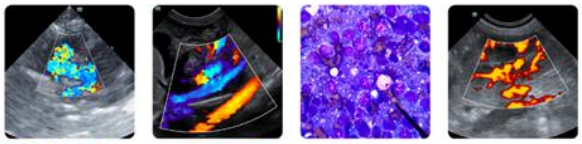


PATIENT
Geno Smith

SPECIES
Canine

BREED
Beagle Mix

SEX
MN

AGE
8yr

WEIGHT
57.7lb

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

IMAGING PERFORMED BY
Justin Eckenrode DVM

HOSPITAL NAME
Carlisle Small Animal Veterinary Clinic

REFERRING VET
Juel Shamitko DVM

INVOICE
25010

DATE
06/03/2026

PRESENTING CLINICAL SIGNS

Major Medical Conditions : 3 week duration of increased frequency urination, straining when urinating, and blood tinged urine or drops of frank blood from penis. Evidence of UTI on UA - RBC/WBC/bacteria seen.

Patient History : P controlled hypothyroid and no changes to drinking amounts. P energy level seems normal. Chronic elevation ALP and ALT - normal kidney values. No bladder stones seen on radiographs. O noted in the last 3 weeks wants to go out to urinate more often and will occasionally strain with frank blood seen. No frank blood seen in the last 72 hours. P currently on Novox and Clavamox trial and seems to be responding well. Evidence of UTI on UA, but culture has not been done.

Primary concern or rule out: neoplasia vs benign growth vs radiolucent stones vs other

Spayed/neutered : neutered

Abnormal PE/Chem/CBC/UA Results: 5/28/26 UA: USG 1.018; WBC 23/HPF; RBC >50/HPF 3/5/26 Chemistry: ALT 264 (121H) - previously 179 on 1/26; ALP 1576 (160H) - previously 921 on 1/26; K 5.5 (5.4H) - previously 5.9 1/26

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was normal in tone. Diffusely thickened to irregular ventral urinary bladder wall with wall thickening extending into the ventroapical urinary bladder was present, the area of thickened ventral wall measured 5.2 cm x 1.4 cm. Non-homogenous mural echogenicity was present without overt evidence of mineralization. Anechoic urine with mildly organized non-dependent non-mineralized sediment. No evidence of macrocalculi. No obstructive pathology to the level of the cystourethral junction or trigone. Normal visible proximal urethral structure and tone to a depth of 2 cm.

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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 6.12 cm in length. The right kidney measured 7.0 cm in length.

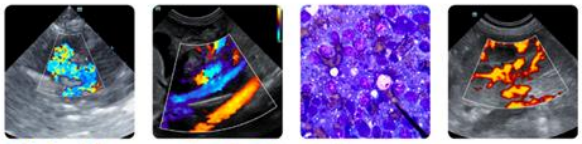
The area of the residual prostate was sonographically normal.

No evidence of medial iliac or sublumbar lymphadenopathy or masses. No evidence of distal aortic thrombus.

Adrenal Glands

The left adrenal gland was normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.8 cm width in the caudal pole.

The right adrenal gland was indistinctly visualized exhibiting subjective asymmetrical enlargement, most notable in the mid to cranial right adrenal gland with non-homogenous parenchyma. The right



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adrenal gland measured 2.0 cm width in the cranial pole and 1.1 cm width in the caudal pole and 2.5 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 thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/Gallbladder

Subjective mild hepatomegaly. Non-homogenous parenchyma exhibiting intermittent and subtle to indistinct hyperechoic intraparenchymal nodules. An example of a liver nodule measured 1.3 cm diameter. A non-homogenous subjective right lateral to potential caudate liver mass with associated hepatic capsule distortion was present measuring ~ 7.5 cm in diameter.

The gallbladder was indistinctly visualized owing to suspected gallbladder displacement. The gallbladder appeared non-distended with subjective anechoic bile. The common bile duct was not visualized.

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 area of the pancreas was sonographically normal.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Thickened ventral to ventroapical urinary bladder wall with non-dependent to accumulated urinary bladder sediment vs potential blood clot- significant cystitis vs diffuse urinary bladder tumor
- Overtly normal visible proximal urethra and area of prostate gland
- Liver mass with concurrent separate hepatic parenchymal nodules- neoplasia favored i.e. carcinoma or other with separate hepatic nodular hyperplasia, lipogranulomas or potential intrahepatic metastasis
- Mild chronic renal changes
- Subjective mild asymmetrical non-homogenous right adrenomegaly

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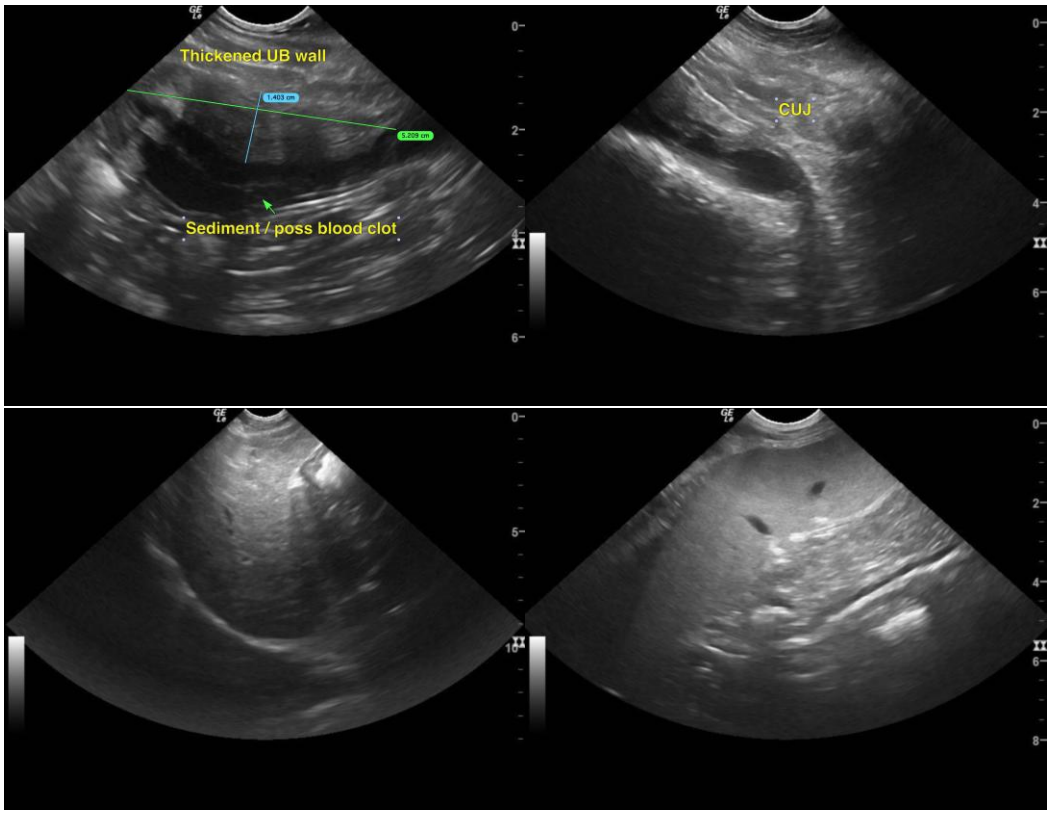
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Screening BRAF assay and urine C/S post completion of current antibiotic protocol is recommended. Assuming normal clotting status, hepatic mass and accessible hepatic parenchymal nodule FNA cytology could be considered for further clarification. Gold standard hepatic and urinary bladder biopsies with histopathology may be required for definitive diagnosis.

The right adrenal gland is non-specific and may indicate incidental hyperplasia or adenomatous change while potential for emerging adrenal tumor or metastasis is not excluded. Monitoring of systemic BP for evidence of hypertension is recommended. Assuming no pathology on 3 view chest radiographs, abdominal CT may be considered for further assessment.



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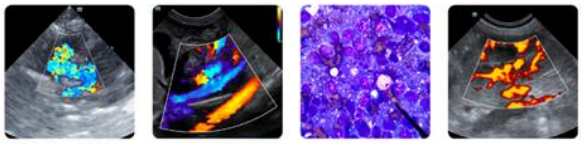

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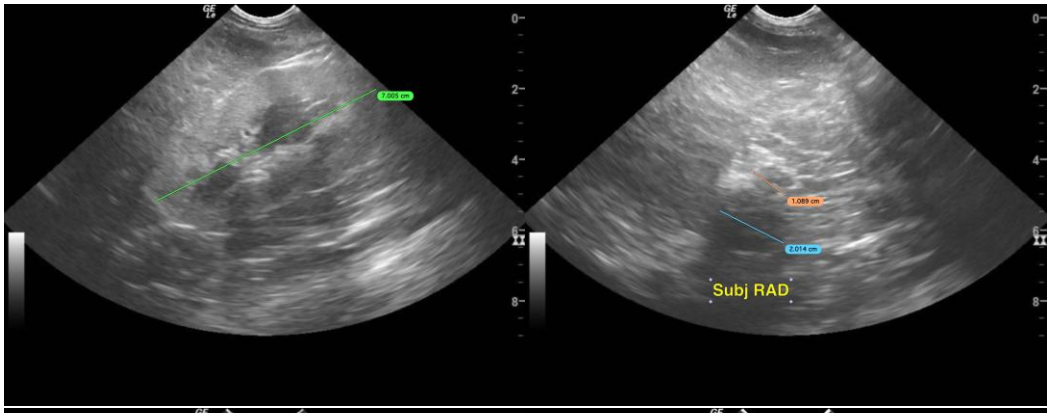

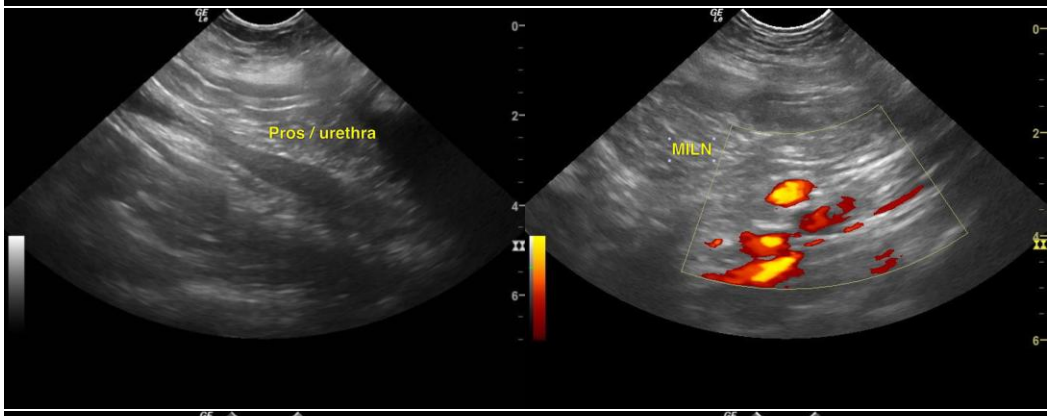

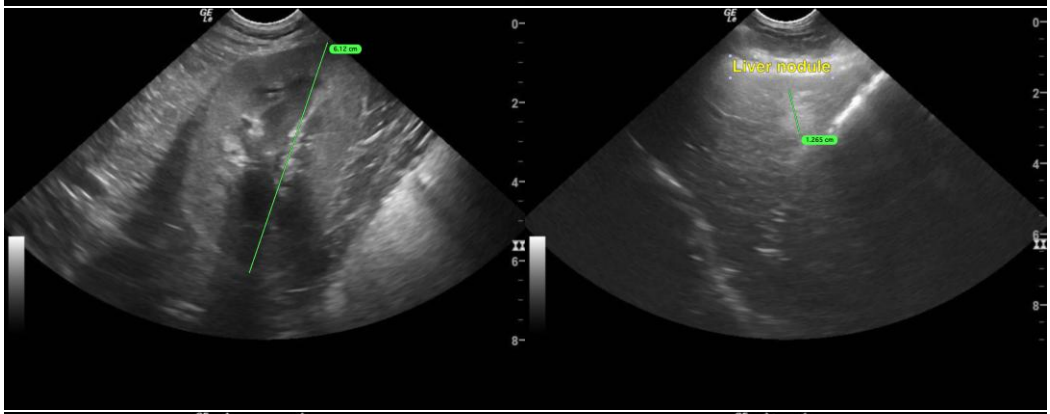

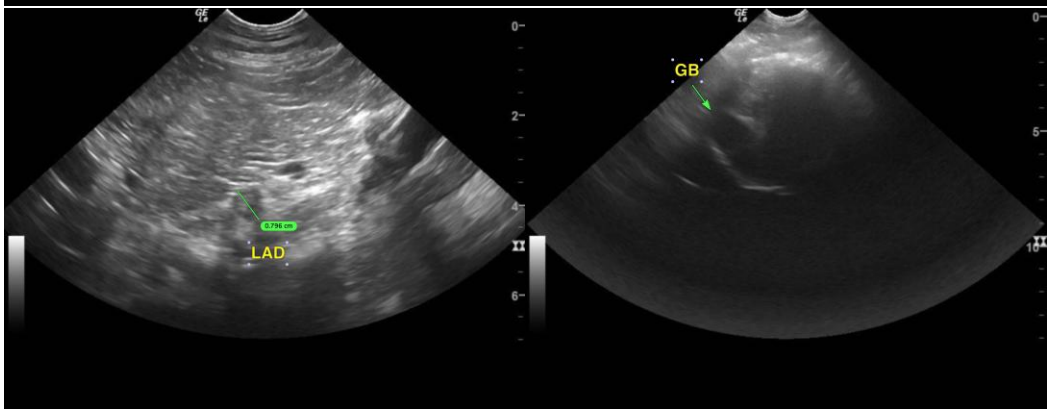

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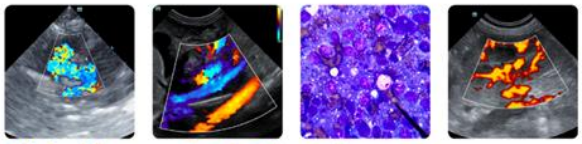

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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