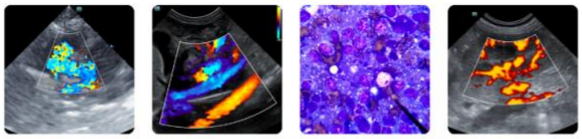

PATIENT

Bodie Sullivan

SPECIES

Canine

BREED

West Highland White Terrier

SEX

Neutered Male

AGE

11 Years

WEIGHT

30.2 Pounds

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

MountainView AH

REFERRING VET

Dr. Bridget Landon

INVOICE

37276

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PRESENTING CLINICAL SIGNS

History: Prev echo and abdominal Sonopath reports- Gabapentin sedation- patient presented for UTI 5/23 and a possible mass was observed on ultrasound for cystocentesis not seen in prev scans- uti clinical signs responded to medical management. no current stranguria, pollakiuria, hematuria. Blood Pressure- BP: 140,150,159, 154. ECG- atropine response test results 12/25/2025-consistent with a sinus arrhythmia. REPEATED ATROPINE TEST TODAY AND ATTACHED BOTH PRE AND POST ATROPINE ECG TESTS FOR REVIEW. MEDS- Amoxi/Clav, Cytopoint, Galliprant, Trazadone, Vetmedin hx cardiomegaly, bradycardia. last echo performed 11/10/2025 (attached report as from another company). Degenerative Valve Disease (DVD)- mild LAE, mild MR, normal LV, normal systolic function, trace TR, normal right heart. (Sonopath Echo report); 11/21/24. Mild LAE, moderate MR, normal LV, normal systolic function, trace TR, normal right heart. (Sonopath Echo report); 3/13//25. Arrhythmia auscultated; 10/30/25. Mild LVEH, moderate LAE, moderate MR, trace TR, normal RA/RV; 11/10/25. Sinus arrhythmia with frequent periods of sinus arrest; suspect early sick sinus syndrome.

Abnormal PE/Chem/CBC/UA Results: cadet braf pending bacturia 5/23 bw 5/23 mild ALP elevation - consistent w/ prev findings non-azotemic otherwise unremarkable findings. RADS- chest radiographs show cardiomegaly, no evidence of chest metastasis.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Within the dorsoapical aspect of the urinary bladder, there is a multilobulated hyperechoic mass lesion present that measures approximately 3.5 cm x 1.6 cm in size, most likely consistent with transitional cell carcinoma. A BRAF test is reported to be pending. 2 hyperechoic uroliths appear to be present, appear to be non-shadowing. The first urolith measures 2.6 mm in width, the second measures 3.1 mm in width.

Prostate is normal in size (8.9 mm in width), with uniform echogenicity and symmetrical shape.

The left kidney presents normal size with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia or ureteral dilation. Mild nonobstructive dystrophic mineralization was noted in the left kidney. The left kidney measured 6.4 cm in length.

The right kidney presents normal size with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia or ureteral dilation. Mild non-obstructive dystrophic mineralization was noted in the right kidney. The right kidney measured 6.2 cm in length.

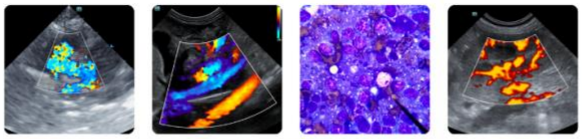
Adrenal Glands

The left adrenal gland was diffusely enlarged, measuring 1.2 cm in width at the caudal pole and 2.4 cm in width at the cranial pole.

The right adrenal gland is also enlarged and heteroechoic in echogenicity. The right adrenal gland measures 2.3 cm in width.

Spleen

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



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Liver

Within the liver there is a hyperechoic, ill-defined lesion present. A second hypoechoic nodule is present measuring 4.5 mm in width. Other than the two lesions described within the liver, the liver appears normal. No obvious metastatic disease is seen within the liver at this time.

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 pancreas revealed age-related remodeling. No obvious evidence of pancreatitis is present at this time.

Free Abdomen

The right medial iliac lymph node is enlarged, measuring 8.3 mm in width. It is mildly hypoechoic and has an irregular shape. This node may be reactive, however, given its appearance, consideration should be given to metastatic neoplastic cause, such as metastatic transitional cell carcinoma. A similar appearing left medial iliac lymph node measures 5.1 mm in width, with similar description and differentials.

The right inguinal lymph node has hypoechoic rim with hyperechoic central region. The right inguinal lymph node measures 5.8 mm in width. This may be reactive, but cannot rule out possible metastatic disease.

No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Mass in the dorsal apical aspect of the urinary bladder consistent with transitional cell carcinoma.
- Diffuse abdominal lymphadenopathy- most likely reactive, however, a neoplastic cause cannot be ruled out.
- Bilateral adrenomegaly- consistent with benign adrenal hyperplasia caused by pituitary dependent hyperadrenocorticism.
- Age-related pancreatic remodeling- may be reactive but cannot rule out possible metastatic disease.
- Liver nodules
- Mild non-obstructive dystrophic renal mineralization bilaterally.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the bilateral adrenal enlargement, suspect patient may potentially have pituitary-dependent hyperadrenocorticism. Recommend low-dose dexamethasone suppression test to determine if patient has hyperadrenocorticism. If hyperadrenocorticism is ruled out, the changes seen within the adrenal

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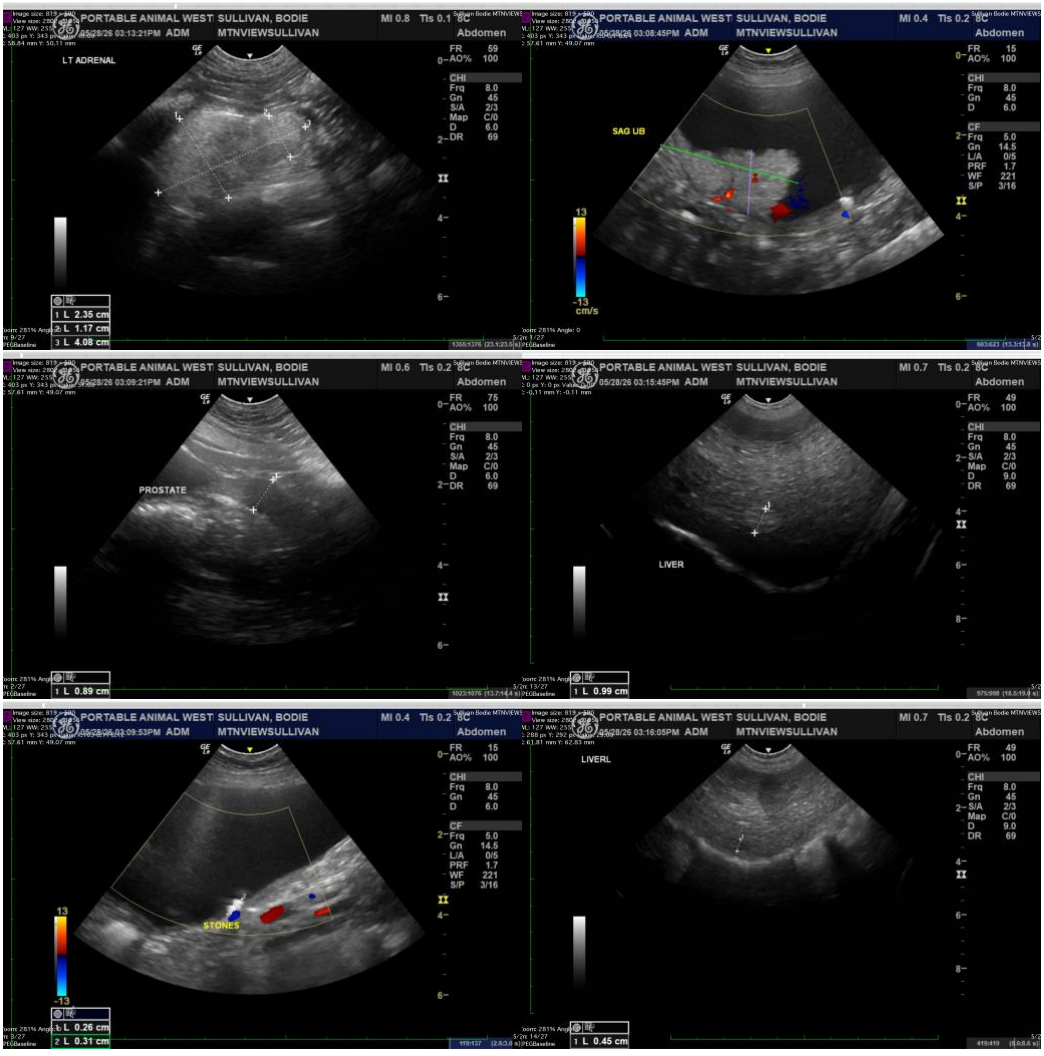
glands may be due to neoplastic cause such as an adrenal carcinoma. If hyperadrenocorticism is ruled out, consider CT scan of abdomen for further evaluation of adrenal changes.

Consider fine needle aspirate of the enlarged inguinal lymph nodes with submission for cytology.

BRAF test is pending. If BRAF test is negative, consider cystoscopy to obtain biopsies of mass for histopathology. If patient is diagnosed with urinary bladder neoplasia such as transitional cell carcinoma, aspirate of the inguinal and iliac lymph nodes should be considered to determine if metastatic disease is present.

The liver lesions are most likely benign regenerative nodules. However, possibility of metastatic neoplasia exists. If feasible, consider fine needle aspirate and submission for cytology.



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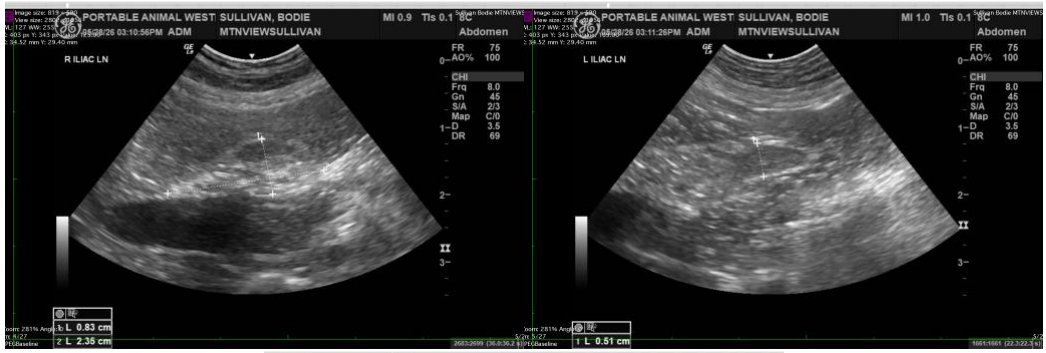

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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