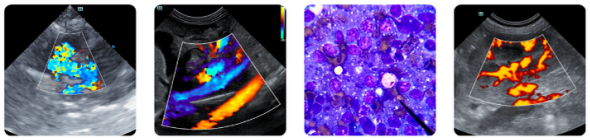

PATIENT

Sirilo Peña

SPECIES

Canine

BREED

Mixed

SEX

Intact Male

AGE

11 Years

WEIGHT

45.2 Pounds

INTERPRETED BY

Brittany Sinclair DVM, DACVECC

IMAGING PERFORMED BY

Dr. Gabriel Ferrer, DVM

HOSPITAL NAME

Pulse Pet Ultrasound Services

REFERRING VET

Dr. Jose Carrasquillo

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PRESENTING CLINICAL SIGNS

History: Presented for an abdominal ultrasound to evaluate hematuria. Pt started to developed. Pt 1 month ago started to develop urinary incontinence and 1 week later hematuria. In 4/2024 Also had hematuria and treated with Ciprofloxacin as UTI/Prostatitis. CBC then showed leukocytosis and hyperglobulinemia. Rads were taken and did not see Renal, bladder or urethral calculi and recommended neuter him. In 10/2025 presented for hematuria, stranguria and prostatomegaly was identified and treated with enrofloxacin, NSAIDs, but medication did not improve the hematuria and recommended abdominal u/s. PT is on Pimobendan due to heart murmur diagnosed win 5/2025 Abnormal PE/Chem/CBC/UA Results: PE: Heart murmur Bloodwork and Radiographs attached as supporting documents.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is severely thickened and irregular, most consistent with mass effacing the majority of the bladder. There is some anechoic lumen visible. Mass does not appear to be invading urinary bladder neck.

The prostate is uniformly moderately enlarged and hyperechoic. No mineralization, evidence of masses or fluid accumulations consistent with cyst or abscess visualized. The prostate measures approximately 5.4 cm x 4.0 cm.

Both testicles are subjectively normal in size and shape with homogenous parenchyma free of masses and normal median raphe visualized.

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio (cortex 1/3 of medulla). Medullary structure differed distinctly from that of the cortex. Left renal pelvis was moderately dilated, measuring 0.7 cm in transverse view. Ureter is dilated, measuring approximately 0.5 cm in diameter. It is not distinctly visualized at the level of the urinary bladder. The right kidney measured 6.2 cm in length. The left kidney measured 6.63 cm in length.

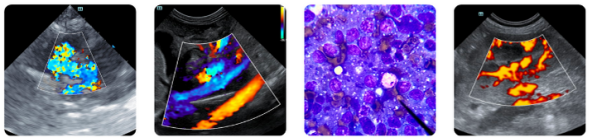
Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 2.03 cm in length and 0.58 cm at the cranial pole and 0.6 cm at the caudal pole. The right adrenal gland measured 1.99 cm in length and 0.81 cm at the cranial pole and 0.64 cm at the caudal pole.

Spleen

The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and smooth capsule, with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver



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The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. Gallbladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis: mucosa layer ratio. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The base and limbs of the pancreas were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour and parenchyma were normal. No overt evidence of active inflammatory or neoplastic disease was noted.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

ULTRASONOGRAPHIC FINDINGS

- Large urinary bladder mass
- Moderate left pelvic dilation with ureter dilation-likely at least partial obstruction from urinary bladder mass
- Prostatomegaly consistent with intact status

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urinary bladder wall changes are most consistent with a bladder wall mass with transitional cell carcinoma being a top differential. Submission of urine for a CADET BRAF to confirm diagnosis is recommended. FNA could be attempted but has a risk of seeding neoplastic cells in the abdomen. This is the likely reason for lower urinary signs. Left renal pelvic dilation and ureter dilation is likely secondary to at least partial obstruction at the trigone from the urinary bladder mass.

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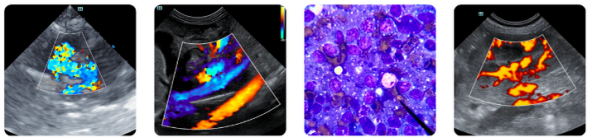

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SonoPath.com info@sonopath.com 1.800.838.4268

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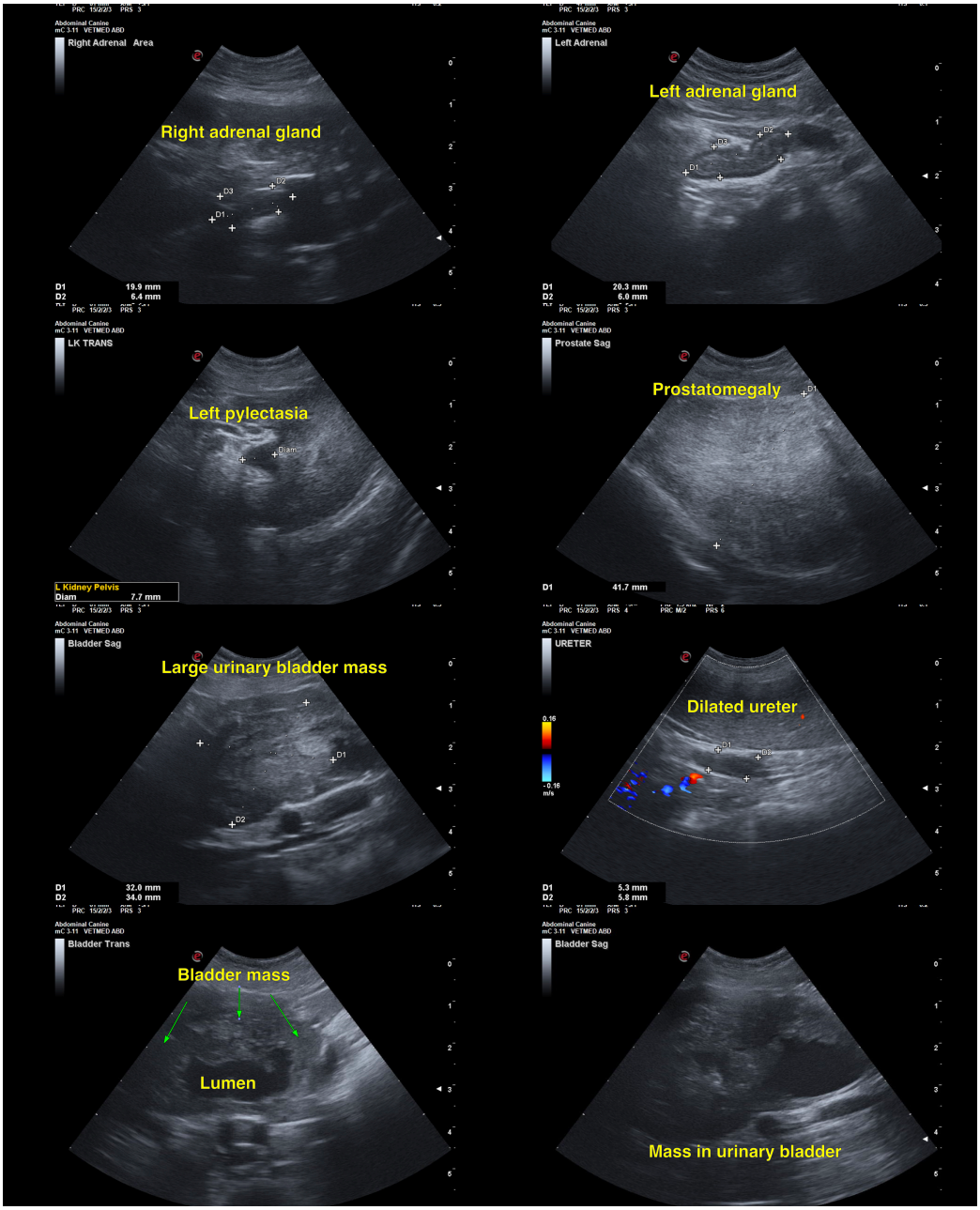

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

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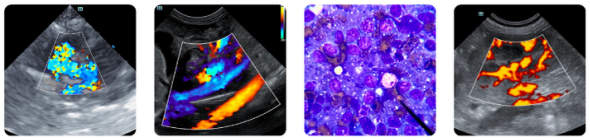

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