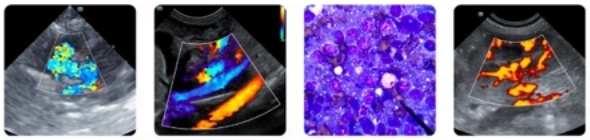


PATIENT

Robin Derea

SPECIES

Canine

BREED

Bulldog Mix

SEX

Neutered male

AGE

7 years

WEIGHT

76 lbs

INTERPRETED BY

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

VCA AVH AH

REFERRING VET

Dr. Dymond-Szabo

INVOICE

68781

DATE

11/18/25

PRESENTING CLINICAL SIGNS

History: Hematuria, pollakiuria (better on abx); ER hosp found bladder mass on AFAST attached to cranial pole of bladder extending through ~50% of bladder lumen. Obese patient. Current Medications: Metacam; Simplicef
Abnormal PE/Chem/CBC/UA Results: Pending NSAID panel

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is full with a mottled echogenic, irregular, poorly vascularized mass on the apex of the wall measuring 2.0 x 2.8 cm in size. The rest of the wall is of normal thickness with a smooth appearance. Normal anechoic urine with no sediment or uroliths evident.

Normal appearance of the trigone area, proximal urethra, and iliac blood vessels.

Normal appearance and size of the iliac lymph nodes. Ureters not visualized, which can be considered a normal finding.

Normal renal size (left measured 6.6 cm, right measured 6.5 cm), architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident. Normal color flow pattern is evident in both kidneys.

The prostate is small and hypoechogenic measuring 1.4 cm in size with patchy mineralization of the parenchyma evident.

Adrenal Glands

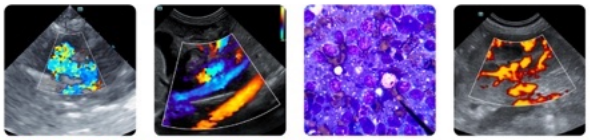
Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 2.37 cm in length x 0.65 cm and 0.46 cm in width. The right adrenal gland measured 2.8 cm in length x 0.56 cm in width.

Spleen

Normal size and echogenic appearance. Smooth homogenous parenchyma and regular curvilinear capsule. Normal volume of the splenic vasculature without any overt congestion or thrombosis evident. Focal, hypoechogenic parenchymal nodule in the body of the spleen measuring 1.0 x 1.4 cm in size. The spleen measures 2.6 cm in width.

Liver

Normal size, echogenic appearance, portal markings, and regular curvilinear capsule. Small, focal, parenchymal nodule in the parenchyma of the left lobe measuring 0.8 cm in size. No additional nodules or masses evident. Normal appearance of the hepatic and portal vasculature.



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Gallbladder

The gallbladder is full containing normal anechoic bile. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.

Gastrointestinal

Normal appearance of the stomach, duodenum, small intestine, ileo-cecal junction, and colon with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen.

Pancreas

The visible sections of the pancreas are of normal size and echogenic appearance with a regular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Normal mesenteric lymph nodes.

No ascites evident.

Thorax

Normal appearance of the heart. No pericardial or pleural effusion evident.

ULTRASONOGRAPHIC FINDINGS

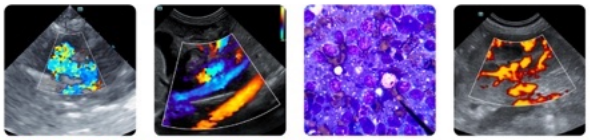
- Urinary bladder mass.
- Prostatic mineralization.
- Splenic nodule.
- Hepatic nodule.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most likely etiology for the urinary bladder mass would be neoplasia with granuloma a less likely differential diagnosis.

Although the most likely etiology for the prostatic mineralization would be previous prostatitis, emerging neoplasia needs to be considered.

The most likely etiology for the splenic nodule would be an incidental, reactive hyperplasia/extramedullary hemopoiesis with hematoma, granuloma and emerging neoplasia an unlikely differential diagnosis.



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The most likely etiology for the hepatic nodule would be an incidental nodular hyperplasia.

Further assessment would be BRAF analysis and/or a catheter assisted aspirate/biopsy of the urinary bladder mass for cytology/histopathology and prostatic wash cytology.

Monitoring of the splenic and hepatic nodules would be recommended and if there is any progressive enlargement of the splenic nodule or bulging of the overlying capsule then splenectomy should be considered. If there is progressive enlargement of the hepatic nodule then FNA cytology would be recommended.

As the urinary bladder mass does not extend to the trigone area and if prostatic neoplasia has been excluded then surgical resection should be considered. Alternatively, palliative therapy would be indicated.

Palliative therapy for urinary bladder neoplasia

Medical palliation

- NSAIDs such as piroxicam (0.3 mg/kg SID), firocoxib 5 mg/kg SID), deracoxib 2–3 mg/kg SID).
- NSAIDs combined with palladia.

Chemotherapy (combined with NSAIDs)

- Mitoxantrone 5–6 mg/m² IV q3wk
- Vinblastine 2 mg/m² IV q2wk.
- Carboplatin 300 mg/m² IV q3–4wk
- Chlorambucil 4 mg/m² PO q24–48h.

Supportive care

- Pain control: gabapentin ± tramadol.
- Manage dysuria with prazosin or phenoxybenzamine.
- Treat UTIs based on culture.
- Control hematuria with hydration and NSAIDs.
- Manage constipation with lactulose.

Interventional palliation

- Urethral stent – relieves obstruction, improves quality of life.
- Cystostomy tube – long-term bladder drainage.
- Palliative radiation – reduces tumor bulk, hematuria, dysuria.
- Laser ablation or debulking.

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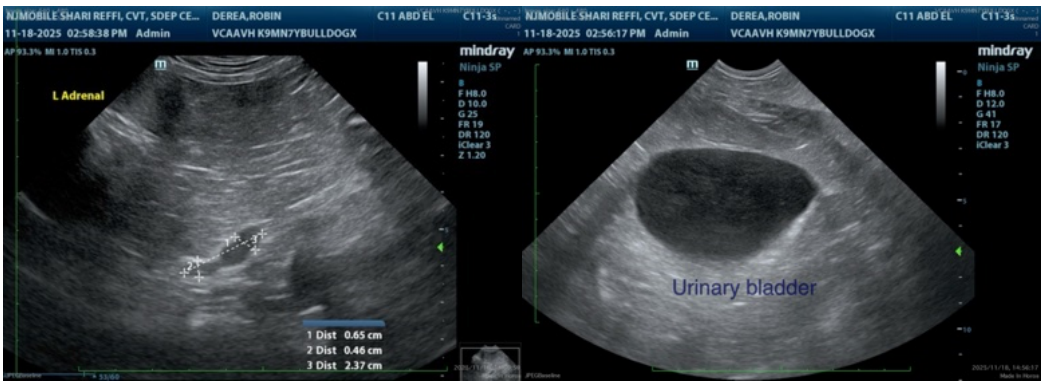

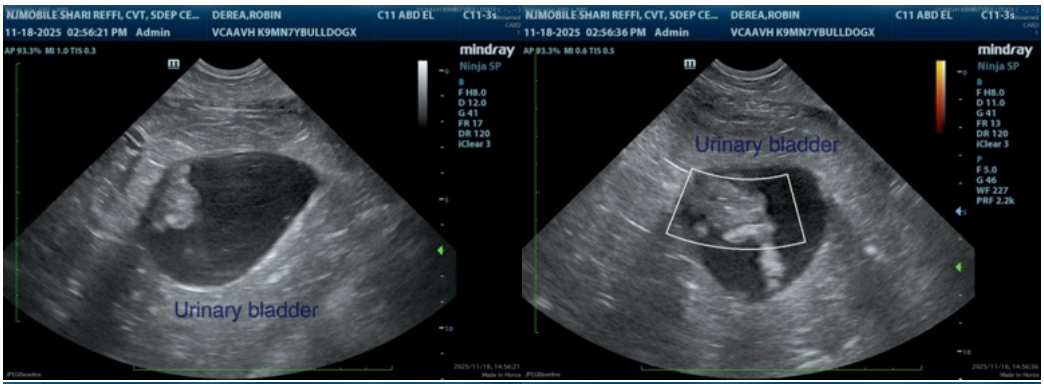

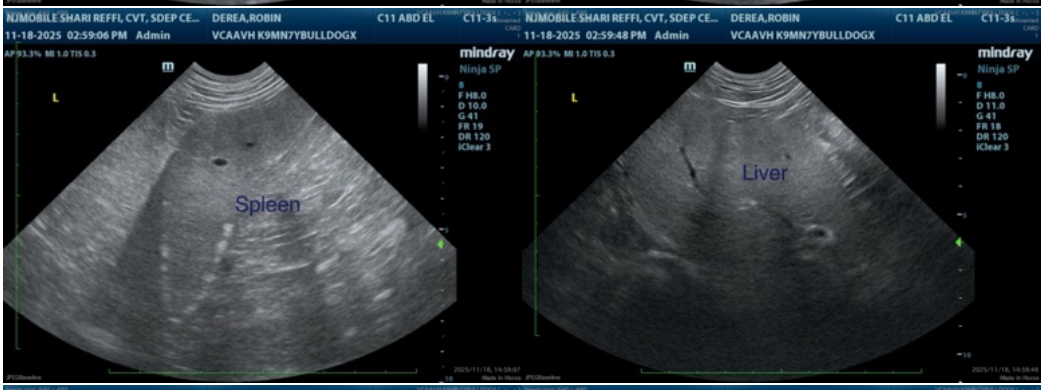

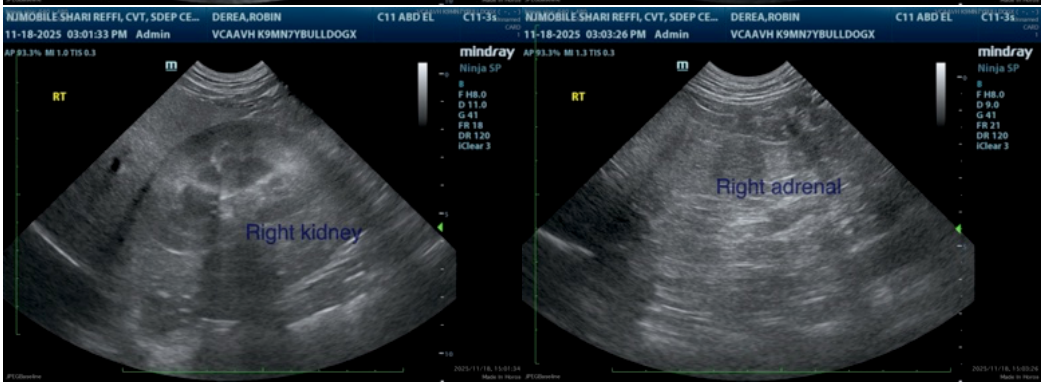

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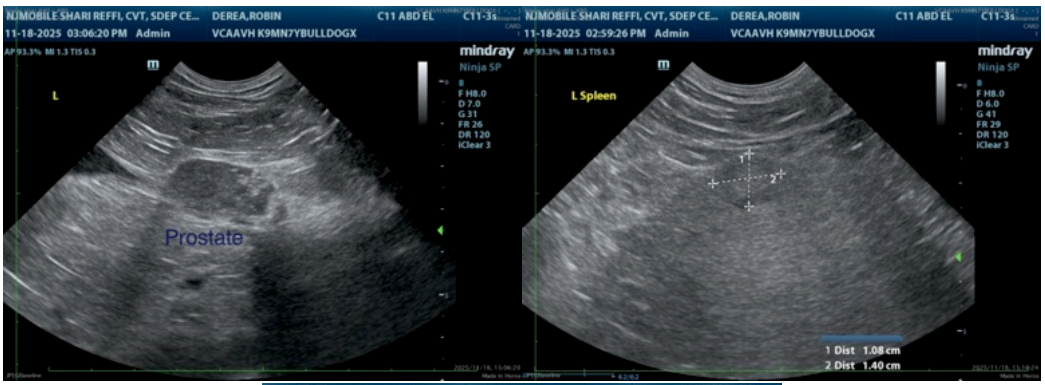

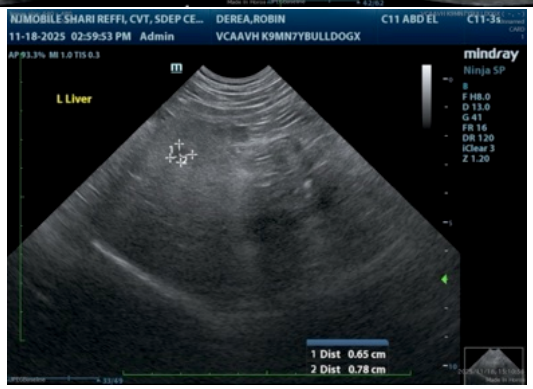

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)

info@sonopath.com