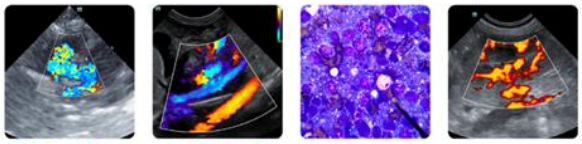


PATIENT
Violet Purnell

SPECIES
Canine

BREED
Cattle Dog Mix

SEX
FS

AGE
9yr

WEIGHT
18.7kg

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

IMAGING PERFORMED BY
Renee Trionfetti, VMD

HOSPITAL NAME
Blue Pearl Wyomissing

REFERRING VET
Blue Pearl Wyomissing

INVOICE
24854

DATE
05/18/2026

PRESENTING CLINICAL SIGNS

AUS to further evaluate inappropriate urination, urinary obstruction (initially resolved with intervention), possible obstructed again. Inappropriate urination (straining, pollakiuria) ~10 days ago, together with perivulvar dermatitis. Treated with Apoquel and Cephalexin and patient seemed to respond well. However seen at BP-Malvern Sunday night for urethral obstruction. Baseline bloodwork (VBG, Chem) unremarkable. Full workup recommended but declined. Patient was sedated, ucath passed, and bladder drained. Sent home w/ empiric clavamox and Rimadyl. Patient presenting today to ER for continued straining with no noted production by owner.

Abnormal PE/Chem/CBC/UA Results: BP-Malvern 5/17 POCUS: bladder large, 12x12 cm, mild edema around bladder EDB (Nova): PCV 49%, TS 7.6, pH 7.45, Na 151, Cl 123, K 4.13, iCa 1.3, BG 109, lactate 1.4, BUN 9, creat 0.9 Chem: creat 0.8, BUN 8, ALT 37, alb 3, glob 5.1 (H), NSF urine culture: on hold BP-Wyo screening rad: no overt radio-opaque urolithiasis noted POCUS: no peritoneal effusion, linear-looking shadowing in bladder

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was mildly distended in size with normal tone and overall normal appearing bladder wall without tumors. Anechoic urine with mild to moderate particulate non-dependent urine sediment was present. The trigone and cystourethral junction were free of overt pathology. The proximal urethra was thickened in appearance with mildly dilated cystourethral junction yet empty visible proximal urethra to a depth of 3 cm. The urethra measured ~ 0.82 cm in diameter. Evidence of dorsal urethral wall mineralization was present.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation or hydronephrosis. The left kidney measured 5.9 cm in length. The right kidney measured 5.4 cm in length.

The area of the aortic trifurcation was free of pathology.

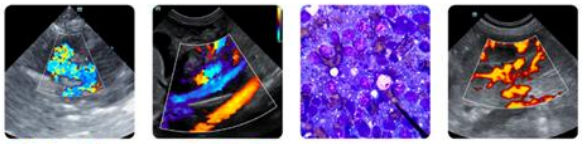
Adrenal Glands

A well-defined, mildly expansive hyperechoic nodule was present in the caudal pole of the left adrenal gland with mild associated symmetrical capsule expansion. The nodule did not exhibit signs of mineralization or vascular invasion. The nodule measured 1.6 cm x 1.2 cm. The left adrenal gland measured overall 2.8 cm length x 0.46 cm cranial pole x 1.36 cm caudal pole width.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.5 cm width at the caudal pole and 2.3 cm in length.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or



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thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. Normal vascular volume. 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.

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 mechanical/metabolic 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 omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Mildly distended urinary bladder with urine sediment.
- Thickened proximal urethra with evidence of dorsal urethral wall mineralization.
- Normal bilateral kidneys.
- Expansive non-mineralized caudal left adrenal nodule.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given evidence of urethral wall mineralization and thickened appearance, neoplastic criteria, i.e. urethral transitional cell carcinoma is suspected. Chronic urethritis is thought less likely. Given location of mineralization, uterine remnant mineralization thought less likely yet is not definitively excluded. However, no overt evidence of uterine remnant enlargement or proximal urethra impingement.

Screening BRAF assay +/- cytospin cytology of a free catch urine sample, or traumatic catheterization of the proximal urethra is recommended. No obvious evidence of left or right ureter obstruction or current regional lymphatic metastasis.

The left adrenal nodule could indicate hyperplasia, functional vs non-functional adenoma or emerging

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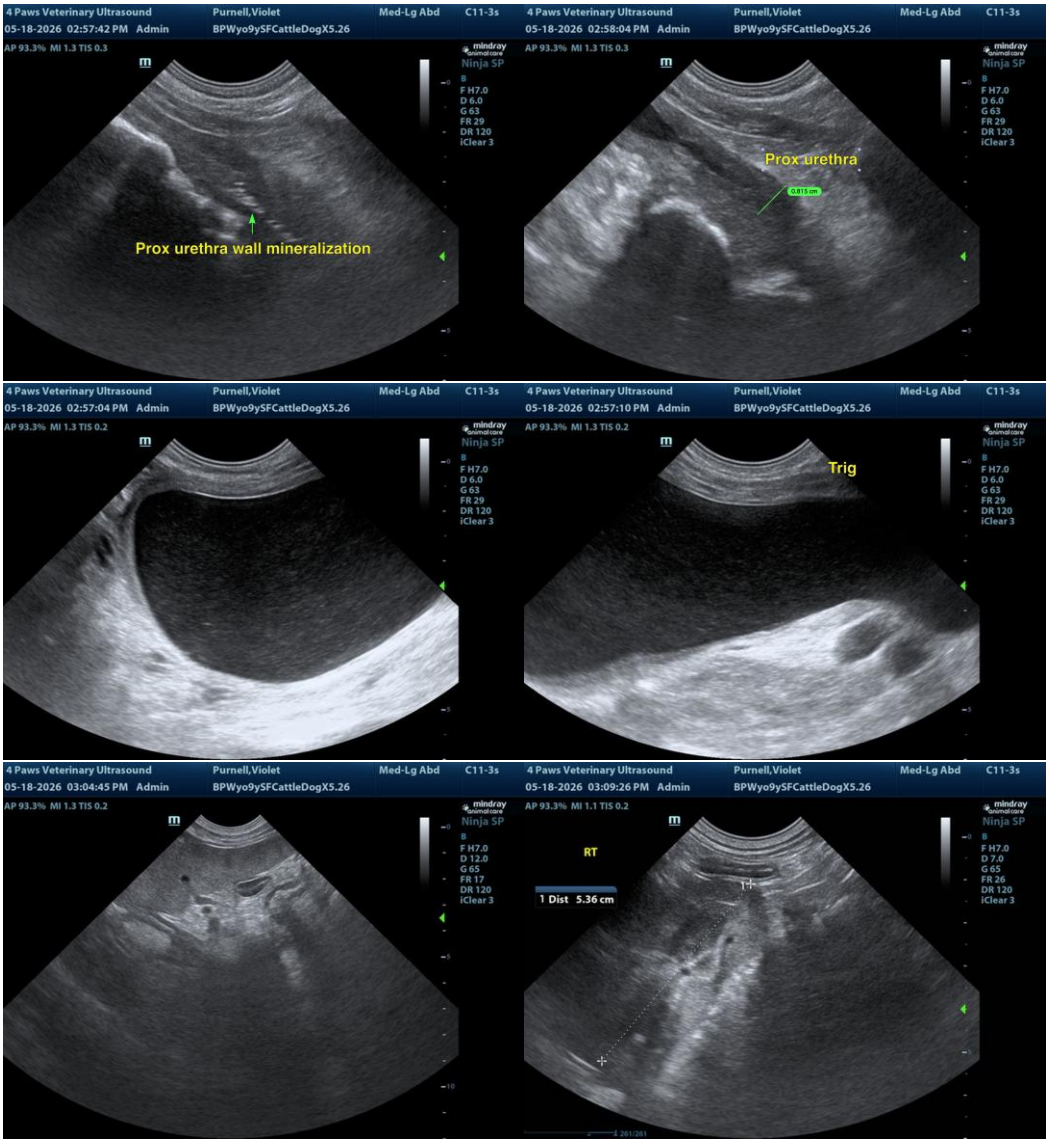
tumor. Adrenal screening warranted if clinical signs consistent with Cushing syndrome are present, although no evidence of current hepatopathy. Monitoring of systemic BP for hypertension, which may allude to left pheochromocytoma, as well as concurrent sonographic monitoring of the left adrenal nodule for evidence of progression is recommended.



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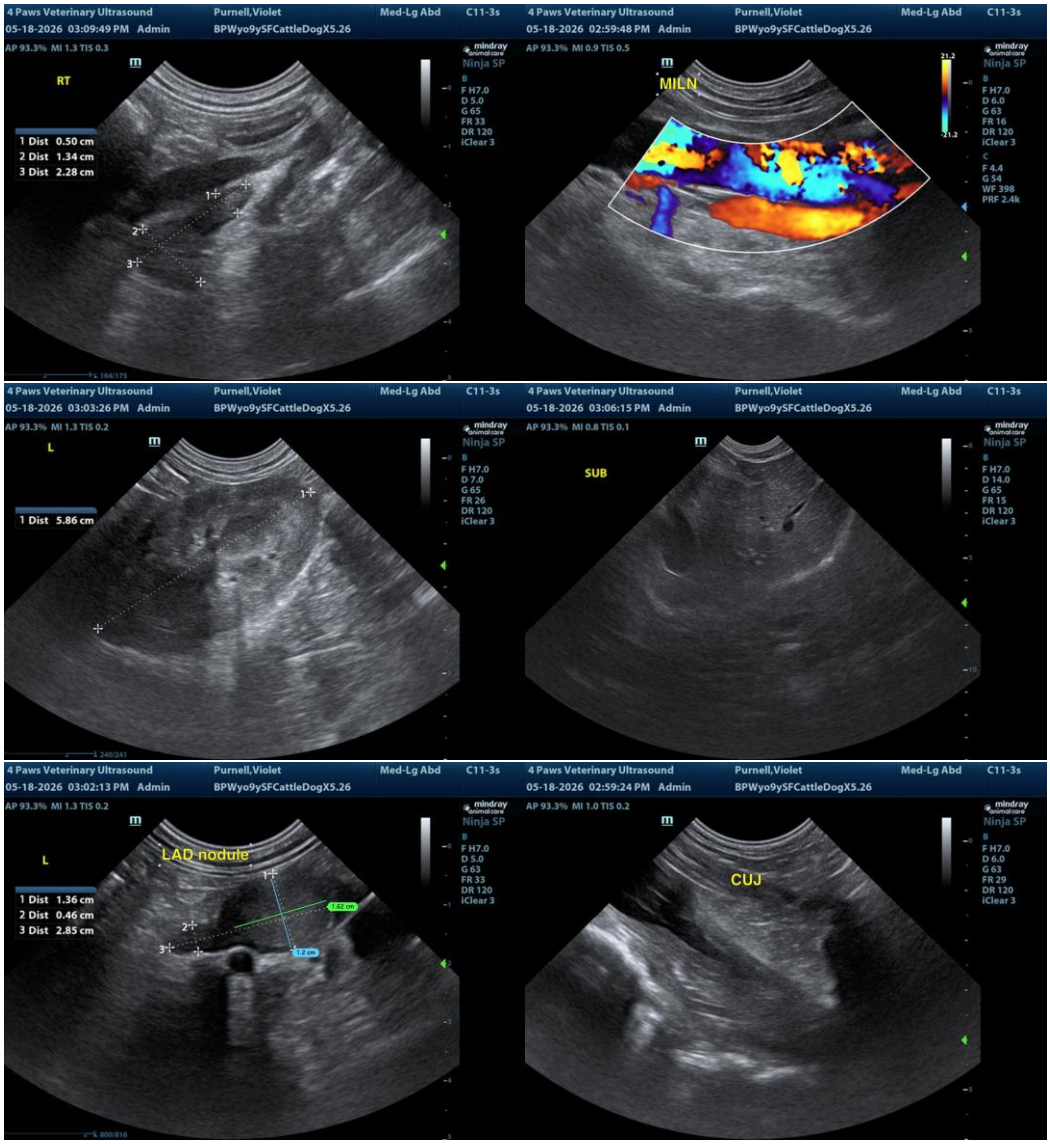

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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