



PATIENT

Little Bear Kirby

SPECIES

Canine

BREED

Poodle X

SEX

Neutered Male

AGE

10 Years

WEIGHT

11.5 Pounds

INTERPRETED BY

Kathleen Sennello DVM,
MS, Diplomate ACVIM
(Small Animal Internal
Medicine)

**IMAGING
PERFORMED BY**

Dr. Katie Buss

HOSPITAL NAME

Kings Vet Hospital

REFERRING VET

Dr. Katie Buss

INVOICE

26397

DATE

10/20/21

PRESENTING CLINICAL SIGNS

Little Bear has had historic elevated liver values- slowly worsening over the past few years. Urine sample showed epithelial cells red and white blood cells so ultrasound recommended. Doing well at home other than arthritis, no urine symptoms

Abnormal PE/Chem/CBC/UA Results: ALT and ALP moderate elevation, UA- SG 1.030, rbc, wbc, and epithelial cells present

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. In the dependent portion of the urinary bladder is a mixed echogenic, partially mineralized mass effect measuring 1.04 cm x 1.81 cm.

This mass appears to arise from the dependent portion of the urinary bladder. No overt evidence of obstruction noted. This mass has some thickening that involves the area of the trigone, but the proximal urethra appears normal. The prostate appears relatively normal.

The prostate is normal in size (1.0 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (4.0 cm) with pinpoint non-obstructive nephroliths and small cortical cysts present. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.5 cm) with non-obstructive nephroliths. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.59 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

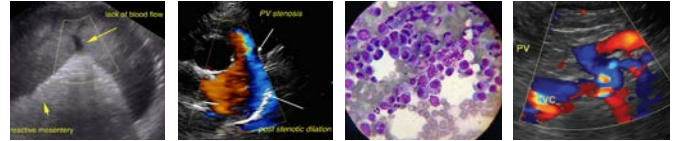
The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

Spleen

The spleen is subjectively normal in size. The spleen echotexture is heterogenous and mildly mottled, the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a 0.71 cm hypoechoic nodule visualized in the parenchyma.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There is an ill-defined, hypoechoic, mixed echogenic mass effect visualized, measuring approximately 2.3 cm in size.



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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

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Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm 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.

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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. The duodenum measured as normal (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.)

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Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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.

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Pancreas

The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

INTERPRETED BY

Kathleen Sennello DVM,
MS, Diplomate ACVIM
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Medicine)

PRIMARY FINDINGS

- Mixed echogenic, partially mineralized bladder mass – concerning for a transitional cell carcinoma, but other possibilities exist.
- Hypoechoic nodule in the spleen – There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.
- Heterogeneous liver with ill-defined, hypoechoic mass effect – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

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SECONDARY FINDINGS

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- Mildly reduced corticomedullary distinction in the kidneys with pinpoint non-obstructive nephroliths
- Moderate gallbladder sludge – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large mixed echogenic, partially mineralized mass effect in the urinary bladder, which is likely responsible for the lower urinary tract signs mentioned and the hematuria/pyuria noted.

The focal mass in the bladder has the characteristics most consistent with a neoplastic lesion, but polyps and inflammatory lesions can sometimes have a similar appearance. A definitive diagnosis cannot be determined by ultrasound alone.

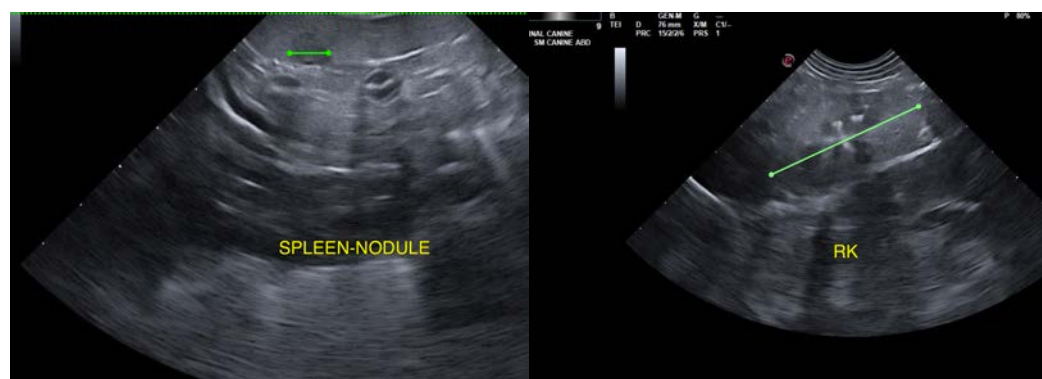
-Recommend urine evaluation for BRAF mutation seen in patients with transitional cell carcinomas. A positive test is diagnostic, a negative test is inconclusive and will need further diagnostics.

-If negative or non-diagnostic BRAF consider traumatic catheterization to obtain representative cells for cytology, or biopsy sampling via either cystoscopy (if a female) or surgery.

-Patients with bladder pathology should always have urinalysis and culture performed. Ideally cystocentesis should be avoided in patients with suspected bladder masses to try and prevent tracking of tumor cells along the needle path.

-If TCC is confirmed consider referral to/consultation with a board certified. Veterinary oncologist for recommendations regarding treatment options and prognosis.

Additionally, there is a hypoechoic nodule in the spleen, and an ill-defined hypoechoic mass effect in the liver. You could consider a fine needle aspirate of both of these lesions. Consider a liver function test. If fine needle aspirate is not diagnostic of the liver lesion, you could consider a CT scan of the abdomen with evaluation for possible surgical intervention, but take these recommendations in light of the diagnosed bladder mass. Recommend 3-view thoracic radiographs and possible referral to a veterinary oncologist once diagnosis of the suspected bladder mass is confirmed.





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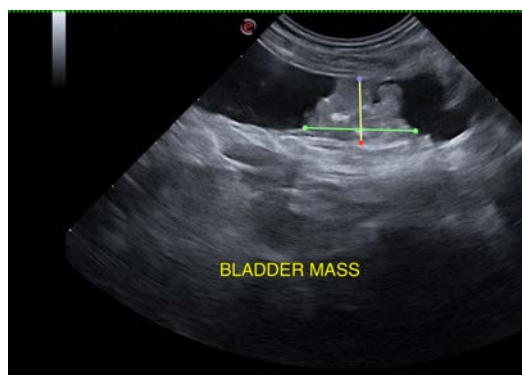
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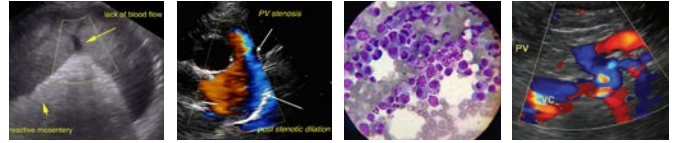
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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