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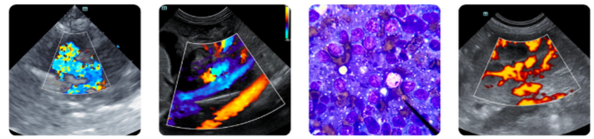


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT
Lenny Hart

SPECIES
Canine

BREED
Shih Tzu

SEX
Male Neutered

AGE
12 y

WEIGHT
6.2 kgs

INTERPRETED BY
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY
Lindsay Powell, CVT

HOSPITAL NAME
Hershey Animal Emergency Center

REFERRING VET
Dr. Cara Sinopoli

INVOICE
12971

DATE
12/19/25

PRESENTING CLINICAL SIGNS

History: Presenting for acute vomiting beginning around 4:00 AM today after reportedly ingesting socks; multiple episodes until ~9–10:00 AM with inappetence and concern for retained gastrointestinal foreign material. Concern for possible FB obstruction on initial rads. Hospitalized for the day at rDVM and received IV fluids and recheck rads still concerning for intestinal dilation. Admitted 12/18 overnight. PE: Unremarkable

Abnormal PE/Chem/CBC/UA Results: EPOC: K+ 3.3 Rads The peritoneal serosal detail is mildly reduced in the cranial abdomen. Stomach contains gas, small quantity of soft tissue content/fluid. Multiple bowel segments are mild to mod dilated containing amorphous soft tissue content, gas compared to others. 1. The segmental sm bowel dilation is concerning for at least a partial obstructive process. given the lack of active vomiting, a segmental functional ileus due to nonspecific gastroenteritis cannot be excluded. this can be influence/masked by use of antiemetics if the patient is stable consider medical management and fasted radiographs in 6 to 8 hours. 2. The peritoneal detail is slightly reduced likely from visceral crowding. Mild effusion/peritonitis is not excluded.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm 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 changes were noted.

The residual prostate was free of pathology.

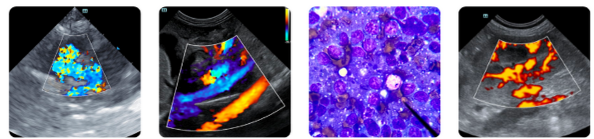
Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Pinpoint areas of medullary mineral present. The left kidney measured 3.8 cm in length. The right kidney exhibited focal to intermittent, small cortical cyst. The right kidney measured 4.5 cm in length.

Adrenal Glands

The left adrenal gland was enlarged in size with cranial and caudal, non-homogeneous, mildly hyperechoic nodules present. Cranial pole nodule measured 1.2 cm x 1.1 cm and caudal pole nodule measured 1.0 cm x 0.85 cm. Overall, the left adrenal gland measured 2.5 cm length x 1.1 cm width in the caudal pole. Intermittent, pinpoint, hyperechoic nodular foci noted. No definitive vascular invasion. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.51 cm width at 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

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented wall thickening with mildly thickened mucosa and mildly prominent rugal fold. Intact wall layering was maintained and distinct. The stomach exhibited moderate distention with retained fluid and no obvious obstruction to pyloric outflow.

The small intestine exhibited overall intact wall layering and maintained wall layer ratio with primarily empty lumen. Minor areas of segmental intestinal ileus were visualized within mid abdomen intestinal segments consistent with jejunal location. Solitary visualized, strongly shadowing lumen echo was present consistent with jejunal foreign body potentially measuring ~3.0 cm in length.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

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

Free Abdomen

Mild surrounding hyperechoic omentum and no obvious visualized significant omental lymphadenopathy or peritoneal effusion noted.

ULTRASONOGRAPHIC FINDINGS

- Hypomotile gastritis
- Subjective non-obstructive jejunal foreign body
- Mild peri intestinal hyperechoic reactive possible mildly inflamed omentum
- Nodular left adrenal gland – hyperplasia, adenomatous change, possible left adrenal tumor
- Bilateral chronic renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Exploratory laparotomy with gross inspection of the gastrointestinal tract and expectation toward enterotomy is recommended. Concurrent inspection of the left adrenal gland at time of surgery and left adrenalectomy, pending gross inspection should be considered. Assessment of systemic BP prior to surgery for evidence of hypertension is suggested. Intestinal biopsies may be considered pending gross inspection of the intestinal tract.

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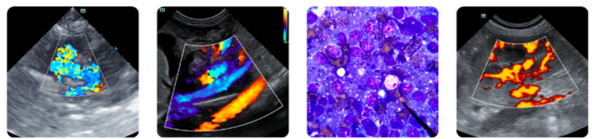

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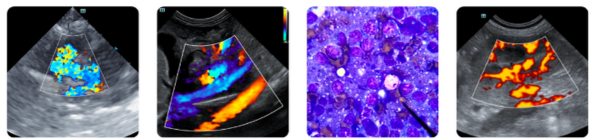

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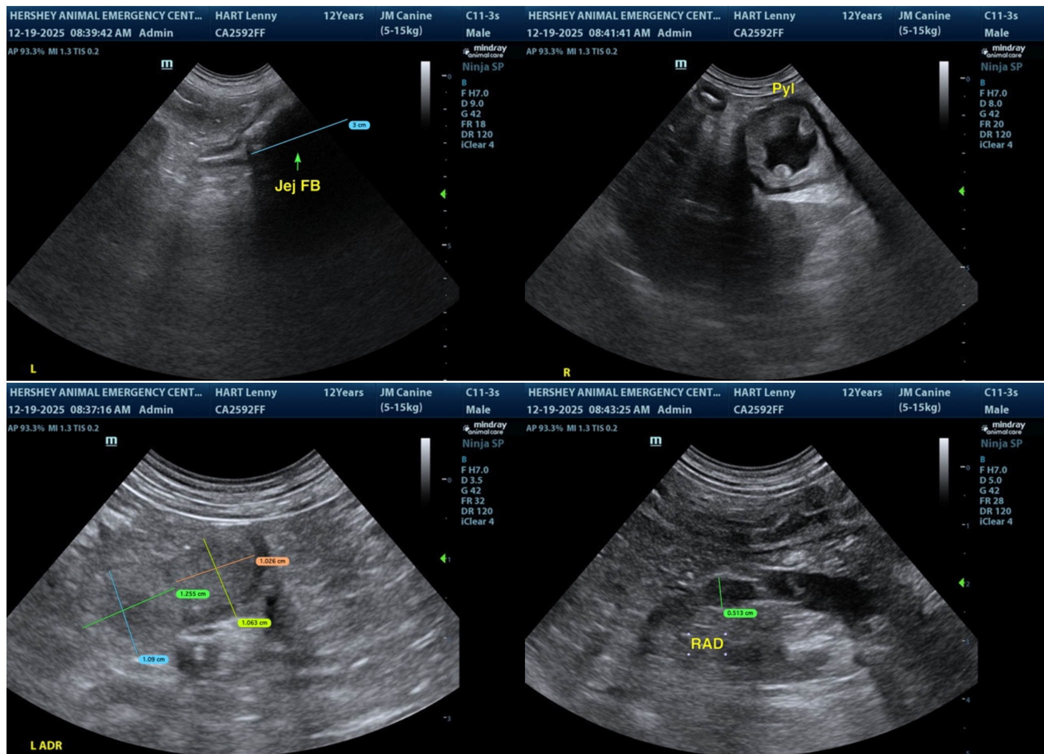

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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