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Clinical Sonography & Telecytology
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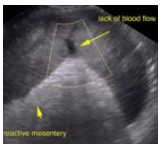
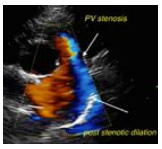
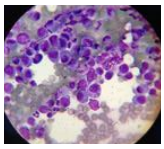
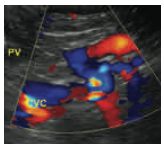

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Sarah B Farris

SPECIES
Canine

BREED
Chinese Pug

SEX
Spayed Female

AGE
1 ½ years

WEIGHT
22 lbs

INTERPRETED BY
Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Katie Buss

HOSPITAL NAME
Kings VH

REFERRING VET
Dr. Freson

INVOICE
96401

DATE
2/28/22

PRESENTING CLINICAL SIGNS

History of stranguria and hematuria, abnormal bladder ultrasound. Elevated TBili on bloodwork.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** presented concentric, apical ventral wall thickening measuring 2.0 x 1.5 cm with a minor amount of dependent sand and debris. The cystourethral junction and ureteral papillae appeared free of evident pathology. The wall thickening appears resectable. Sand accumulation measured approximately 0.6 cm.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The right kidney measured 3.74 cm. The left kidney measured 3.58 cm.

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.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

Gastrointestinal

The **stomach** was filled with ingesta. The small intestines and colon were unremarkable.

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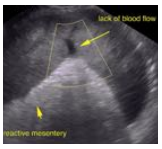
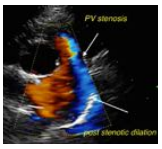
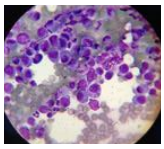
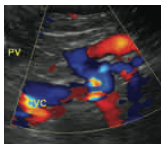

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Pancreas

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

ULTRASONOGRAPHIC FINDINGS

Apical ventral bladder wall thickening. Likely cystitis or congenital mural dysplasia of the bladder wall with possibility of transitional cell carcinoma.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the age of the patient neoplasia is unlikely. Severe chronic cystitis is a primary, congenital mural lesion. The cause of elevated bilirubin is unclear. Reassessment for lab artifact is recommended to ensure that the bilirubin is persistently elevated. Given the stranguria and hematuria resection of the apical ventral bladder wall with sand analysis would be the best option to obtain histopathology of any inflammatory cell type and resect the pathology as well as lavage this with bladder sand. Otherwise, cystoscopy can be considered with mucosal biopsies and bladder lavage. There is no evidence of metastatic disease. Cytospin of the free catch urine sample can be considered with immediate slide preparation to assess for possible transitional cells even though the age of the patient should suggest that neoplasia is unlikely.


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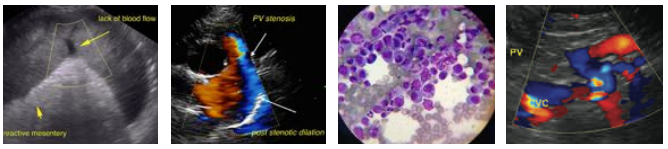

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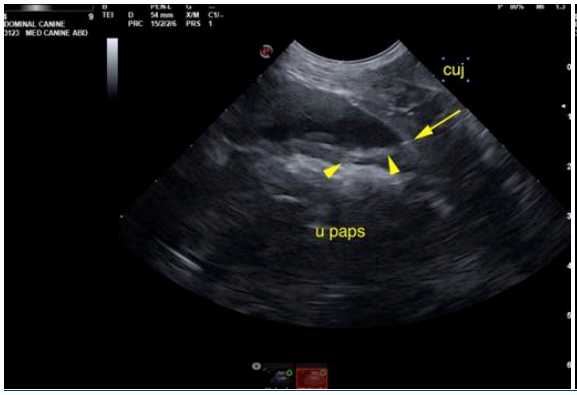

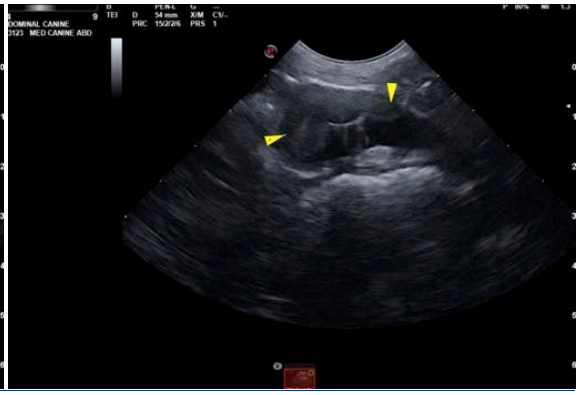

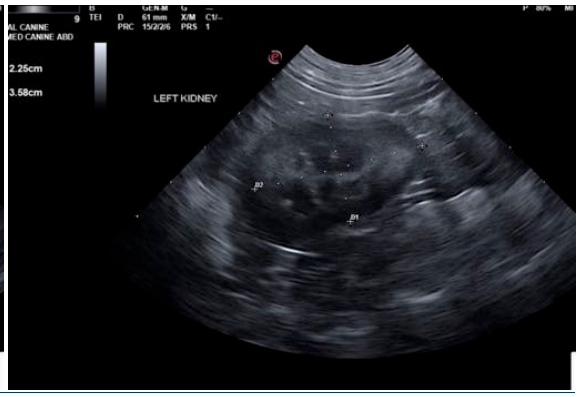

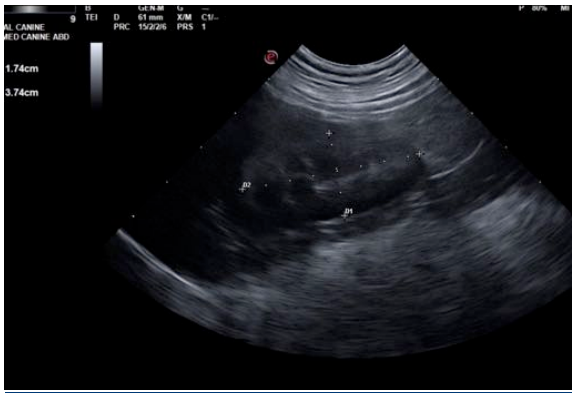

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
info@SonoPath.com