



## PATIENT

Stormy Troutman

## SPECIES

Canine

## BREED

Mini Aussie Mix

## SEX

FS

## AGE

3yr

## WEIGHT

9.2kg

## 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. Brittany Lang

## INVOICE

23964

## DATE

02/24/2026

## PRESENTING CLINICAL SIGNS

- Presented Monday 2/23 at 9:30p for continued lethargy and not eating. Initially seen at HAEC earlier that day - received SQ fluids and Cerenia. Pt seems dehydrated and was having D+, tacky gums and lethargic at home after discharge.
- 5-6% dehydrated, quiet, tense/painful abdomen cranially
- 2/23 (first visit, daytime):
- EPOC: K 3.2 L PCV/TS: 62/5.8 panc lipase: 31
- Imagyst fecal and giardia: Negative

Abnormal PE/Chem/CBC/UA Results: 2/23AM rads: 1. Small amount of gastric soft tissue may be secondary to gastric secretions/fluid and residual food material. A small amount of intermixed foreign material not causing a gastric outflow tract obstruction cannot be excluded. 2. Gas-filled SI loops may represent a variation of normal or segmental small intestinal ileus, e.g. secondary to nonspecific enteritis. 2/23 (re-admission overnight): PCV/TS: 56%/5.0 clear EPOC: Na 139 (L) K 2.9 (L) Cl 100 (L) Albumin: 2.6 Rads: gastric lumen more dilated than original with increased gas throughout gi tract, concern for moving fb vs ileus 2/24 day: Repeat rads: Progressive gastric and duodenal dilation is concerning for a mechanical obstruction that could be due to a duodenal foreign body. Severe and acute gastroenteritis possible.

## 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 mild non-dependent particulate sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 5.0 cm in length. The right kidney measured 5.3 cm in length.

The area of the aortic trifurcation was free of pathology.

### Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.66 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.6 cm width at the caudal pole.

### Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. 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



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thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

### *Liver/Gallbladder*

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. Normal vascular volume. 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 intact wall layering with a normal wall layer ratio. The stomach exhibited moderate to significant distension with retained primarily anechoic fluid. The fluid appeared to exhibit potential oral / aboral movement in the area of the pylorus. No definitive evidence of obstruction to pyloric outflow was present.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Overall empty intestinal lumen in the visualized mid to descending duodenum, as well as primarily through the jejunum to the level of the colon.

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

### *Pancreas*

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

### *Free Abdomen*

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

## ULTRASONOGRAPHIC FINDINGS

### Primary

- Moderate to markedly distended stomach with retained fluid exhibiting potential for oral /aboral pyloric fluid movement
- Overall empty visualized small intestine
- Normal area of pancreas

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the degree of gastric distension with concurrent overall empty visualized small intestine, primary concern for non-obvious upper gastrointestinal tract obstruction, i.e. non-visualized or indistinct foreign body, stricture or mass thought less likely is warranted. Significant metabolic or functional gastric ileus secondary to gastritis cannot be definitively excluded yet no obvious evidence of gastric visualized mural changes which may suggest inflammation.



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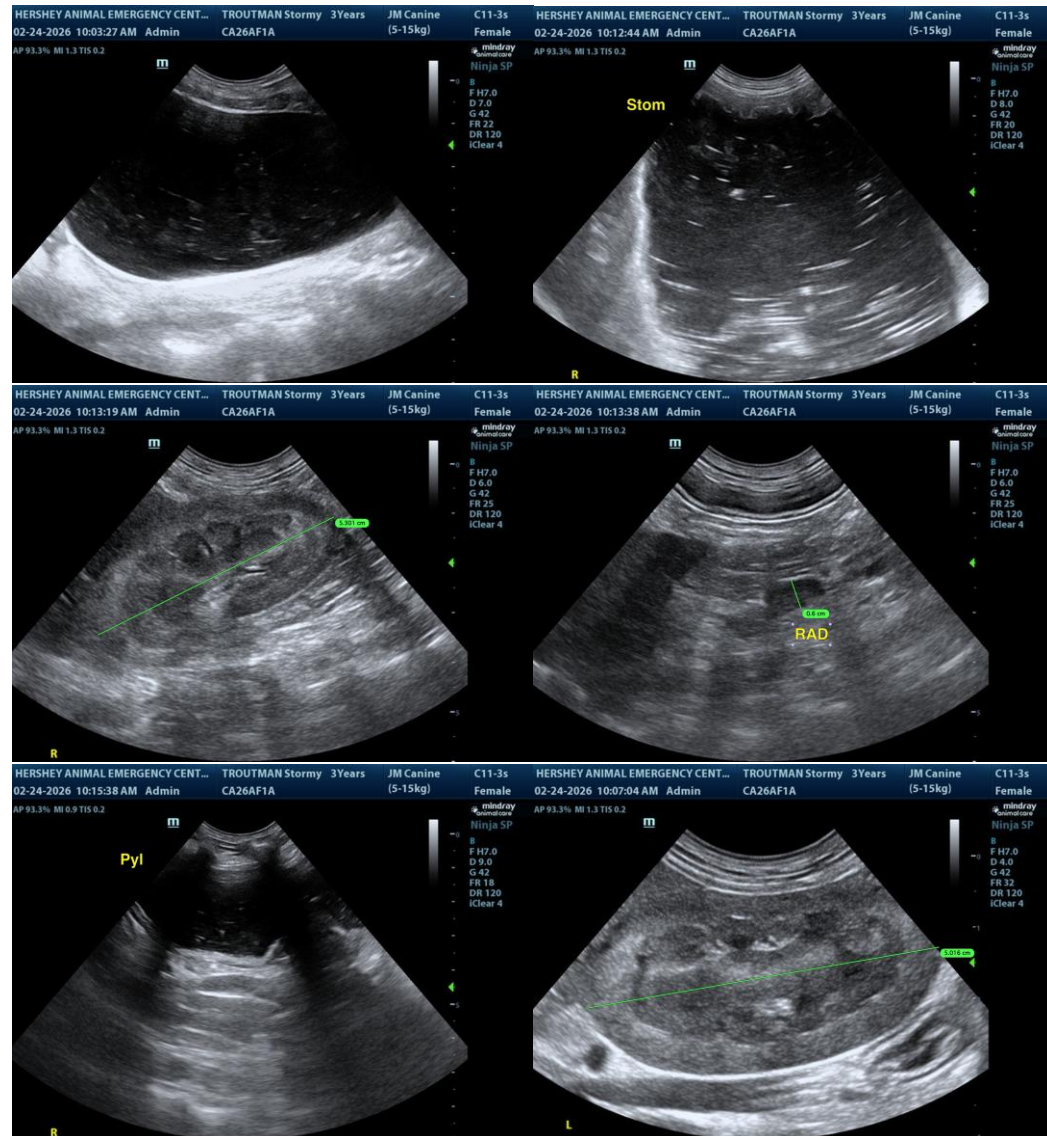
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Exploratory laparotomy with gross inspection of the upper gastrointestinal tract and with biopsies strongly suggested despite exploratory findings is recommended. Alternatively gastric evacuation via nasogastric or esophageal tube ideally followed by upper gastrointestinal endoscopy if available vs gastrointestinal support, documented 12 hour fast and sonographic reassessment of the upper gastrointestinal tract would be more conservative.



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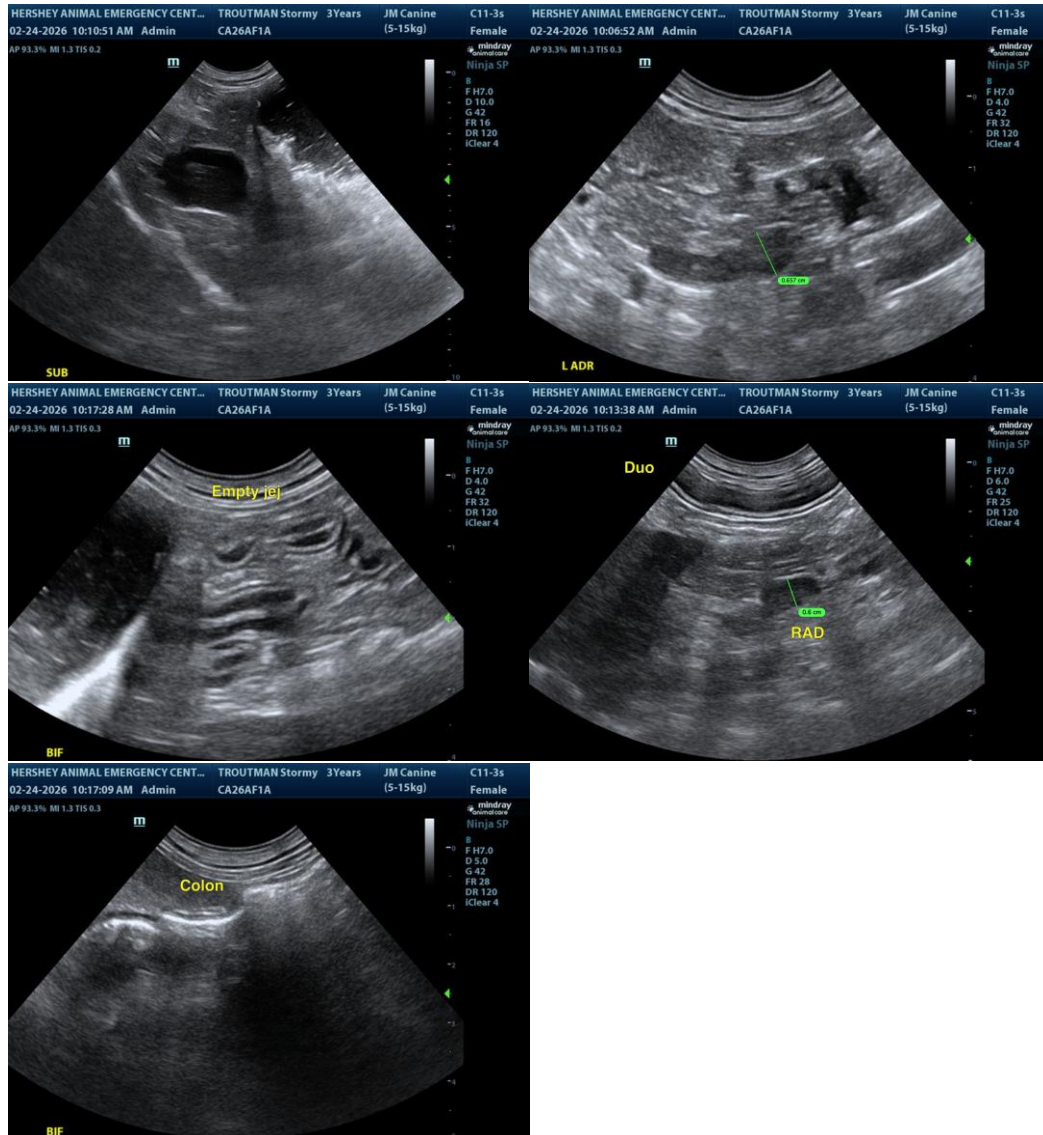
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)  
[info@sonopath.com](mailto:info@sonopath.com)