



PATIENT

Carl Hartman

SPECIES

Canine

BREED

Scottie

SEX

Neutered Male

AGE

11 Years

WEIGHT

10.5 kg

INTERPRETED BY

Brad Harris, DVM,
DACVECC, DACVIM
(cardiology)

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershey Animal
Emergency Center

REFERRING VET

Dr. Sarah Moser

INVOICE

73468

DATE

3/7/26

PRESENTING CLINICAL SIGNS

Vomiting intermittently since Dec. U/S rDVM on 3/5 concerning for cranial abd masses or LNs and possible gastric foreign material. Eating but vomits if they do not give Cerenia. 5 lb weight loss since Nov '25. 2/6 heart murmur, no oral exam (fractious), abd sl tense, sig borborygmi ausc

Abnormal PE/Chem/CBC/UA Results: EPOC - wnl PT/PTT - 16.8/115 rDVM diagnostics: ABDOMINAL xray, ABDOMINAL ULTRASOUND radiographs are dated January 30, 2026. Ultrasound is dated March 5, 2026. CONCLUSIONS: 1. Gastric foreign material with gastric wall thickening. This combination of changes is most consistent with foreign body induced gastritis which is expected to contribute to the patient's clinical signs. . Infiltrative neoplasia of the gastric wall (lymphoma) is also considered with gastric foreign material being incidental 2. Cranial abdominal masses are most consistent with enlarged gastric and portal lymph nodes and are subjectively larger than expected for reactive lymphadenopathy secondary to gastritis and gastric foreign material though this is still possible. Lymphoma is also a top consideration.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is mildly thickened with an irregular mucosa. There is a minimal amount of suspended echogenic debris.

The kidneys are normal in size. The cortices are hyperechoic with a slight decrease in corticomedullary definition. There is multifocal dystrophic mineralization. Normal cortex to medulla ratio. No significant pyelectasis. The renal capsules are mildly irregular. Left kidney measures 5.0 cm. Right kidney measures 5.06 cm.

Adrenal Glands

Both adrenal glands are visualized and have 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 measures 0.58 cm x 2.33 cm. Right measures 0.55 cm x 2.6 cm.

Spleen

The spleen measures 1.52 cm at the hilus. It is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented.

Liver

The liver is subjectively normal in size with a diffusely mildly mottled parenchymal pattern. Vasculature is within normal limits with no evidence of congestion. The gallbladder is moderately distended with echogenic debris and dependent sediment. The cystic and common bile ducts appear normal. There is no evidence of intra- or extrahepatic biliary dilation.

Gastrointestinal

The stomach is non-distended with an eccentric hypoechoic wall with loss of normal wall layering. It is severely thickened in some regions. There is a possible secondary small intestinal lesion with similar



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eccentric nature. However, this may also represent either a different view or a different focal region of the gastric wall. The small intestine is non-distended. There is no evidence of gastrointestinal mechanical obstruction.

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Pancreas

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

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Free Abdomen

There are several severely enlarged hypoechoic gastric and jejunal lymph nodes with abnormal length to width ratio and hypoechoic, irregular parenchyma.

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No significant free fluid noted.

ULTRASONOGRAPHIC FINDINGS

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- The urinary bladder contains echogenic, suspended debris contrasted with anechoic urine. This is often related to urinary tract infection but may represent exfoliated debris or sterile inflammation.

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- There is thickening of the cranioventral and craniodorsal urinary bladder wall with mucosal changes and echogenicity consistent with suspended debris. This is most consistent with chronic cystitis. Technically transitional cell carcinoma cannot be ruled out without histopathology but is not overtly suspected based on this pattern.

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- The kidneys are relatively normal in size and structure, and cortex:medulla ratio (cortex 1/3 of medulla) is essentially maintained. There is age-related loss of the normal smooth capsular contour and C/M junction definition. The cortices are largely uniform in texture with mild hyperechogenicity expected for this patient's age. Dystrophic mineralization was noted and appears non-obstructive at this time, with no evidence of pylectasis.

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- The gallbladder contains echogenic, suspended and dependent unorganized debris. This is not yet to the level of an organized mucocele, however early/developing mucocele cannot be ruled out. This dependent sediment is often an incidental finding or may be associated with concurrent endocrine disease such as hyperadrenocorticism or diabetes mellitus.

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- The gastric and jejunal lymph nodes presented abnormal length to width ratio with distorted, swollen, irregular contour. Parenchymal detail was indiscernible. This is most consistent with lymphoproliferative disease such as lymphoma/round cell neoplasia, metastatic disease, or an aggressive inflammatory process. FNA, cytology and culture are warranted

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- The eccentric gastrointestinal lesion is concerning for infiltrative neoplastic disease such as round cell neoplasia or carcinoma.

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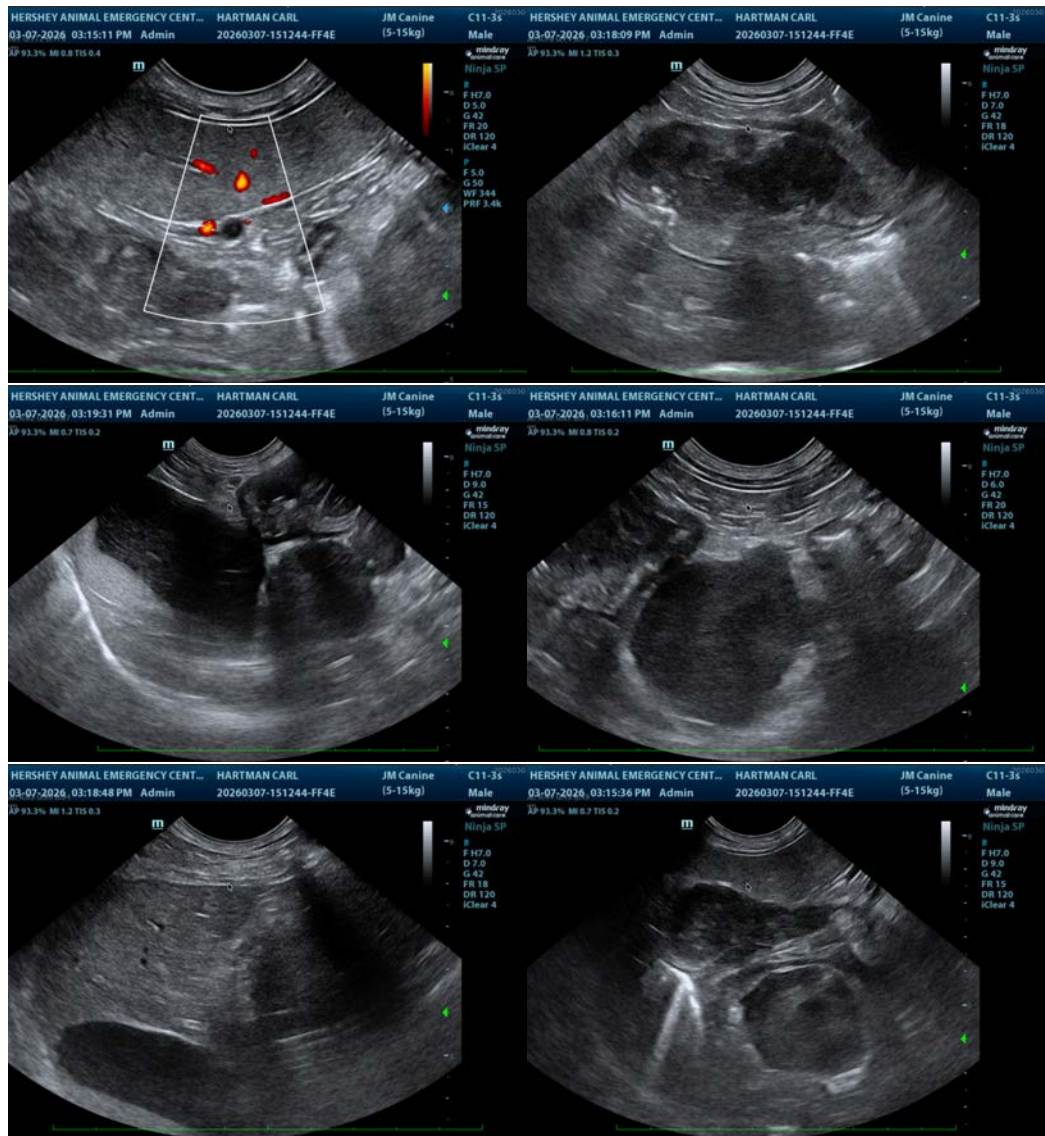
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Fine needle aspirates of the lymph node and gastric mass 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.

Urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.





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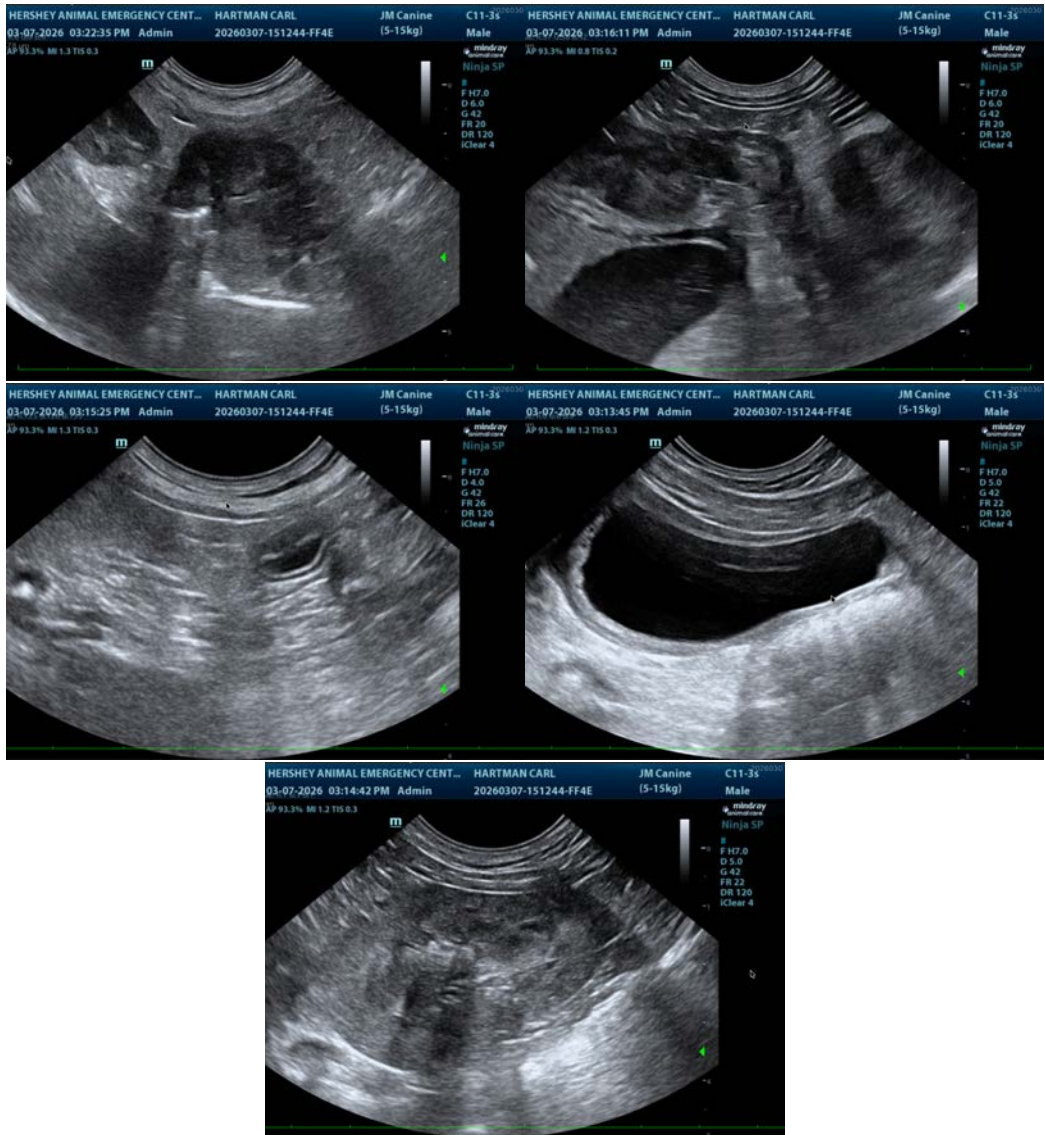
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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