



## PATIENT

Zoey Reichwein

## SPECIES

Canine

## BREED

Boxer

## SEX

FS

## AGE

11yr

## WEIGHT

26.2kg

## 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. Lauren Keibler

## INVOICE

24211

## DATE

03/16/2026

## PRESENTING CLINICAL SIGNS

- Zoey presented 3/16 morning for acute onset vomiting and abdominal distension. She has not eaten since 3/15 morning. No toxin exposure and not known to eat things she shouldn't. Owner has noticed weight gain and increased drinking recently.
- DDX: Gastric distension
- foreign body vs. ileus Hepatopathy endocrine disease vs. infectious vs. toxic vs. allergic vs. neoplastic Hypovolemia
- PE: Eyes: nuclear sclerosis Abd: abdomen markedly tense, tympanic
- 8-10% Dehydration: Obvious decreased skin turgor; Retracted globes within orbits
- Abnormal PE/Chem/CBC/UA Results: CBC: LYM 0.57, EOS 0.01 CHEM15: GLU 253, ALT 406, ALP 468, CHOL 373 EPOC: Na 152, LAC 5.81, GLU 252 Rads 1. Sm cardiac silhouette and intrathoracic vasculature seen with hypovolemia 2. changes w/in the right middle and cranial lung lobe may represent bronchopneumonia, e.g. secondary to aspiration. Hypoinflation and atelectasis are considered diff dx 3. Gastric soft tissue opacity material suspicious for foreign material with associated gastric gas distention. Residual food material is less likely. A gastric functional ileus currently no convincing radiographic signs of GI outflow tract obstruction. However, a partial or intermittent obstruction cannot be excluded.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. 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 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. Small left kidney cortical cyst was present. The left kidney measured 6.3 cm in length. The right kidney measured 6.3 cm in length.

The area of the aortic trifurcation was free of pathology.

### Adrenal Glands

The bilateral adrenal glands were indistinctly visualized with no obvious pathology. The left adrenal gland subjectively measured 0.51 cm width at the caudal pole The right adrenal gland subjectively measured 0.53 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/Gallbladder**

The liver was subjectively mildly enlarged. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with mild to variable coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. Normal vascular volume. The gallbladder was indistinctly visualized. No evidence of gallbladder overdistension or inflammation.

### **Gastrointestinal**

The stomach was non-distended with overtly normal visible stomach wall. Strongly shadowing lumen content was present measuring ~ 3.5 to 4 cm in diameter along with lumen gas.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine contained mild segmental non-shadowing intestinal ingesta.

Normal visible colon wall layers were present with apparent formed feces 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**

- Strongly shadowing gastric content with mild segmental non-shadowing small intestine ingesta
- Hepatopathy
- Overtly normal bilateral adrenal glands
- Mild chronic renal changes

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

Given reported inappetence for greater than 24 hours, the strongly shadowing gastric content is strongly consistent with gastric foreign material. No overt visualized gastrointestinal mural pathology or small intestine obstructive pattern with mild segmental intestinal ingesta/ chyme probable.

The hepatopathy is non-specific yet most suggestive of benign criteria, metabolic, reactive, vacuolar inflammatory and non-obstructive cholestatic hepatopathy possible with occult hepatic neoplasia thought less likely. Initial rehydration protocol with as needed gastric protectants and sonographic monitoring of the shadowing gastric content for evidence of persistence or gastric emptying would be



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reasonable. If persistent and assuming normal clotting status, gastrotomy with recommended hepatic biopsies at time of surgery would be indicated.

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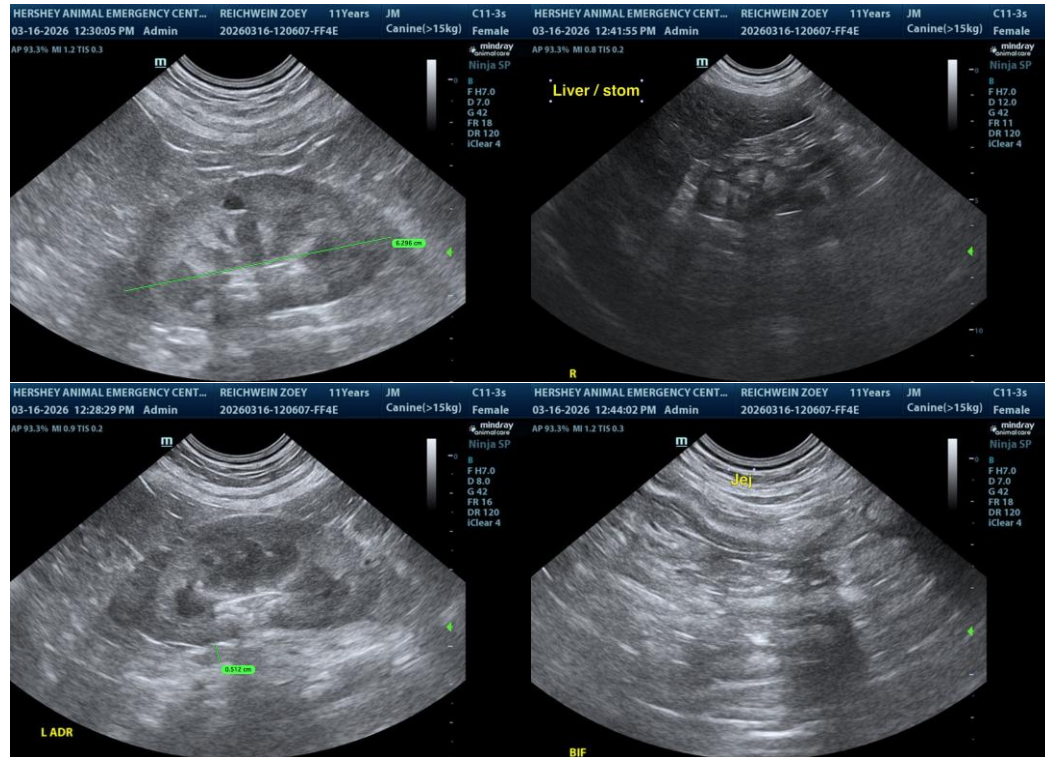
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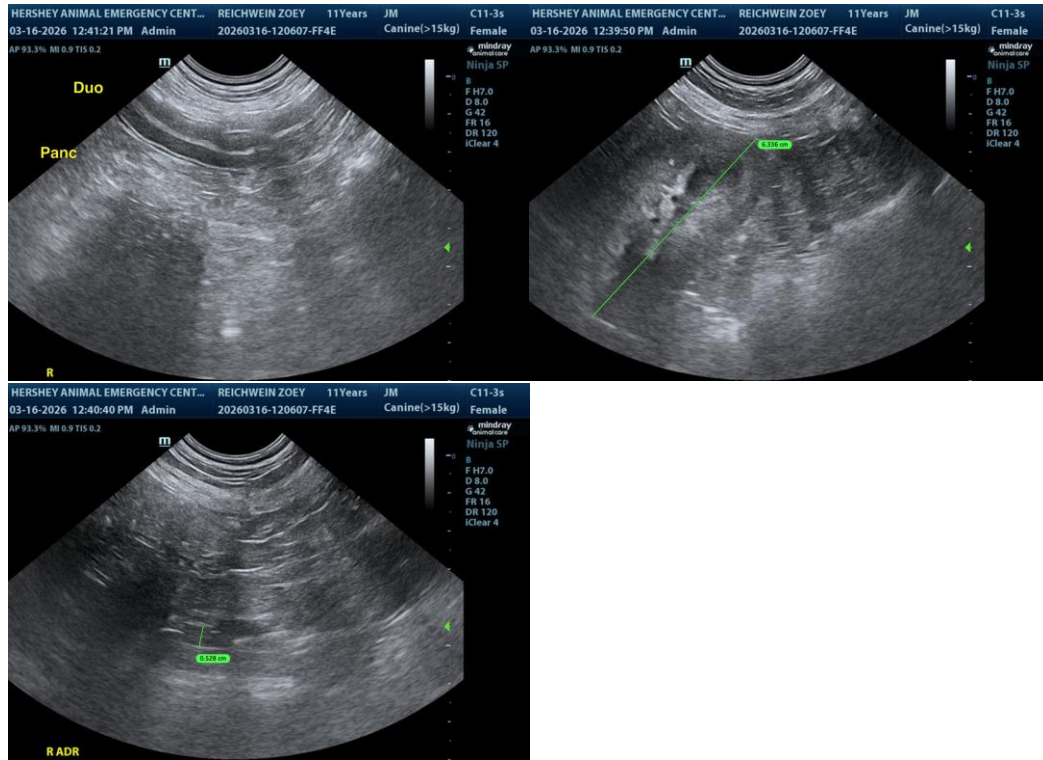
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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