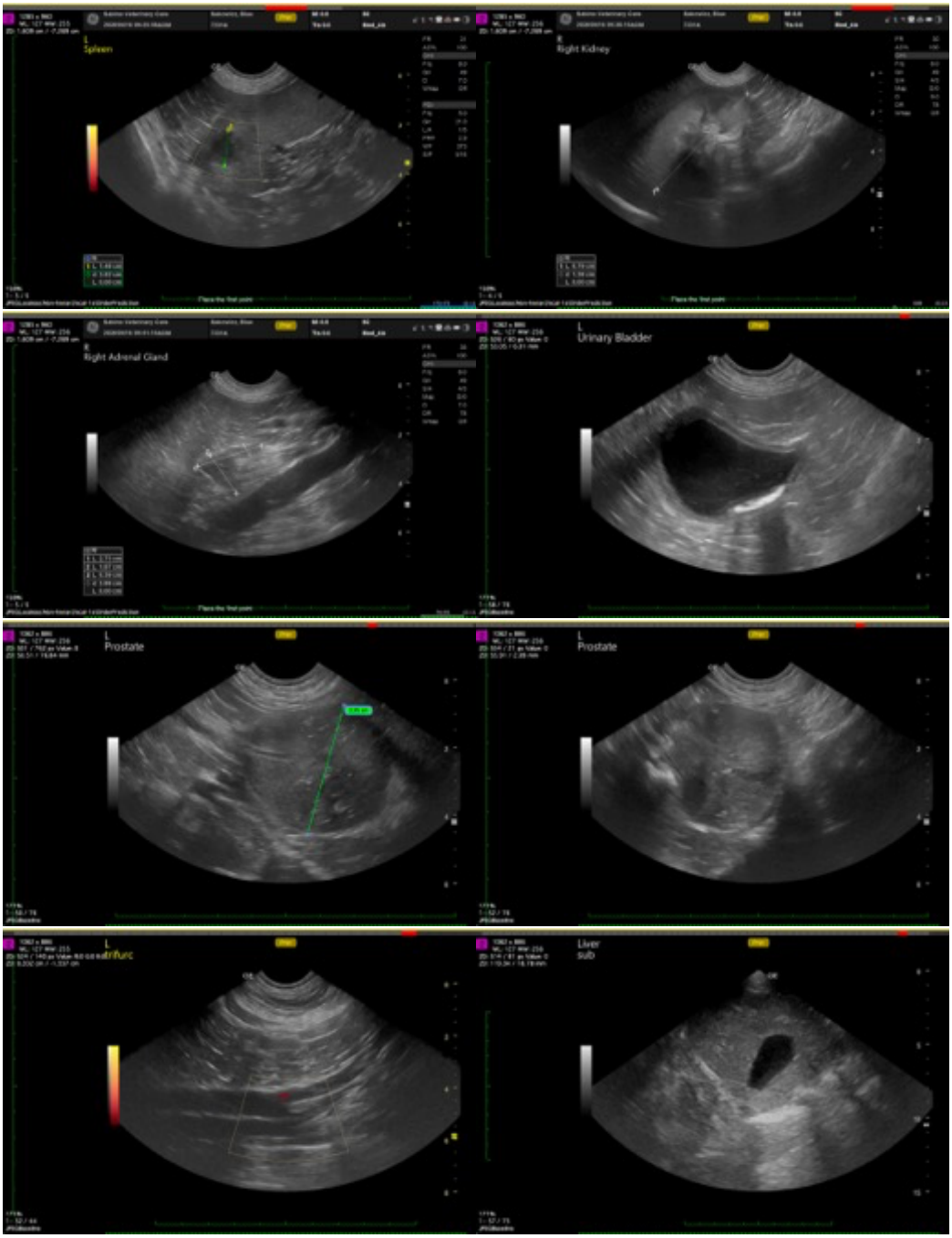

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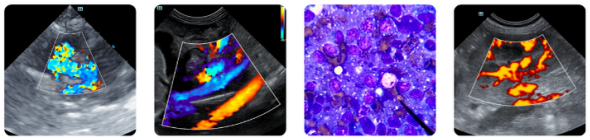

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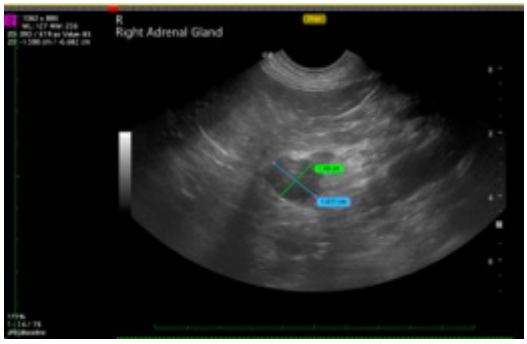

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com