

PATIENT

Zoey Robinson

SPECIES

Canine

BREED

Westie

SEX

Spayed Female

AGE

11 Years

WEIGHT

24.5 Pounds

INTERPRETED BY

Lisa Carioto, DVM,
DVSc, Diplomate
ACVIM

IMAGING PERFORMED BY

Dr. Hadley Harris

HOSPITAL NAME

TotalBond VH

REFERRING VET

Dr. Hadley Harris

INVOICE

36069

DATE

3/10/22

PRESENTING CLINICAL SIGNS

11yo FS Westie with a several week history of pollakiuria. First seen on 2/4/22 for annual and O reported frequent straining to urinate. UA was performed and revealed significant hematuria, pyuria, and cocci. Pt was prescribed amoxicillin. Returned on 2/19/22 for continued pollakiuria. UA was repeated which revealed hematuria and pyuria, but no bacteria. Patient was started on Simplicef and Rimadyl. Patient returned on 3/4/22 for continued pollakiuria. Urine culture and UA were performed with no growth, but persistent hematuria. A-FAST at that time did not reveal stones or obvious mass. Ultrasound to further rule out bladder mass and to image kidneys. Rectal and vaginal exam performed today under sedation and no abnormalities palpated.
Abnormal PE/Chem/CBC/UA Results: see attached

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is not fully distended, which makes it somewhat difficult to accurately evaluate wall thickness (2.1 mm and 2.3 mm depending on where measured). It appears thickened to the eye. The mucosa is smooth and regular, except at the apex, where it is very mildly irregular. A small amount of free-floating sediment is observed within the bladder's lumen.

An ill-defined, irregularly shaped, echogenic mass effect is observed at the junction of the trigone and proximal urethra. It measures approximately 7.7 mm x 8.2 mm. Differential diagnoses include a transitional cell carcinoma, however, hematoma due to a previous hemorrhage, cannot be excluded. The mass effect does not appear to be attached to the dorsal aspect of the urinary bladder, but may be arising from the ventral wall of the trigone area, i.e., it depends on the angle of the probe.

The left kidney is within normal limits in size for the patient's weight (4.82 cm). The capsule is smooth. The cortex is mildly hyperechoic and there is a mild loss of the normal definition of the corticomedullary junction. Very small punctuate mineralizations of the diverticulae are noted, without signs of pyelectasia or nephroliths. The surrounding mesentery is not hyperechoic. There are no signs of pyelonephritis.

The right kidney is within normal limits in size for the patient's weight (4.94 cm). All other findings are similar to the left kidney.

The changes observed with both kidneys are suggestive of age related degeneration.

Adrenal Glands

The left adrenal gland measures 0.55 cm. No abnormalities are noted with the gland's shape, overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

Based on the angle of the image, the image annotated as the right adrenal, measuring 0.56 cm, is more likely be the left adrenal from the right lateral approach. The right adrenal gland does not appear to have been visualized with the images that were received.

Spleen

The spleen is within normal limits in size, echotexture, and echogenicity. It is hyperechoic to the liver. The capsule is smooth. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified. Mild perivascular cuffing consistent with myelolipomas is observed, which is not considered clinically significant.

Liver



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There are no obvious signs of hepatomegaly and its borders are smooth and sharp. The liver's echotexture is homogeneous and its echogenicity is within normal limits. No abnormalities are observed with the hepatic vessels or hepatic lymph nodes.

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The gall bladder is mildly distended, which may be due to the fact that the patient is fasted. A mild to moderate amount of echogenic debris is present within the lumen. The presence of sludge is most likely clinically insignificant. There are no signs of an obstruction, and the remainder of the biliary system is within normal limits. There are no signs suggestive of cholecystitis.

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Gastrointestinal

The gastric wall and pylorus are normal in thickness. There is no loss of definition of the normal architecture of the layers of the stomach wall. No obvious abnormalities are observed with its peristalsis.

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The small intestinal wall thickness is within normal limits and there is no evidence of dilation. The definition of the wall layers is preserved. The colonic wall is not thickened and mural detail is considered normal. There are no obvious signs of a mass, foreign body, infiltrative disease or an obstruction.

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Pancreas

A mildly coarse echotexture is visualized with both the left and right limbs of the pancreas. These changes are most suggestive of nodular hyperplasia, i.e. age related degeneration. There is no evidence of hyperechogenicity of the surrounding mesenteric fat (i.e., active signs of pancreatitis are not evident).

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Other

Lymph nodes: No abnormalities are observed.

Abdominal effusion is not visualized.

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PRIMARY FINDINGS

- Mass effect at the junction of the trigone and proximal urethra of the urinary bladder

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SECONDARY FINDINGS

- Age related degenerative changes affecting both kidneys – not considered clinically significant.
- Nodular hyperplasia of the pancreas, also an age-related change.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pollakiuria Zoey is experiencing may be due to a previous hemorrhage and a hematoma that is now organized. Further diagnostics may include obtaining a urine sample to perform the CADET® BRAF test since a hematoma cannot be excluded. If the test is not conclusive, cystoscopy or a traumatic wash via a urinary catheter may be considered. Treatment with gabapentin, (+/- buprenorphine), and an NSAID, such as meloxicam or deracoxib, may be administered to decrease discomfort and inflammation, respectively. Please note, meloxicam or deracoxib have anti-neoplastic effects against carcinomas, and is worthwhile administering, despite lack of response to Rimadyl. Referral to a board-certified oncologist may also be pursued.

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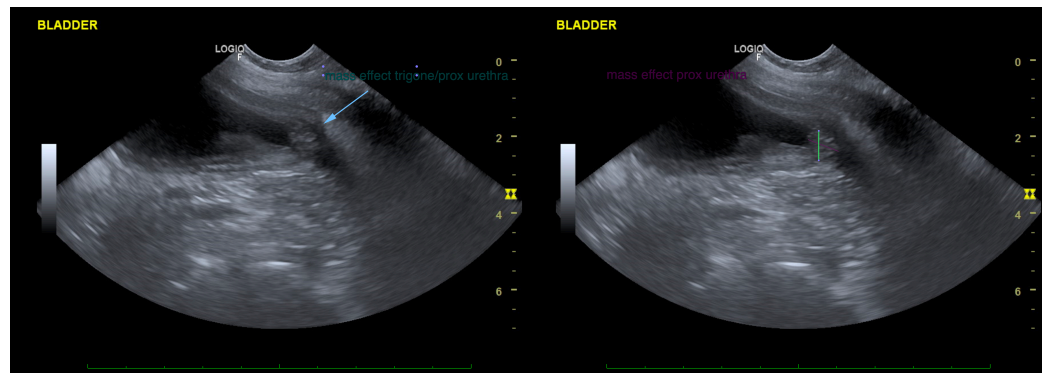
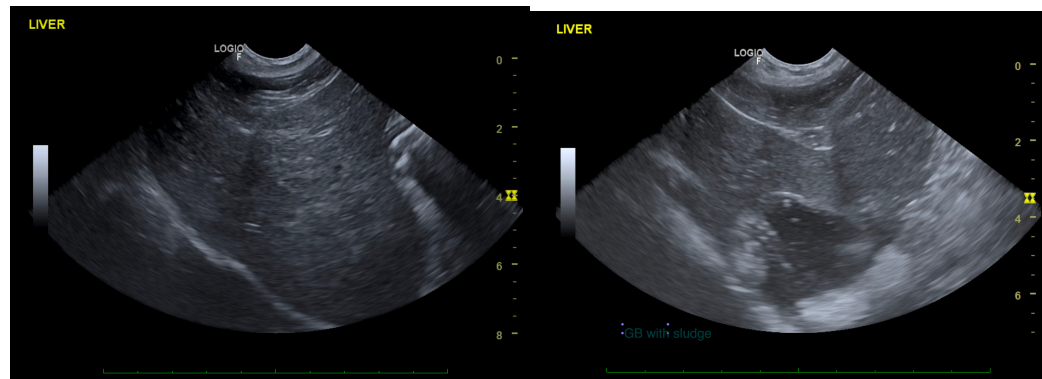
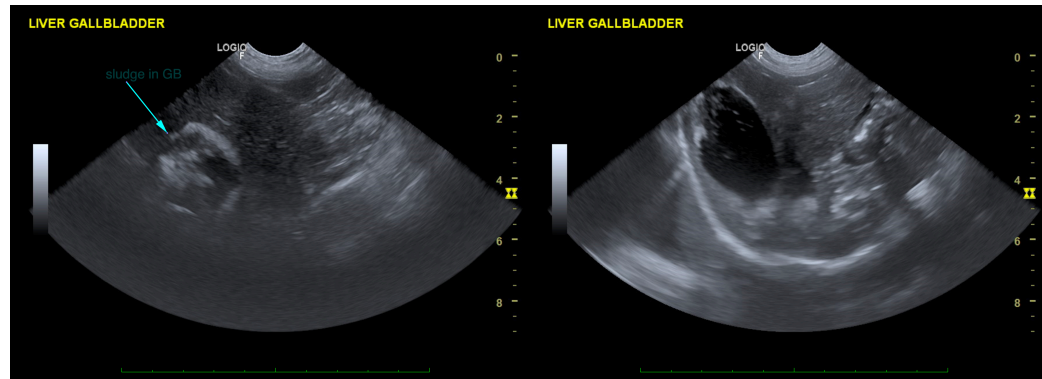
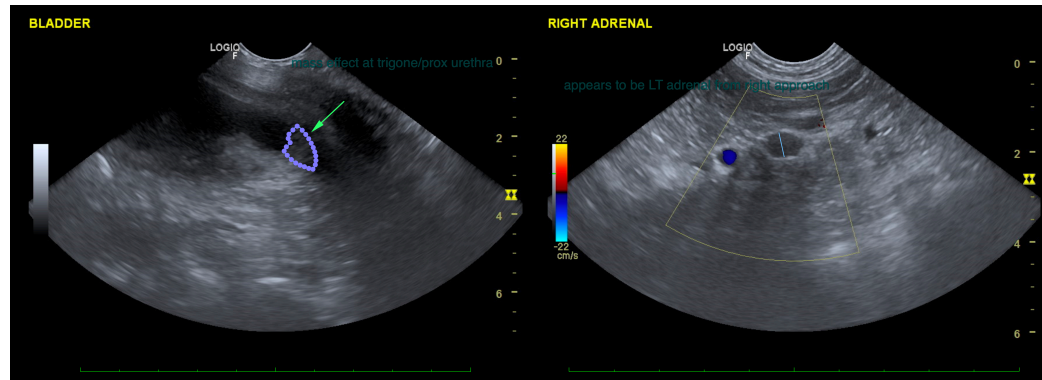
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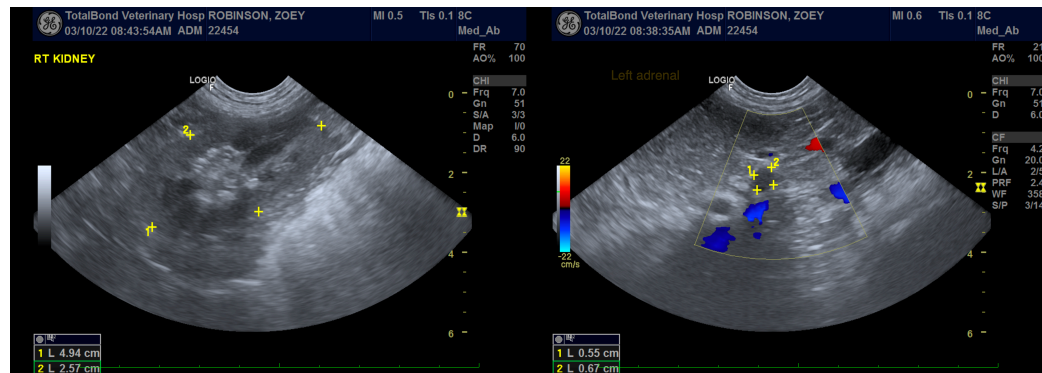
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

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