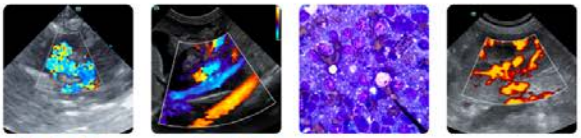

PATIENT

Chloe Walsh

SPECIES

Canine

BREED

Labrador Retriever

SEX

Spayed Female

AGE

11 Years

WEIGHT

70 lbs

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Meghan Morse, LVT, CVT

HOSPITAL NAME

Bergen County Veterinary Clinic

REFERRING VET

Dr. Halloran

INVOICE

74052

DATE

3/26/26

PRESENTING CLINICAL SIGNS

Screen for neoplasia, underlying cause of GI upset/ mega esophagus. Pt seemed uncomfortable yesterday AM and was hacking. Rads showed megaesophagus + lymphadenopathy @ hilus.

Current meds: Cerenia, Famotidine, Sucralfate, Unasyn

Abnormal PE/Chem/CBC/UA Results: CBC WNL Chem: lipase 1942, rest WNL Panc Lipase 188

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder contains minimal urine. Diffusely, the bladder wall is irregular in shape and thickened. The cranial pole of the urinary bladder measures 7.2 mm in width.

The right kidney presents normal size (6.3 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

The left kidney presents normal size (6.5 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

Adrenal Glands

The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 12.6 mm and the caudal pole measures 7.8 mm. There appears to be a hyperechoic nodule within the cranial pole of the right adrenal gland. This nodule measures 1.1 cm x 0.90 cm.

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 7.0 mm and the caudal pole measures 7.7 mm.

Spleen

The spleen is normal in size, shape, margination and echogenicity. No masses are seen.

Liver

The liver presents normal size and shape with smooth lobar margins. The parenchyma has normal echogenicity with normal echotexture. No focal lesions are seen. Intrahepatic bile ducts are normal. Normal vascular pattern.

The gallbladder presents normal size with anechoic contents. Normal gallbladder wall. No evidence of bile duct distention or obstruction.

Gastrointestinal

The stomach and intestines have normal wall layering and thickness. Colon contains normal contents with normal wall thickness.

Pancreas

The visible pancreas is normal in size with normal echogenic parenchyma and surrounded by normal peri-pancreatic mesentery.

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Free Abdomen

There are no enlarged abdominal lymph nodes seen on this exam. No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

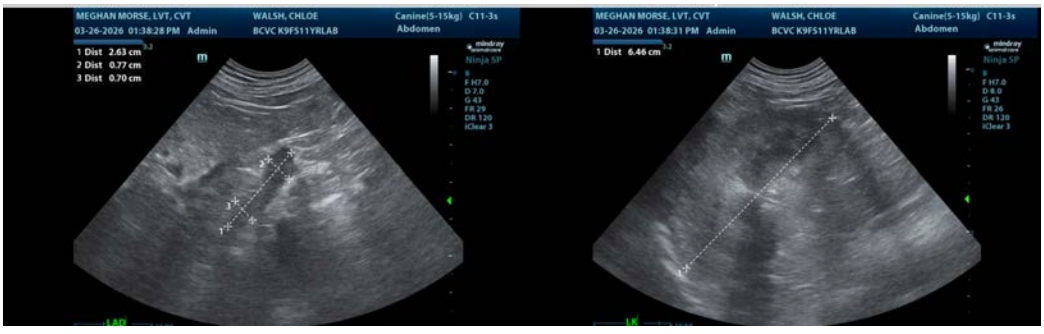
- Right adrenal nodule – This may be a functional lesion causing either hyperadrenocorticism or pheochromocytoma.
- Thickened urinary bladder wall – This may be consistent with chronic bacterial cystitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If clinically warranted, recommend testing for hyperadrenocorticism with a low-dose Dexamethasone test. Recommend submitting a urine metanephrine testing. If functionality of the right adrenal nodule is identified, then recommend treatment of disease process prior to pursuing any further diagnostics. If functionality is determined, then consider right-sided adrenalectomy. It would be recommended to perform a CT scan prior to adrenalectomy to determine feasibility of right-sided adrenalectomy. If no functionality is identified on additional testing for the right-sided adrenal nodule, then periodic monitoring of the right adrenal via ultrasound every 3-6 months would be recommended to determine if it remains stable in size or is showing evidence of progressive growth. If progressive growth is identified, then at that time right-sided adrenalectomy would be recommended.

Regarding the urinary bladder, if not already performed, consider urine culture. If bacterial cystitis is ruled out, then consider (although less likely), possible neoplastic cause such as transitional cell carcinoma, which could be tested for via a BRAF test. If BRAF test is negative, then recommend cystoscopy for biopsies of the urinary bladder wall and possible culturing for bacteria such as corynebacterium.

No obvious cause for the patient's GI upset or megaesophagus seen on this exam. Megaesophagus may be due to esophagitis. However, other causes can be idiopathic or due to hypothyroidism, focal myasthenia gravis, or possibly Addison's disease. Recommend treating the patient supportively for GI upset and megaesophagus. The current medication plan appears appropriately for this supportive care. Recheck radiographs once clinical signs have resolved to determine if megaesophagus resolves. If it resolves, then esophagitis is the suspected cause. If megaesophagus does not resolve, then recommend acetylcholine receptor antibody testing, ACTH stimulation testing, and submitting a thyroid panel. If all of these tests are negative and megaesophagus remains, then the most likely cause is idiopathic megaesophagus.



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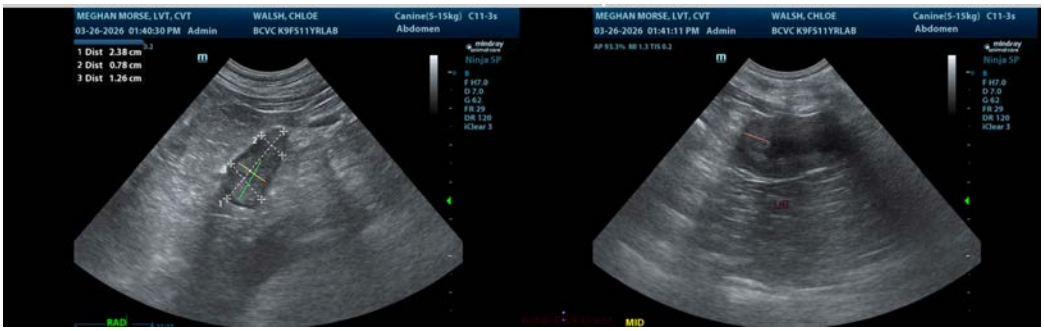

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Greg Kuhlman, DVM, DACVIM (SAIM)

Veterinary Internal Medicine Specialist
info@SonoPath.com