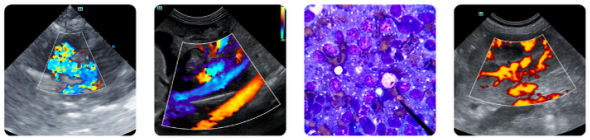


PATIENT

Sunny Kirby

SPECIES

Canine

BREED

Dachshund Mix

SEX

FS

AGE

8 years

WEIGHT

16 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Julia Bakker

HOSPITAL NAME

Orange Blossom Veterinary Imaging

REFERRING VET

Dr. Kristen Henry

INVOICE

11633

DATE

4/7/2026

PRESENTING CLINICAL SIGNS

Patient has had two UTIs since September. Presents for persistent hematuria.

Assessment/Differentials 1. Hematuria and cystitis- Rule outs: Urinary bladder stones/uroliths, urinary sediment, transitional cell carcinoma or other urinary bladder mass, bacterial cystitis 2. Recurrent urinary tract infections- Rule outs: Urolithiasis, neoplasia, antibiotic resistance Plan Procedures/Treatments Performed in Hospital:- Urinalysis: Small amount of bacteria, numerous red blood cells and white blood cells- Abdominal radiographs (3 views: left lateral, right lateral, VD): - Mild to moderately distended urinary bladder - Speckling within bladder suggesting possible uroliths or sediment - Odd outline on bladder wall raising concern for possible mass Page 2 of 9- U.Bladder single organ ultrasound: Performed to differentiate sediment vs mass fixed to urinary bladder wall and assess urethra -- sediment observed, possible blood clot. normal u. bladder wall thickness.

THE SUSPECTED MASS DID DETACH and was gravity dependent and rolled at the end of the AUS

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with primarily anechoic contents as well as a moderate to large amount of echogenic non-shadowing, suspended debris, as well as some mineral/sand settled debris. Along the apex of the urinary bladder are several irregular mildly thick areas. The most significant extends from the inner ventral apical area, and measures 0.6 cm x 0.9 cm in diameter. The density appears in most views to have blood supply but is reported by sonographer to have fallen off with agitation, and landing along the inner dependent portion of the bladder wall. Otherwise, no definitive cystoliths are observed and the trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal is size (4.5 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 (4.0 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.

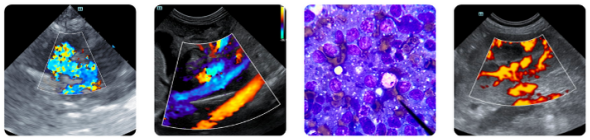
Adrenal Glands

The right adrenal gland is normal in size (0.77 cm at cranial pole and 0.37 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.59 cm at cranial pole and 0.5 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.



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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.

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

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach 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. 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. 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

- Suspect chronic cystitis, potentially polypoid cystitis with a moderate to large amount of mineral/sand debris. Having said that, infiltrative neoplasia can't be ruled out without additional information.

- Moderate gallbladder debris (canine) - 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. Some mineral/sand debris within the gallbladder is suspected as well.

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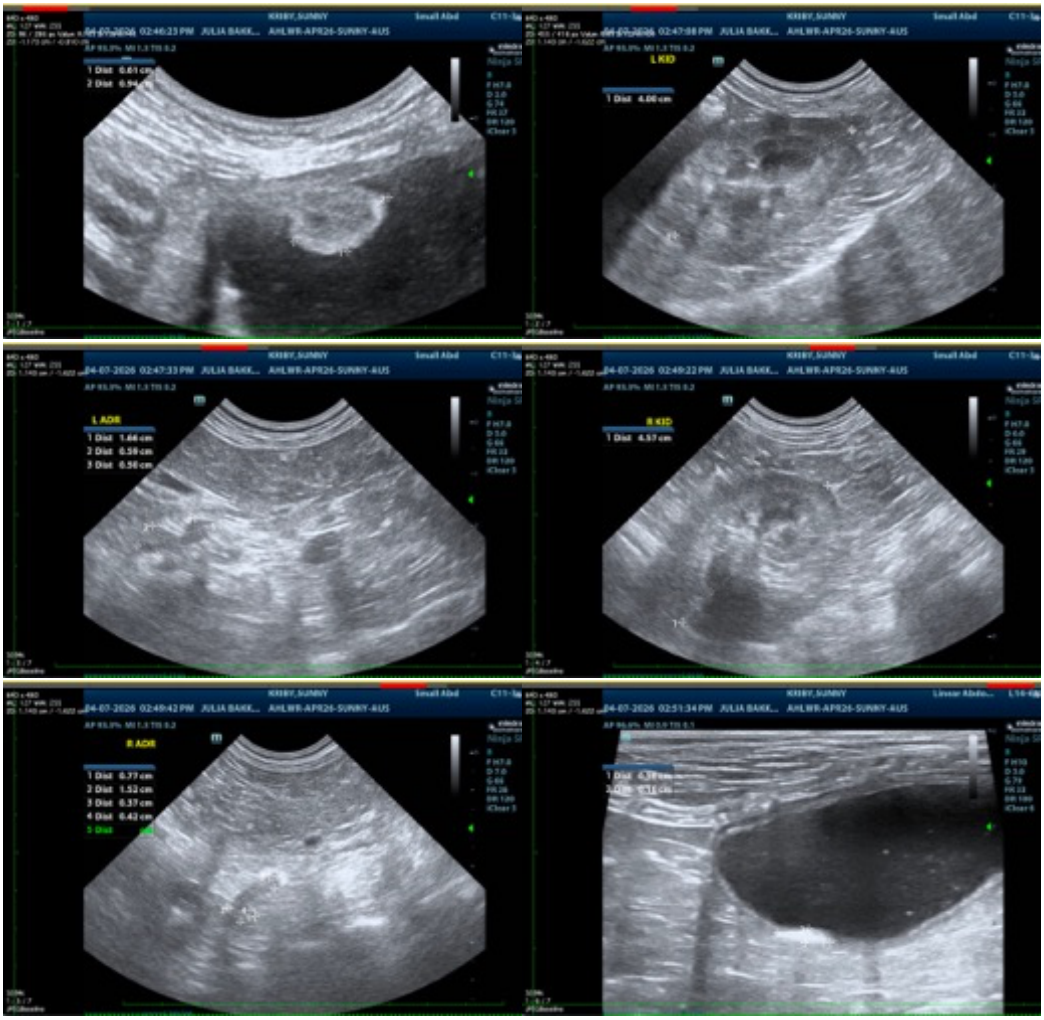
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

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

Submission of urine to look for BRAF gene mutation could be considered.

Pending results of above, an anesthetized urinary bladder flush/voiding urohydropropulsion could be considered both as a therapeutic, to remove as much of the mineral/sand debris as possible, as well as a diagnostic, to analyze the debris for composition which may help further guide medical management. Ultimately, however, if clinical signs persist and a diagnosis is not made, advanced imaging including potentially cystoscopy may be indicated.



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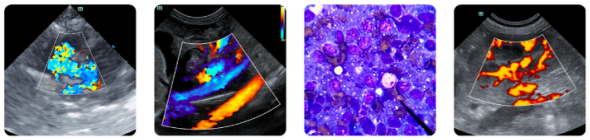

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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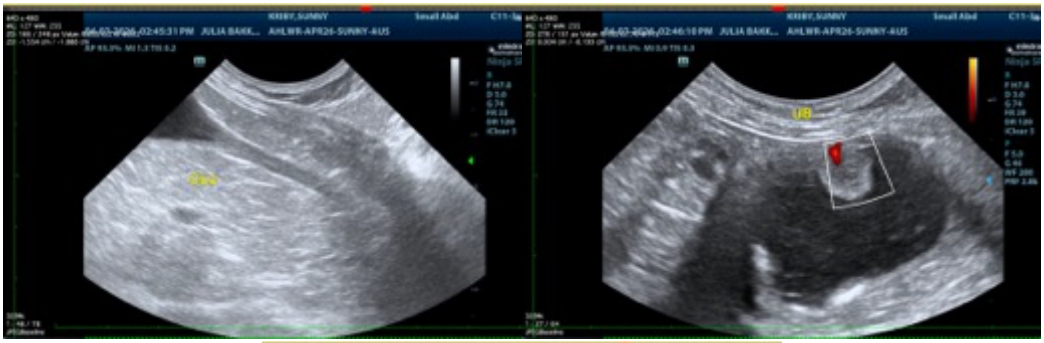

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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