



## PATIENT

Ziggy Carr

## SPECIES

Canine

## BREED

Mini Schnauzer

## SEX

Intact Male

## AGE

8.5 years

## WEIGHT

12.9 kg

## INTERPRETED BY

Kathleen Sennello DVM,  
MS, Diplomate ACVIM  
(Small Animal Internal  
Medicine)

## IMAGING PERFORMED BY

Dr. Meghan Myers

## HOSPITAL NAME

Hershey Animal  
Emergency Center

## REFERRING VET

Dr. Brittany Lang

## INVOICE

11545

## DATE

3/25/2026

## PRESENTING CLINICAL SIGNS

- O says normal during day. Tonight was ataxic/falling over and disorientated. Still responding to name during this episode. No known trauma and nothing P could of got into. O says that P was trying to attack house mate twice which is not normal for him. PE unremarkable other than unilateral cryptorchid and overweight.

Abnormal PE/Chem/CBC/UA Results: Chem: ALP 297 (H) EPOC: pH 7.324 (L), Glu 134 (H) CBC: Plt 562 (H), Plt crit 0.63 (H) BP: 205/136 (159) ECG: NSF CONCLUSIONS: Small intestinal content supports dietary indiscretion. Underlying toxins cannot be excluded. There is no evidence of complete gastrointestinal mechanical obstruction. Diffuse mild hepatomegaly: This finding is nonspecific with possible etiologies to include metabolic hepatopathy, cholangiohepatitis, infiltrative neoplasia (such as lymphoma, mast cell tumor) cannot be excluded. Prostatomegaly compatible with benign prostatic hyperplasia. Oval soft tissue opacity in the right inguinal region: Correlate with the clinical examination. DDX. Inguinal lymphadenopathy [metastasis, reactive hyperplasia], superimposed subcutaneous nodule [granuloma, neoplasia].

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The prostate is large (3.08 cm in height in the sagittal view), hyperechoic and mottled for an intact male.

The left kidney has a normal shape and size (5.63 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.7 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

### Adrenal Glands

The left adrenal gland is normal in size measuring 0.45 cm at the cranial pole and 0.4 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.66 cm at the cranial pole and 0.52 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

### Spleen



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The spleen is subjectively normal in size (1.57 cm) and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

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### Liver

The liver is large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

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### Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured as normal (0.39 cm in wall thickness) and the jejunum measured as normal (0.29 cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

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### Pancreas

The pancreas is prominent and mottled in the left limb. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

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### Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

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### Other

There's a subcutaneous mass effect visualized in the right inguinal region, with the general size and shape consistent with a cryptorchid testicle, measuring 0.98 cm x 2.42 cm. There's an irregular, hypoechoic nodule visualized measuring 0.62 cm x 1.04 cm.

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## ULTRASONOGRAPHIC FINDINGS

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- Large, hyperechoic, mottled prostate. Findings are most consistent with benign prostatic hypertrophy +/- prostatitis.
- Age related changes visualized associated with both kidneys.



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- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Large heterogenous liver. The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, infiltrative neoplasia (less likely) or other hepatopathy.
- Suspect right cryptorchid testicle with a hypoechoic nodule (an alternate subcutaneous mass effect cannot be definitively ruled out.) There is a nodule visualized in the testicle. Consider such differentials as benign or neoplastic lesions such as Leydig cell tumor, Sertoli cell tumor, seminoma, granuloma, etc. Recommend neuter with histopathology (as treatment of choice), or cytology.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

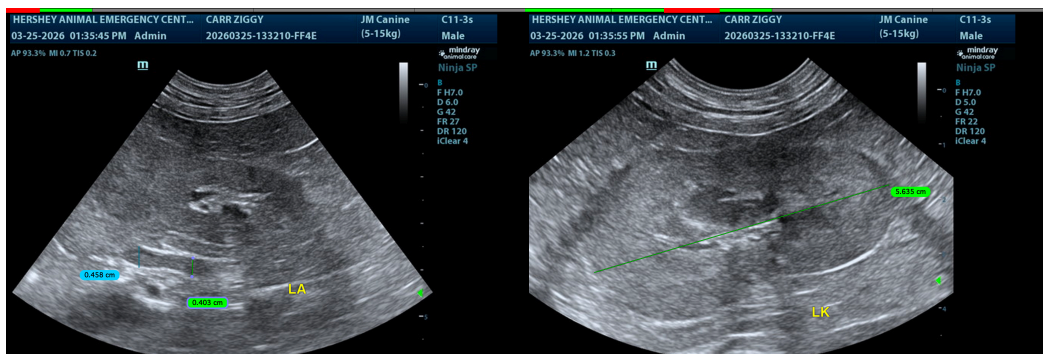
An obvious lesion responsible for the neurologic episode described is not visualized. The prostate is large and hyperechoic, most consistent with benign prostatic hypertrophy. If there's any concern for prostatitis recommend a urinalysis and culture +/- fine needle aspirate of the prostate.

The liver is large and heterogenous, possibly consistent with a mild vacuolar hepatopathy. IF there's concern for a more significant hepatopathy consider pre- and post-prandial bile acids and a fine needle aspirate of the liver.

The inguinal structure has the appearance most consistent with a cryptorchid testicle. The median raphe is difficult to clearly visualize but is suspected. There's an ill-defined hypoechoic nodule. The most definitive plan would likely be neutering with the testicle submitted for histopathology as this would be likely help with the prostatic issues as well. If the patient is not stable enough for this, you could consider a fine needle aspirate of the hypoechoic region of the testicle for further evaluation.

Other differentials to consider would include cardiac issues (an arrhythmia, etc.), an atypical seizure, hypoglycemia, or possibly a stroke? (with the hypertension?) Consider a consultation with a veterinary neurologist and advanced imaging if clinically appropriate.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.





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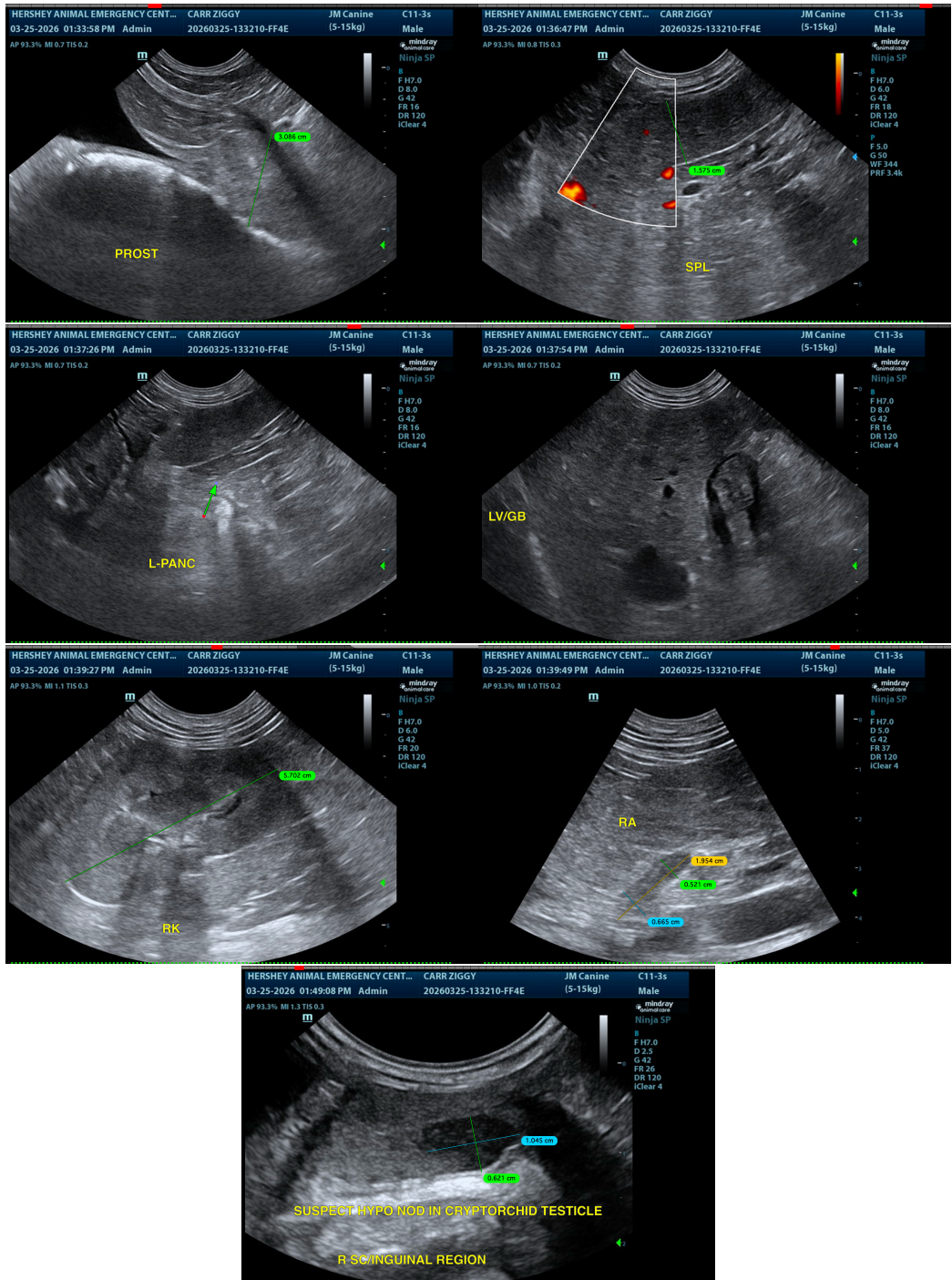
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I



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can be of any further assistance please contact me.

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