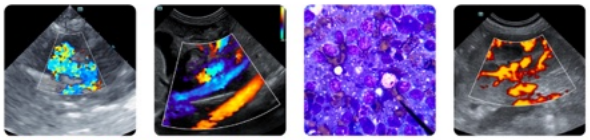

PATIENT

Blue Sakowicz

SPECIES

Canine

BREED

Pitbull

SEX

Neutered male

AGE

11 years

WEIGHT

71.7 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Julie Kang

HOSPITAL NAME

Sabino VC

REFERRING VET

Dr. Kang

INVOICE

74551

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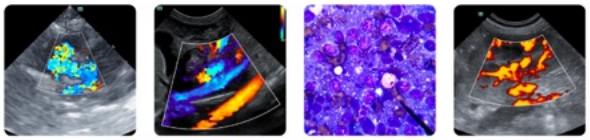
PRESENTING CLINICAL SIGNS

History: Investigate ALKP elevation that is trending upwards and urinary tract pathology or neoplastic process.
3/2025: 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 HEART

The echocardiogram in this patient demonstrated normal **left atrial** size based on 3 different LA measurement methods. Chamber volumes and echogenicity were normal. The **mitral** valve leaflets presented vegetative thickening consistent with endocardiosis. Doppler indicated measurable insufficiency. The **left ventricle** presented thicknesses with linear contour and was not dilated nor restricted. The **myocardium** presented normal echogenicity without subjective evidence of significant fibrotic or ischemic disease. **Contractility** of the ventricular walls was adequate and in normal range for this patient evidenced by the fractional shortening measurement and subjective evaluation of the different regions of the myocardium. The **left ventricular outflow** tract demonstrated normal laminar flow and subjective structural integrity. The **right atrium** and auricle revealed normal size, structure and content. No evidence of masses was noted or chamber overload. **Tricuspid** valvular assessment demonstrated adequate linear morphology. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. **Pulmonic** tract assessment revealed normal valve structure, laminar flow, and diameter (approx.1:1 pa/ao ratio). No visible **pericardial** or free pleura fluid was noted. No echographically detectable evidence of infiltrative disease was visible. The cranial **mediastinum and pericardial regions** were free of masses in the visible window.

CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO	LA/AO (Heart Base)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	<1.6	28-40	40-100	<0.6
PATIENT	-	-	1.0	1.03	30	60	0.1
CANINE CARDIAC PARAMETERS	**HR** (BPM)	**AV VMAX** (m/s)	**PV MAX** (m/s)	**BODY WEIGHT**	**LA** 2D short axis Base view (cm)	**LVIDd** Avg; 2D and m-mode short axis (cm)	**LVIDs** Avg; 2D and m-mode short axis (cm)
NORMAL PARAMETER	50-100	0.7-1.7	0.7-1.6	BELOW	BELOW	BELOW	BELOW
PATIENT	60	1.09	0.69	71.7 kg	3.2 max	3.8	



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ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** and trigone presented normal thicknesses and normal tone. The pelvic urethra was imaged 4.0 cm beyond the cystourethral junction and appeared normal. Calculus was embedded in the distal pelvic urethra. The deep pelvic urethra revealed calculus that was embedded just prior to prostate. The ureters were not visible which is normal. Sand accumulation was noted with a grouping of which measuring 1.8 cm. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 6.9 cm. The right kidney measured 6.8 cm.

The **prostate** in this patient measured 4.0 cm and was enlarged and mineralized. Peripheral enhanced fat was noted as well. This is suggestive for concurrent inflammation.

Adrenal Glands

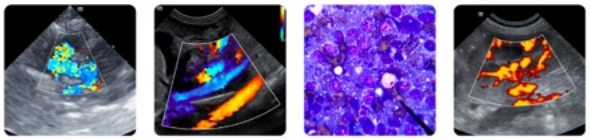
Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The right adrenal gland measured 2.73 x 1.87 cm at the cranial pole and 0.4 cm at the caudal pole. The left adrenal gland measured 2.38 x 0.45 cm.

Spleen

The **spleen** revealed a hypoechoic, 1.5 cm cavitated or disruptive nodule was noted at the cranial pole. The spleen otherwise revealed heterogenous parenchymal changes.

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.



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Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

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

Stage B1 valvular disease.

Concerning splenic nodule. Differentials include abscessation, necrosis, emerging round cell neoplasia and hemangiosarcoma.

Prostatic mass.

Urolithiasis with bladder and sand and deep urethral calculus.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The heart is stable without clinical disease. No overt contraindication for anesthesia of brief to moderate duration. I suggest Torbutrol premed, Propofol induction, Isoflo maintenance or similar protocol if anesthesia is desired. Blood pressure recommended if not already performed and target white coat negative systolic pressure of < 160 mmHg. If higher than this ACE-inhibitor is suggested to reach this level. Recheck echocardiogram is recommended in 6 months, earlier if murmur grade increases or clinical signs initiate.

The prostatic presentation is strongly consistent with prostatic carcinoma. Ultrasound-guided traumatic catheterization of the prostate or ultrasound-guided FNA is indicated. There is a minor potential for tumor training with FNA. FNA of the splenic nodule is also indicated. However, the prognosis is guarded to poor given the prostatic presentation, yet chemotherapy and stent placement may be options. Prognosis is poor long term.

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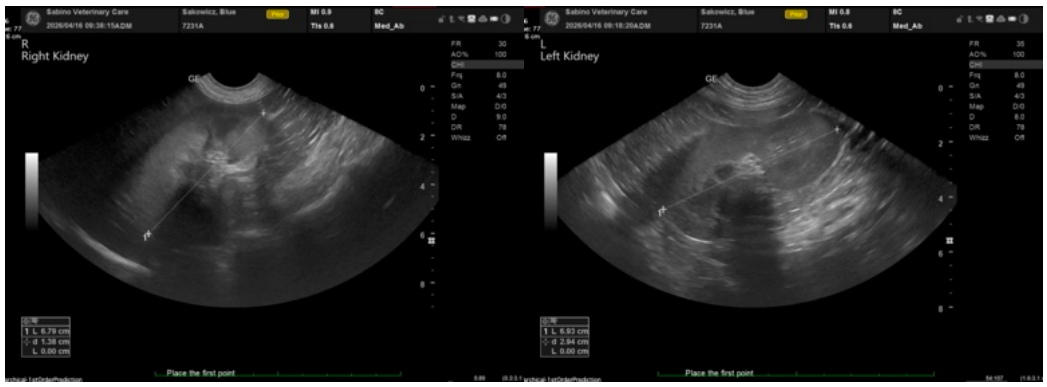

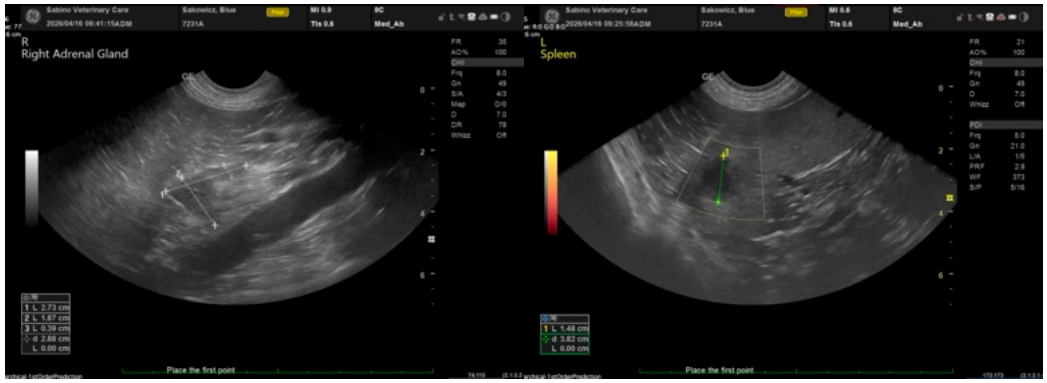

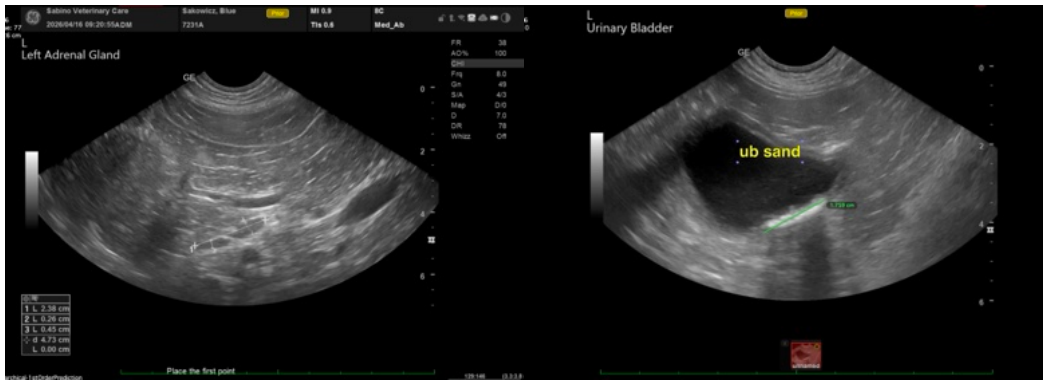

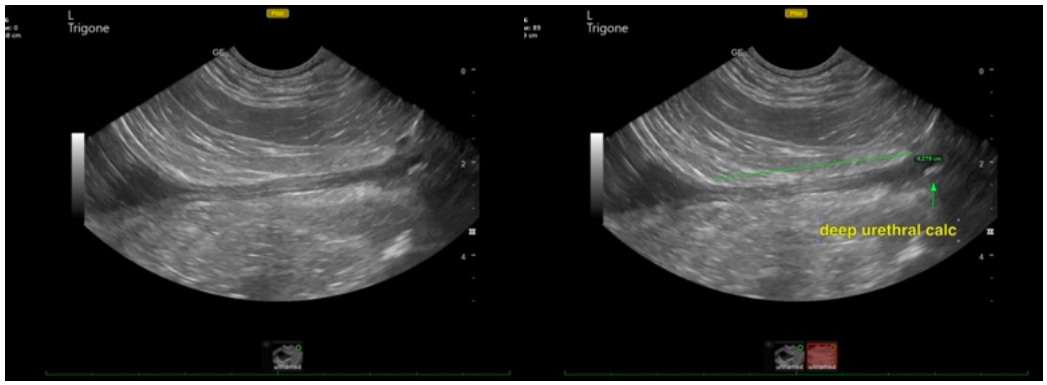

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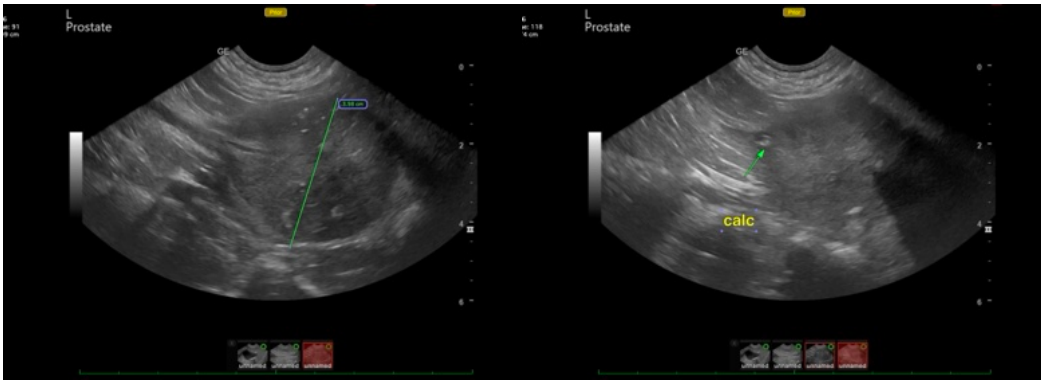

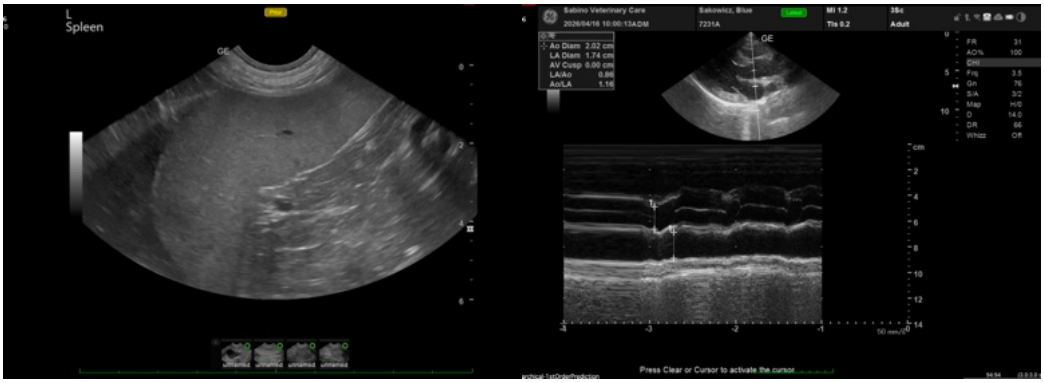

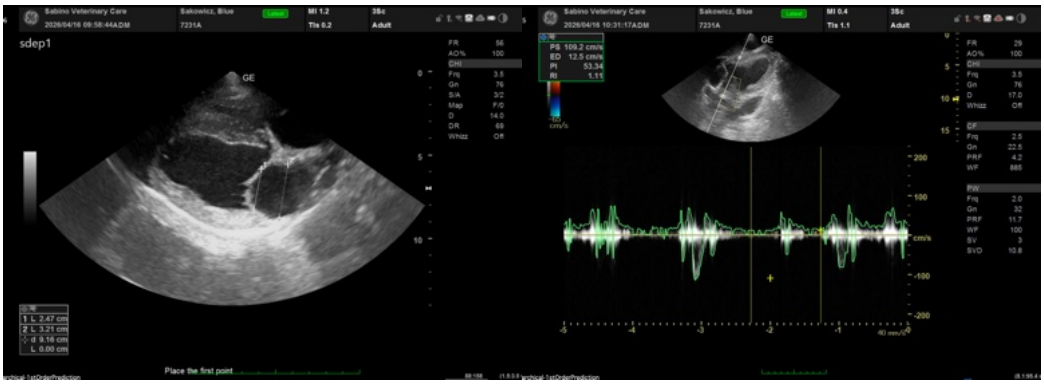

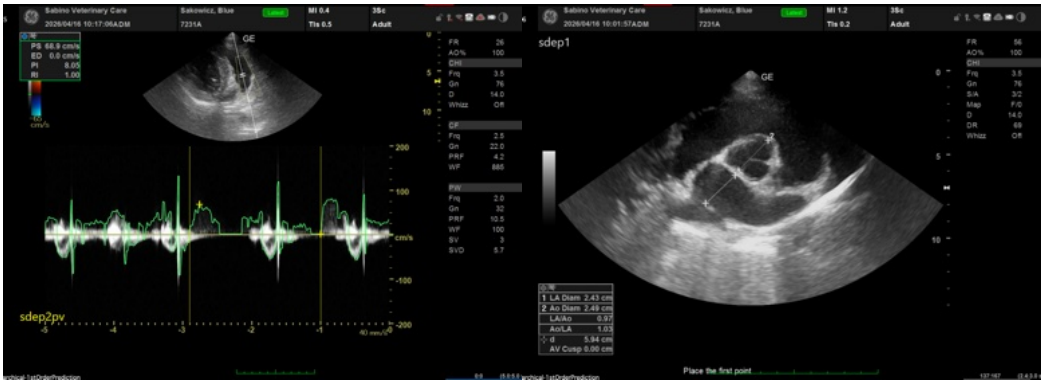

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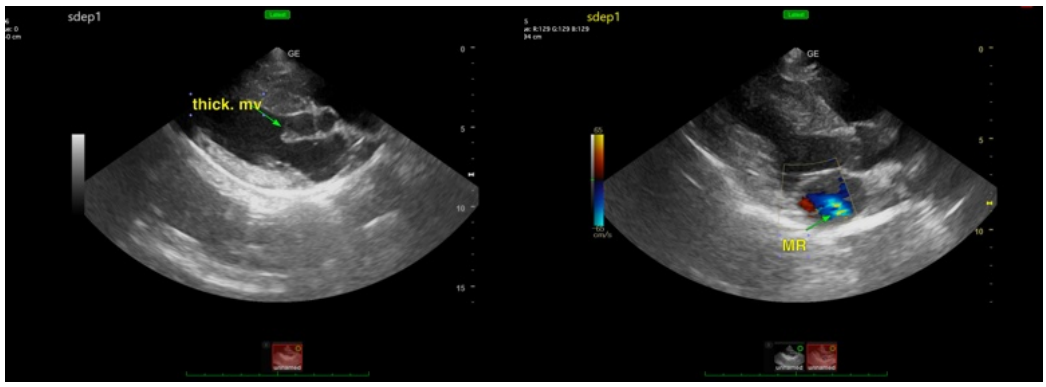

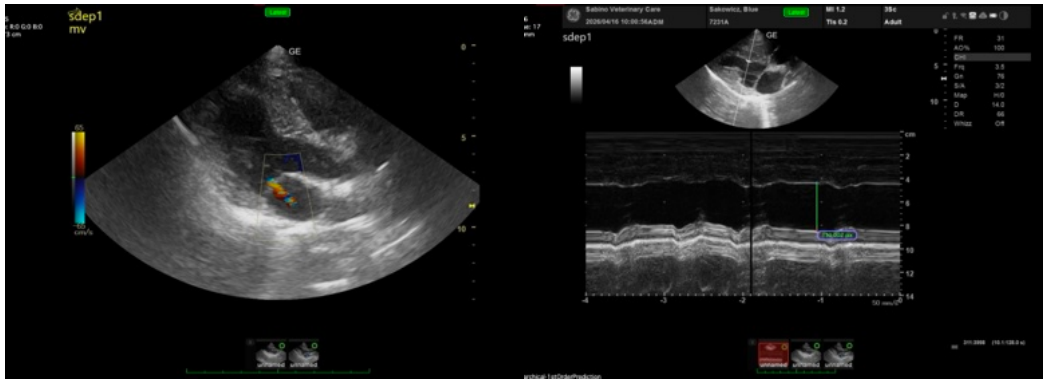

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS, CEO of SonoPath.com

info@SonoPath.com