



## PATIENT

Mason Rhone

## SPECIES

Canine

## BREED

Maltese Mix

## SEX

Neutered Male

## AGE

12 Years

## WEIGHT

5.02 kg

## INTERPRETED BY

R. McKenzie Daniel,  
DVM, DABVP

## IMAGING PERFORMED BY

Lindsay Powell CVT

## HOSPITAL NAME

Hershey Animal  
Emergency Center

## REFERRING VET

Dr. Leann Murphy

## INVOICE

13261

## DATE

01/20/26

## PRESENTING CLINICAL SIGNS

- Acute gastrointestinal signs since Saturday morning, including vomiting and ongoing diarrhea, with inappetence this morning and restlessness overnight. RDVM bloodwork from yesterday showed elevated kidney values.
- Enlarged left prescapular lymph node, enlarged submandibular lymph nodes, mildly enlarged and firm popliteal lymph nodes
- Severe calculus, gingivitis and halitosis

Abnormal PE/Chem/CBC/UA Results: Diagnostics at RDVM 1/19/26: CBC: RBC 3.8 L, Hb 10.2 L, Hct 32 L, MCV 85 H, Platelets 87K L with few platelet clumps, Lymphocytes 531 L, Basophils 177 H Chem15: Albumin 2.2 L, Globulin 4.3 H, A/G ratio: 0.5 L, BUN 159 H, Creatinine 4.4 H, Calcium 8.8 L, PSL 441 H T4: 1.2 Diagnostics at HAEC 1/20/26: EPOC: pO2 62.4 H, pcO2 28L, bicarb 10.6L, TcO2 10.3 L, PH 7.187 L, BE,ECF -17.6 L, NA 139, Lac 0.45L, BUN >120 H, Crea 4.97 H, HCT 21 L PCV/TS: 27%, 7.4g/dL CBC: Hct 22.8 L, RBC 3.17 L, Hb 8.3 L, MCH 26.2 H, Retic 30.1 H, Lymphocytes 0.53K L, Platelets 11K L panc lipase: 959H Chem: BUN >130, creat 4.9 H, phos >16.1 Witness Lepto- Neg, 4dx Lyme + UA: pro 500, blood 250 UPC: Pending Abdominal/thoracic radiographs: Unremarkable

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted. Foley catheter present in the area of the cystourethral junction and proximal urethra.

The residual prostate was sonographically normal.

The area of the aortic trifurcation was free of pathology.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild to moderate indistinct corticomedullary border demarcation expected for the age of the patient. Bilateral mild pyelectasia and small cortical cysts were visualized. The left kidney measured 3.9 cm in length. The right kidney measured 4.5 cm in length.

### Adrenal Glands

The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.53 cm width in the caudal pole. The right adrenal gland measured 0.65 cm width in the caudal pole.

### Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The



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parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease.

### **Liver & Gallbladder**

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non distended in size with moderate nonorganized gravity dependent to peripheral lumen biliary sludge. No evidence of pericholecystic inflammation. The common bile duct was not visualized.

### **Gastrointestinal**

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained variably echogenic, mild to moderate nonshadowing ingesta without evidence of obstruction to pyloric outflow.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

Normal visible colon wall layers were present. The colon was nondistended containing semi formed to soft fecal matter and lumen gas in the lumen.

### **Pancreas**

The pancreas was normal in size and contour with heterogeneous variably hyperechoic parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

### **Free Abdomen**

No overt lymphadenopathy or peritoneal effusion was present.

## **ULTRASONOGRAPHIC FINDINGS**

- Nonspecific chronic renal changes exhibiting mild pyelectasia and small cortical cysts.
- Heterogeneous remodeled pancreas.
- Structurally normal gastrointestinal tract/colon with nonshadowing gastric ingesta and semi formed/soft fecal matter/gas in colon.
- Mild hepatosplenic parenchymal remodeling- subjective benign.
- Congealed nonorganized gallbladder debris- not consistent with mature mucocele.

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The kidneys exhibited primarily chronic renal changes which suggests chronic nephropathy or potential chronic renal failure although did not obviously appear to be end stage, indicating potential for acute on chronic renal insult i.e. infectious disease, toxin, etc. Correlation with pending urine diagnostics including screening culture/sensitivity on sterile urine sample if not done. Leptospirosis titers/PCR could be considered if clinically indicated.

No evidence of significant or active pancreatitis with metabolic or secondary gastrointestinal signs suspected. Concurrent mild to chronic pancreatitis may be considered if evidence of cranial



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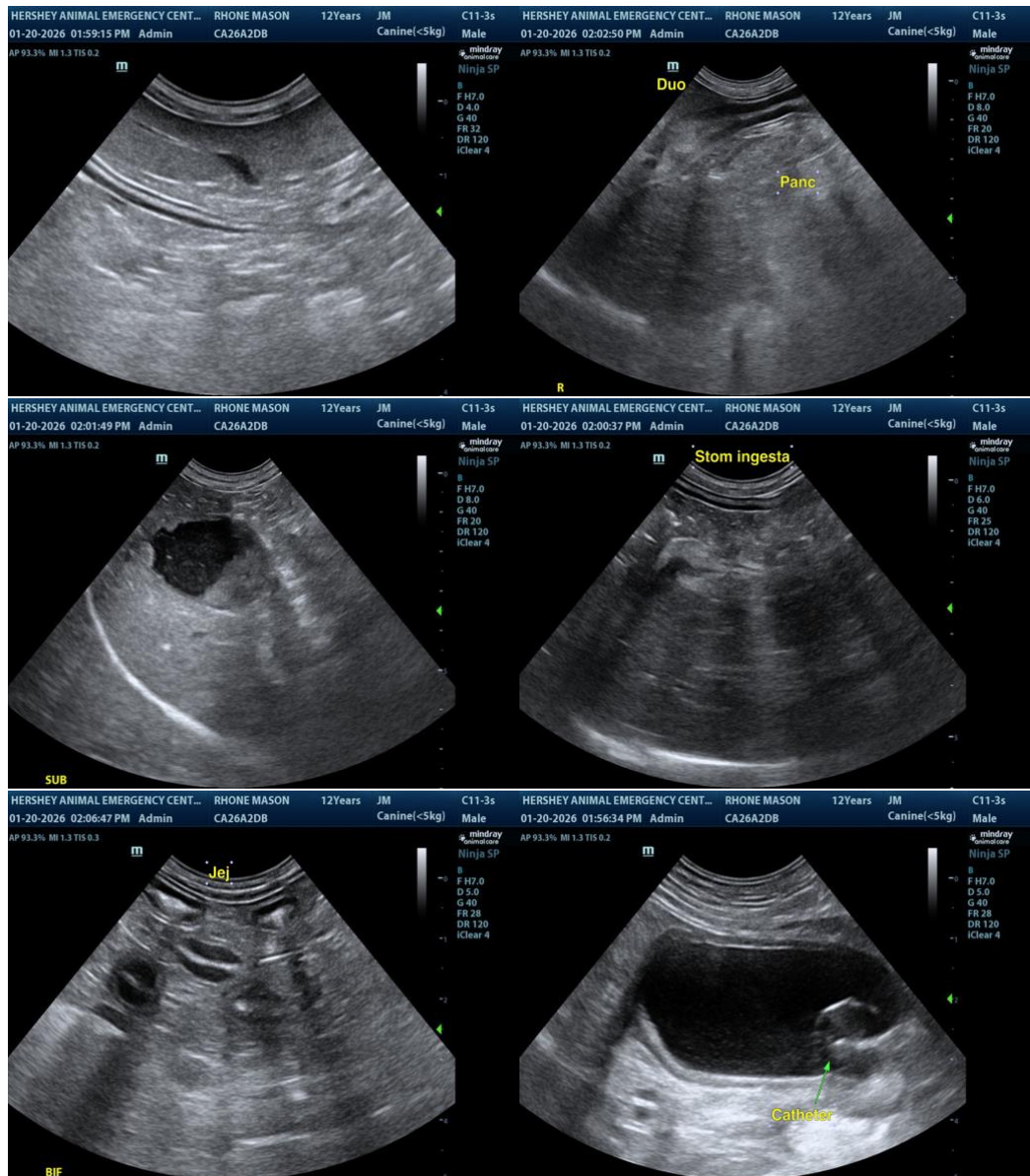
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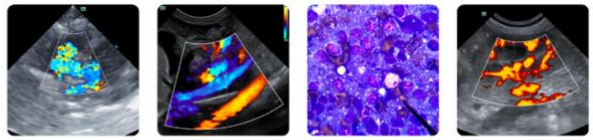
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abdomen/subxiphoid discomfort on palpation. Renal and gastrointestinal support pending additional diagnostics with clinical monitoring and as needed sonographic reassessment if non-responsive or progressive gastrointestinal signs or progressive azotemia is recommended.





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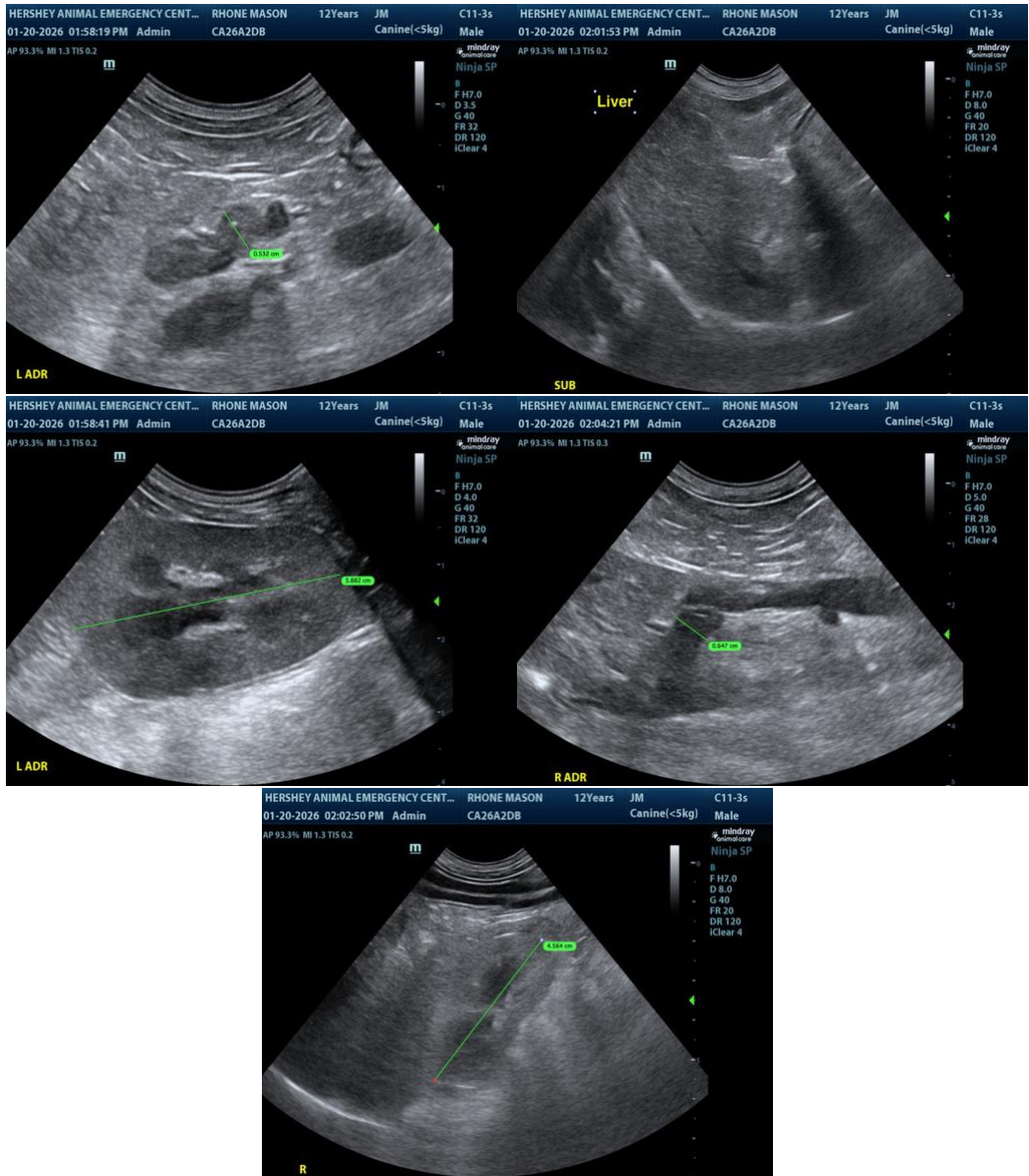
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

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