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Clinical Sonography & Telecytology
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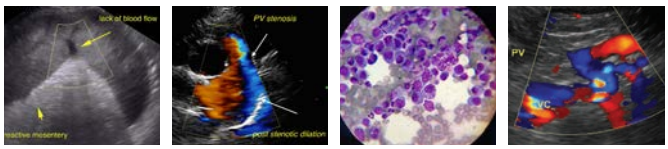

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1-800-838-4268 info@sonopath.com

PATIENT
Sasha Logiudice

SPECIES
Canine

BREED
German Shorthaired Pointer

SEX
Spayed Female

AGE
13.5 Years

WEIGHT
58 Pounds

INTERPRETED BY
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY
Dr. Jennifer Todd

HOSPITAL NAME
Lambs Gap AH

REFERRING VET
Dr. Cynthia Kinney

INVOICE
26765

DATE
11/2/21

PRESENTING CLINICAL SIGNS

Sasha is a 13.5 year old GSP who presented ~2 weeks ago for hematuria, increased frequency of urination, had UA 7/21 some blood noted then, owner had wiped clear mucous from vulva, UA results: WBC, RBC, no cyrstals, some protein (increased due to cellularity?), non-squamous epithelium, pH down from 7 to 5, bacteria not detected on sedivue, suspected cocci when looking at sedivue images, started on clavamox and carprofen, patient is on proin 25mg daily for urinary incontinence, presented today 10-27-21 for follow up-some improvement in UA results for all previous abnormalities, owner noted some improvement in clinical signs but not complete resolution, still squatting a lot, does get some good streams and large quantities, she is active and eating well in general, took lateral abdominal rad: bladder small, no obvious urinary calculi, gas in intestines, food in stomach, opaque area on splenic capsule? v superimposition? LS bridging spondylosis noted, recommend AUS to evaluate urinary system and also look at spleen and general organic appearance Thank you!

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder exhibited a moderately sized apical mural mass extending mildly into the urinary bladder lumen with associated mild ventral and dorsal apical mural hypertrophy. The bulk of the mass measured approximately 3.0 cm x 3.0 cm with associated apical wall measuring 0.5 cm in width. By comparison, normal appearing ventral urinary bladder wall measured 0.2 cm in width. The mass exhibited non-homogeneous to mildly mixed echogenic parenchyma. The overall involved apical urinary bladder wall potentially measured 3.0-4.0 cm in length. Primarily anechoic urine was present with minor particulate sediment, likely indicative of minor cellular or crystalline debris. The proximal urethra exhibited subjective decreased tone toa depth of 2.0 cm. No overt evidence of concurrent urethral masses.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Pinpoint areas of dystrophic medullary mineral were present.

Adrenal Glands

The left adrenal gland was normal in size, measuring 0.80 cm at the cranial pole and 0.71 cm at the caudal pole. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The right adrenal gland was indistinctly visualized, yet without evidence of enlargement, subjectively measuring 0.51 cm at the caudal pole.

Spleen

The spleen was normal in size and contour with primarily finely textured parenchyma with mild to moderate coarse echotexture. A solitary, non-expansive, subtly hypoechoic nodule was noted in the subjective mid to cranial spleen measuring 2.1 cm diameter.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

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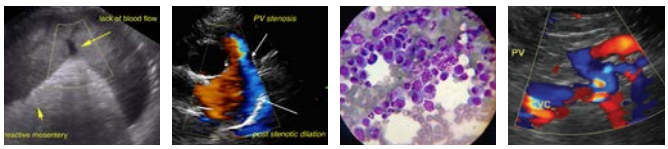

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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

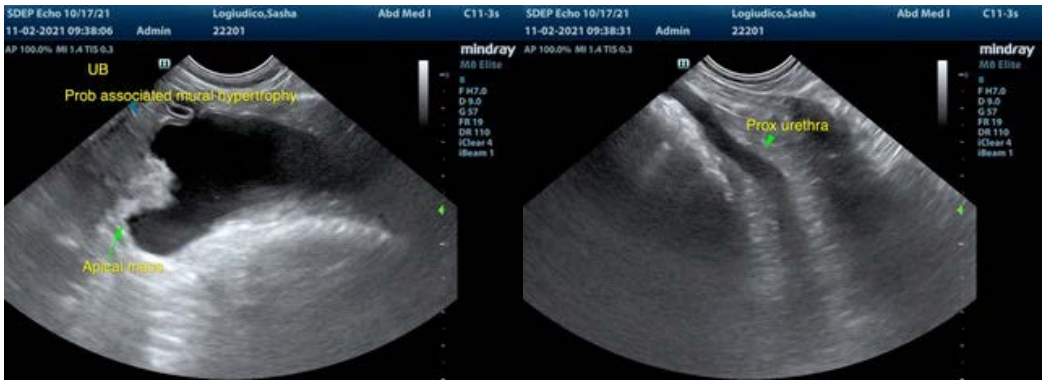
ULTRASONOGRAPHIC FINDINGS

- Apical urinary bladder mass with associated mild ventral and dorsal regional mural hypertrophy
- Mild chronic renal changes with pinpoint dystrophic medullary mineral
- Non-expansive, subtly hypoechoic splenic nodule
- Mild parenchymal remodeling – subjectively benign

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The apical urinary bladder mass is suggestive of neoplastic criteria (i.e., transitional cell carcinoma or other). Screening BRAF assay may be considered. Given the location of the mass, potential for surgical resection may be possible. Surgical consultation may be considered. No overt evidence of regional metastasis. Empirically, and assuming normal renal function, NSAIDs such as Piroxicam +/- as needed analgesic with sonographic monitoring of the apical urinary bladder mass could be considered.

Potential etiologies for the splenic nodule may include benign processes such as nodular hyperplasia, extramedullary hematopoiesis, hematoma, infection, infarction, or neoplasia. Ultrasound guided FNA of the nodule using 25-gauge needle and assuming normal coagulation parameters may be considered. Otherwise, sonographic monitoring of the splenic nodules for any changes in size or appearance with initial recheck in 3-4 weeks would be a more conservative approach.



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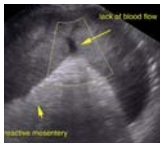
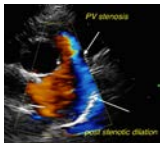
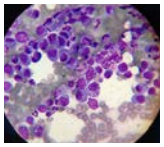
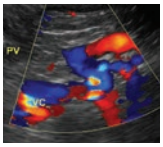

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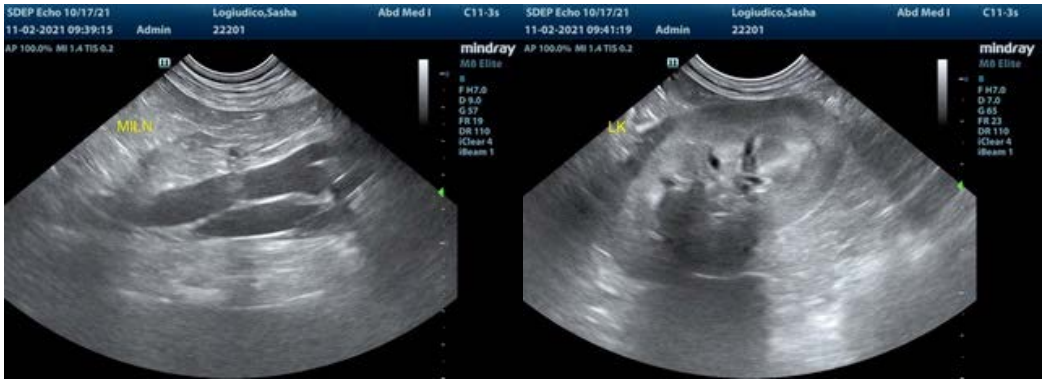

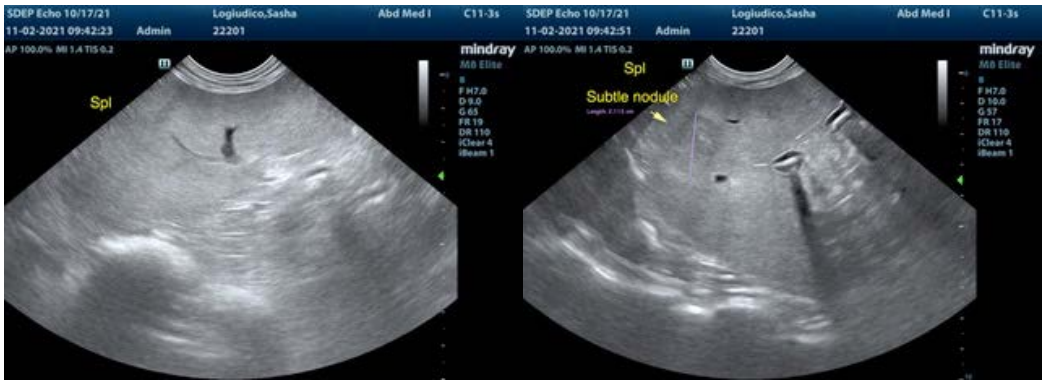

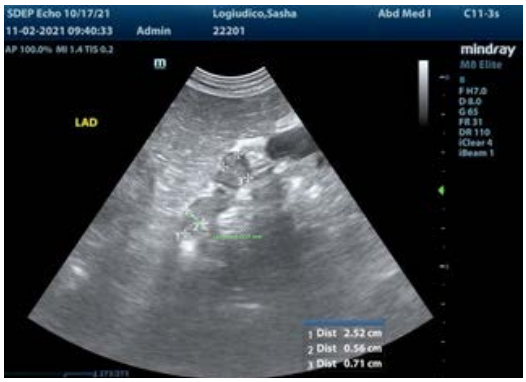

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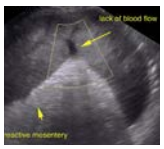
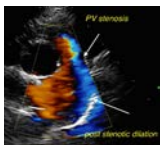
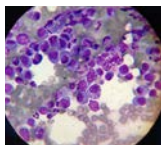
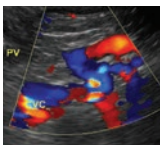

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com