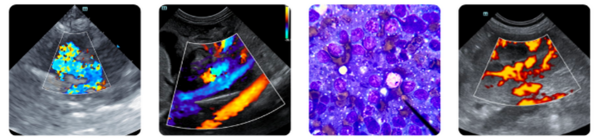


PATIENT

Chloe Moyer

SPECIES

Canine

BREED

Shih Tzu

SEX

Spayed Female

AGE

12.3 years

WEIGHT

17.7 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal Hospital

REFERRING VET

Dr. Jen Heller

INVOICE

10940

DATE

12/16/2025

PRESENTING CLINICAL SIGNS

Employee Pet. Not sedated. Patient presented yesterday after 1 week of ongoing congestion and new acute severe bilateral nasal bleeding. Patient has no airflow through both nostrils. Mild cranial abd organomegaly on exam and has been recently PU/PD/PP with a suspicion of Cushings. Rads: Skull rads NSF. Chest rads NSF. Abd rads - moderate hepatomegaly noted. Bloodwork: HCT 35% (L), platelets ~100,000 (mildly decreased), bands/left shift noted. Chem NSF except ALP 1,340 (H). Patient was started on IVF, Baytril/Unasyn, yunnan baiyou and 1 dose injectable vit K. Patient also on gabapentin and hepatosupport. Main ddx severe rhinitis/sinusitis vs nasal tumor. AUS performed to investigate hepatomegaly and r/o abdominal disease. Epistaxis is improved today but ongoing and patient has forceful sneezing.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of mineral or infarcts observed. Left kidney measures 4.07 cm with mild pyelectasia noted. The right kidney measures 4.49 cm.

Adrenal Glands

The right adrenal gland is mildly plump in size, primarily at the cranial pole measuring 0.8 cm. The caudal pole is normal in size. The right adrenal is normal in shape and contour are maintained without evidence of capsular invasion. Some likely age related parenchymal heterogenicity is present. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.4 cm at cranial pole and 0.5 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

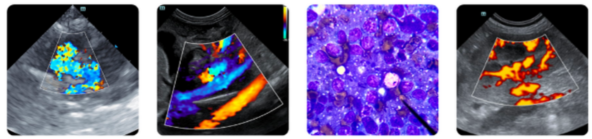
The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal



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The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

Medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

PRIMARY FINDINGS

- The mild right adrenomegaly should be interpreted in combination with clinical history as it could indicate early or emerging adrenal disease, either hyperplasia or adenoma, with infiltrative neoplastia being considered much less likely. Although normal patient variant, chronic stress, etc., is also a possibility.

- Heterogenous Liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.

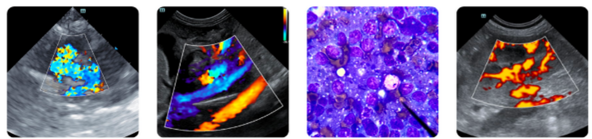
- Mildly reactive medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

SECONDARY FINDINGS

- Age related kidney changes with mild pyelectasia in the left kidney.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's reported clinical history, a blood pressure is recommended if not recently evaluated, as



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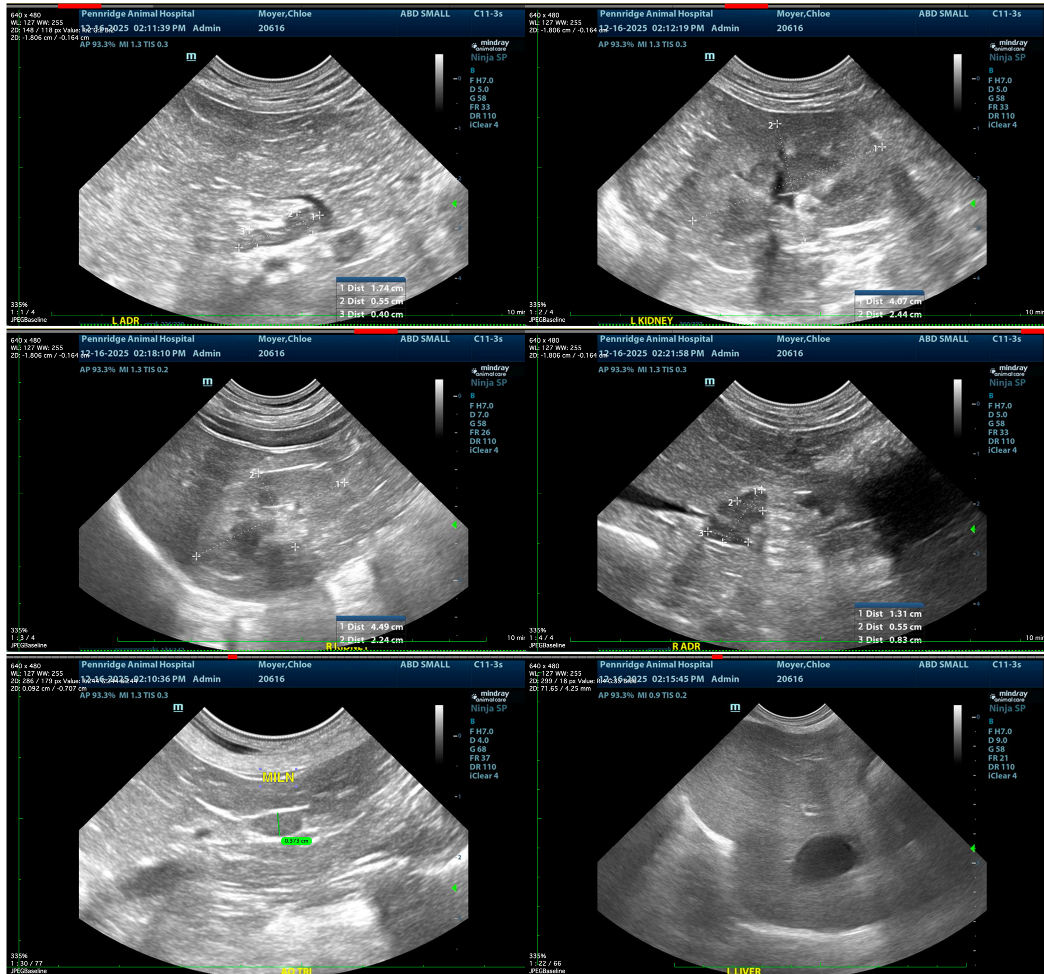
is full assessment of patient's coagulation status. Ultimately, advanced imaging of the nose, including potentially contrast CT scan +/- rhinoscopy may be warranted.

Regarding patient's reported clinical signs consistent with hyperadrenocorticism, alkaline phosphatase, etc., further testing for hyperadrenocorticism could be considered beginning with a low dose dexamethasone suppression test but hyperadrenocorticism likely is not contributing to patient's reported epistaxis.



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.

Beth Johnson, DVM, DACVIM
info@sonopath.com