



PATIENT

Zoey Hopkins

SPECIES

Canine

BREED

Labrador

SEX

FS

AGE

10

WEIGHT

82 lbs.

PRESENTING CLINICAL SIGNS

10yo FS Labrador presenting with chronic recurrent UTI over the last 12 months, now progressed to non-productive stranguria starting yesterday. Presenting Complaint: Zoey presents for chronic urinary issues with recent worsening

Patient History:

- Chronic/recurrent urinary signs since January of this year, recurring after antibiotic courses end
- Recent visit to previous vet Jan'26 to late April'26: radiographs showed no stones
- Recent visit to Urgent Vet on 4/29: ultrasound suggested possible bladder stone (shadowing reported), radiographs showed no stones. 200mL urine removed via cystocentesis due to severe distension and pain
- Currently on Royal Canin Urinary Diet (wet and dry)
- Client adding water to food for adequate hydration
- Decreased water consumption noted by client
- Recent episode of straining to urinate in house with panting
- Currently on Carprofen, Clavamox, and Gabapentin from Urgent Vet
- Gabapentin causes sedation and urinary dribbling at night

Abnormal PE/Chem/CBC/UA Results: A culture and susceptibility were done in late January '26, reportedly showed susceptibility to clavamox, though culture results are not available to us.

INTERPRETED BY

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

IMAGING PERFORMED BY

Wes Spangler

HOSPITAL NAME

TotalBond Vet
Hospitals –
Paw Creek

REFERRING VET

Luke Boliek

INVOICE

10871

DATE

5/6/26

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was distended in size with normal tone. Primarily normal urinary bladder body wall was noted including the ventroapical and dorsal wall extending into the area of the trigone. Anechoic urine was present with no mineral or calculi. Thickened cystourethral junction / urinary bladder neck was noted with indistinct visualization of the proximal urethra to a depth of 3.0-4.0 cm.

A solitary, visualized, symmetrically enlarged, primarily homogeneous medial iliac lymph node was present, measuring 2.6 cm x 1.6 cm. There is no evidence of peripheral inflammation.

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. The left kidney measured 7.5 cm in length. The right kidney measured 7.5 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.56 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.54 cm width at the caudal pole.

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



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splenic vasculature at the hilus was normal in volume with no evidence of congestion or 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. Normal hepatic vascular volume was present. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size containing primarily anechoic content with mild nonorganized gallbladder debris. 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 contained nonshadowing ingesta, consistent with food echogenicity without signs of 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 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

Primary Findings

- Urinary bladder neck mass, possibly extending into the proximal urethra
- Distended urinary bladder with anechoic urine
- Solitary, mild homogeneous medial iliac lymphadenopathy
- Normal bilateral kidneys

Secondary Findings

- Mild gallbladder debris (non mucocele)
- Gastric ingesta – consistent with food echogenicity / post prandial presentation

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of the patient's clinical signs is most consistent with urinary bladder neck mass with possible proximal urethral involvement, which suggests probable neoplastic criteria, i.e., transitional cell carcinoma, and with inflammatory or non-neoplastic etiologies thought less likely. Concern for early medial iliac metastasis is warranted, with reactive hyperplasia or inflammation possible.



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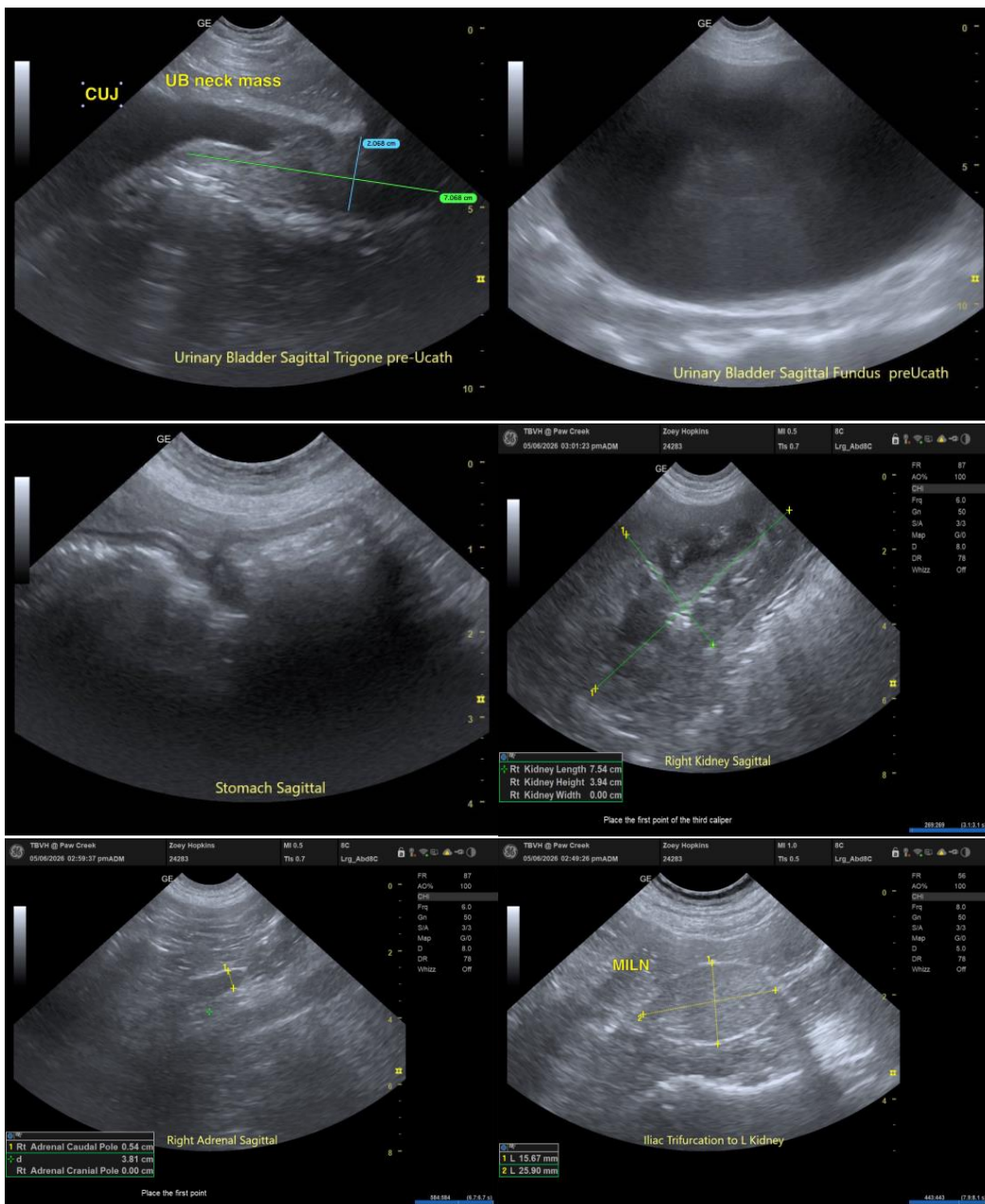
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Further assessment may include traumatic catheterization for cytology, biopsy via cystoscopy, and correlation with BRAF assay. If accessible, FNA cytology of the medial iliac lymph node could be considered. Referral for interventional procedures, such as stent placement and oncology consult, may be considered.





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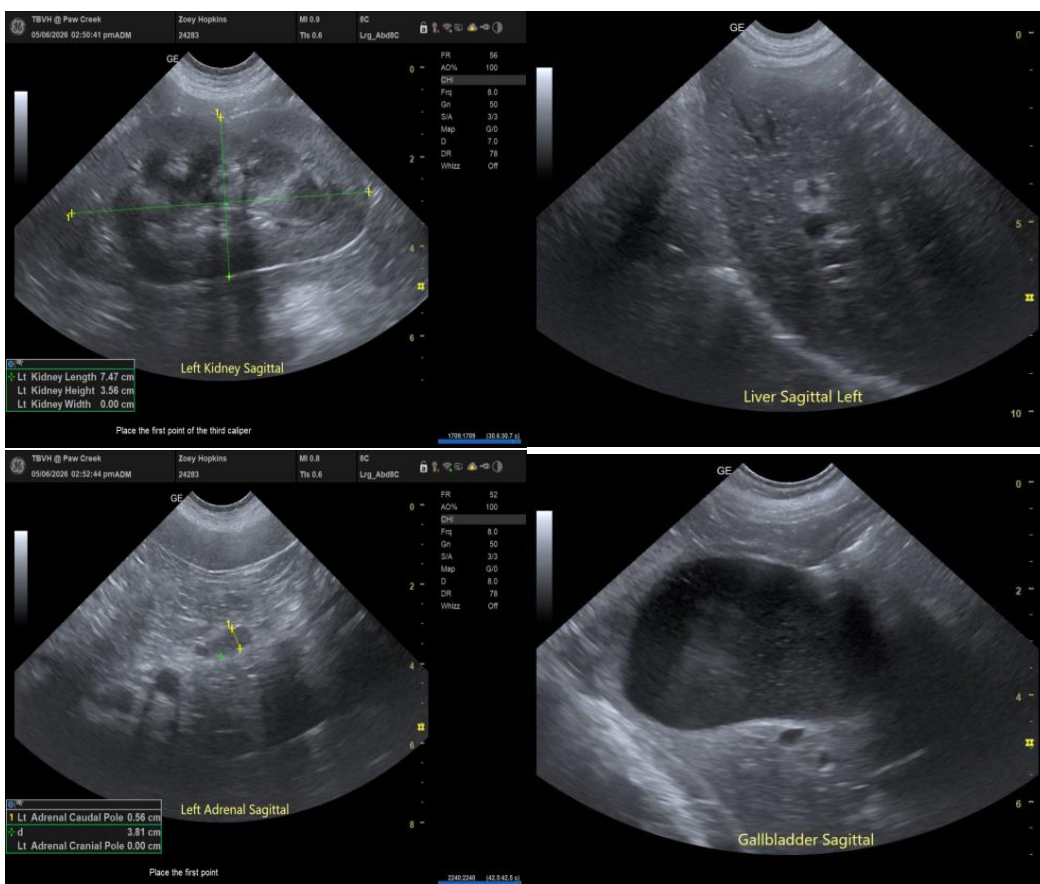
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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info@sonopath.com