



PATIENT

Scrappy Writer

SPECIES

Canine

BREED

Cattle Dog

SEX

Neutered Male

AGE

12 years

WEIGHT

24.3 kg

INTERPRETED BY

Bradley Harris, DVM,
DACVECC, DACVIM
(cardiology)

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershey Animal
Emergency Center

REFERRING VET

Dr. Brittany Lang

INVOICE

11006

DATE

12/23/2025

PRESENTING CLINICAL SIGNS

Was seen at rdvm for anorexia, abdominal pain and vomiting after eating a ham bone radiographs showed hepatomegaly was given metro, sq fluids, kenalog injection sq, cerenia cpl was borderline for pancreatitis.

Abnormal PE/Chem/CBC/UA Results: at rdvm prior to transfer ast: 101 alt: 215 alp: 7299 t bili 3.3 chol: 402 wbc: 30.1 with neutrophilia and mild toxic changes lymphopenia.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. There are no uroliths or sediment noted, and anechoic urine is present. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size. The cortices are hyperechoic with a loss of corticomedullary definition. There are numerous cortical cystic changes bilaterally. The cortex to medulla ratio is appropriate with no evidence of pyelectasis or pelvic dilation. The cortices are mildly irregular. Left kidney measures 6.8 cm, and the right measures 7.3 cm.

Adrenal Glands

The left adrenal gland is visualized and has normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. Left adrenal measures 0.55 cm at the caudal pole x 2.13 cm.

The right adrenal measures 0.59 cm at the caudal pole x 2.89 cm. The cranial pole of the right adrenal has a large, heterogenous mass effect that distorts the normal adrenal capsule and measures 2.13 cm x 1.69 cm. The phrenic vasculature is normal and there is no evidence of vascular invasion identified.

Spleen

The spleen is diffusely mottled with a heterogenous reticular pattern. The spleen is subjectively enlarged in size, and the vasculature is normal with no evidence of congestion, spontaneous echo contrast, or thrombosis. The spleen measures 2.19 cm at the hilus.

Liver

The liver is subjectively enlarged in size with a diffusely heterogenous or mottled parenchyma, and slightly rounded contour or margins. The vasculature is normal with no evidence of congestion. There is no hepatic lymphadenopathy noted. The gallbladder has thin walls which contain anechoic bile. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. No hepatic lymphadenopathy is documented. There is no overt structural evidence of inflammatory, infiltrative or regenerative pathology evident.

Gastrointestinal

The stomach is minimally distended with echogenic ingesta. The gastric wall is thickened with a prominent muscularis layer that distorts the normal 1:3 muscularis to mucosal ratio. There is a single



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prominent gastric lymph node with normal length to width ratio. The small intestine is non-distended with normal wall thickness and maintenance of normal wall layering. The pyloric-duodenal junction is patent, and the colon contains normal shadowing feces.

Pancreas

The base and limbs of the pancreas are isoechoic to surrounding omental fat. The pancreatic duct and capsular contour are normal. There is no overt evidence of active inflammatory or neoplastic disease.

Free Abdomen

Aside from the previously noted gastric lymph node, there is no other intraabdominal lymphadenopathy or free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- There is increased renal cortical echogenicity and thickening with a mildly irregular capsular contour. Multifocal cystic cortical changes are noted. This is secondary cystic formation consistent with chronic age related degeneration and remodeling. There is no evidence of abscessation or suspicion of neoplasia.
- The cranial pole of the right adrenal gland was enlarged with a swollen capsule and mild heterogenous parenchymal changes. This is most consistent with hyperplasia or an adenoma. Capsular expansion was noted without capsular escape or vascular invasion.
- The mildly enlarged spleen with a coarse/mottled reticular pattern is most consistent with a reactive spleen, or possible splenitis. Round cell neoplasia is considered less likely but cannot be definitively excluded.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory, immune-mediated, metabolic, or endocrine disease. Infiltrative neoplasia or acute hepatitis cannot be ruled out.
- The gastric wall is thickened with a prominent muscularis layer which may represent early onset of infiltrative inflammatory bowel or another chronic enteropathy. Additionally, infiltrative neoplastic disease cannot be definitively excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection.

Fine needle aspirates of the spleen and liver with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy.

Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.

A gastrointestinal panel (TLI, PLI, B12, folate) via Texas A&M gastrointestinal laboratory is indicated to further evaluate for potential chronic enteropathy. Ultimately, gastrointestinal biopsies may be required for a definitive diagnosis.

Consider a spec CPLI for further evaluation of the pancreas for active inflammation or pancreatitis.

Despite overt ultrasonographic changes. Once clinical signs have resolved and the patient appears to



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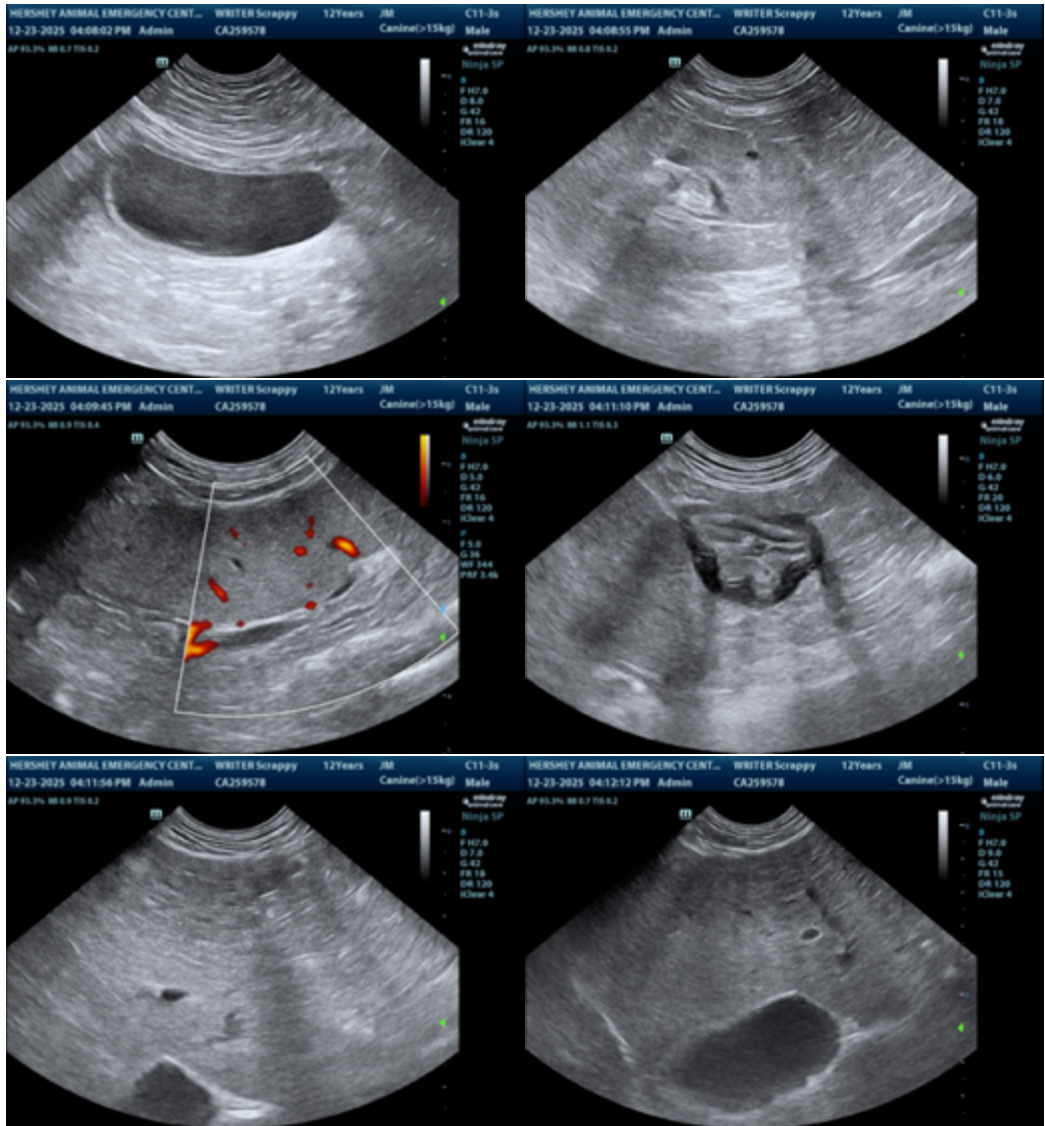
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have recovered, consider an ACTH stimulation test and low dose dexamethasone suppression test are indicated to evaluate for potential hyperadrenocorticism.





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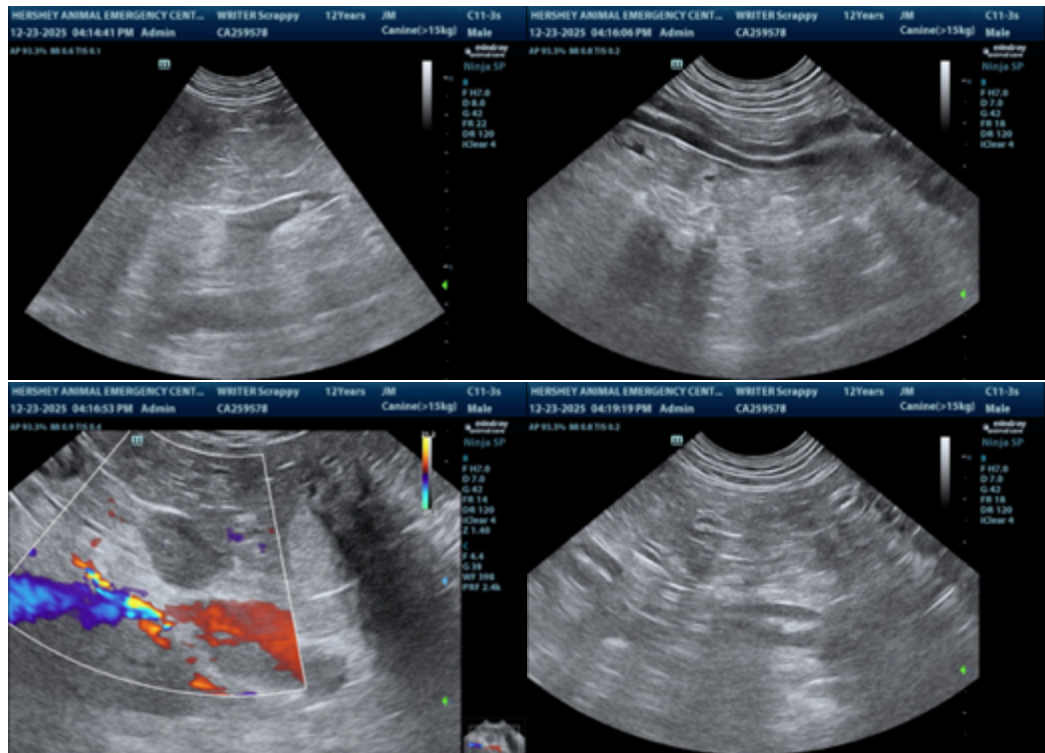
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

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