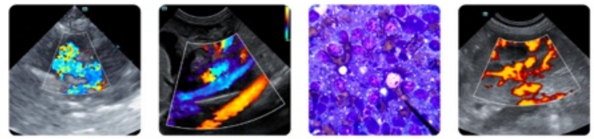


PATIENT

Lucky Lotta

SPECIES

Canine

BREED

Shih Tzu

SEX

Neutered male

AGE

6 years

WEIGHT

14.8 lbs

INTERPRETED BY

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM

IMAGING PERFORMED BY

Danielle Shemanski, DVM, MA

HOSPITAL NAME

Western New York Vetererinay Service

REFERRING VET

Dr. John Hughes

INVOICE

72150

DATE

3/3/26

PRESENTING CLINICAL SIGNS

- RDVM REASON FOR REFERRAL: Vomiting bile daily for two weeks, possibly regurgitation.
- CLINICAL SIGNS: - Presents with a 2-week history of nocturnal bile vomiting (middle of the night, followed by relief/tail wagging). History of atopy/food reactions. - Recent 1-lb weight loss. Diet: Boiled hamburger, rice, carrots, and watermelon (given at 2:00 PM). Water is added to food as the dog won't drink from a bowl. Fed twice daily (9:30 AM and 5:00 PM). Receives daily, long-term 4-in-1 OTC vitamin supplement. Bowel movements are not daily, but stools are normal/non-diarrheic and often require a walk to encourage defecation. Recently began randomly jumping up in pain during the night. Owner reports recent borborygmus. No history of dehydration or fever.
- MEDICATIONS: Famotidine 5 mg BID
- Diagnostics (rDVM) - CBC: Unremarkable. - Blood Chemistry: Unremarkable.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is small with a normal thickness and smooth appearance of the wall. Normal anechoic urine with no sediment or uroliths evident.

Normal appearance of the trigone area, proximal urethra, and iliac blood vessels.

Normal appearance and size of the iliac lymph nodes. Ureters not visualized, which can be considered a normal finding.

Normal renal size (left measured 4.3 cm, right measured 4.2 cm), architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident. Normal color flow pattern is evident in both kidneys.

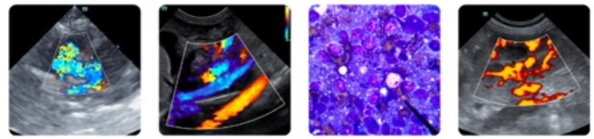
The prostate is small and hypoechogenic measuring 0.7 cm in width.

Adrenal Glands

Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 1.52 cm in length x 0.51 cm and 0.42 cm in width. The right adrenal gland measured 0.61 cm in width.

Spleen

Normal size and echogenic appearance. Smooth homogenous parenchyma and regular curvilinear capsule. Normal volume of the splenic vasculature without any overt congestion or thrombosis evident. No inflammatory, neoplastic, infarction, or infiltrative changes evident. The spleen measured 1.2 cm in width.



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Liver

Normal size, echogenic appearance, portal markings, and regular curvilinear capsule. No nodules or masses evident. Normal appearance of the hepatic and portal vasculature.

Gallbladder

The gallbladder is small containing normal anechoic bile. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.

Gastrointestinal

Normal appearance of the stomach, duodenum, small intestine, ileo-cecal junction, and colon with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen.

Pancreas

The visible sections of the pancreas are of normal size and echogenic appearance with a regular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Enlarged mesenteric lymph nodes measuring up to 1.0 x 2.6 cm in size with an increased echogenic appearance, but maintained a normal shape. FNA was taken of the mesenteric lymph node.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

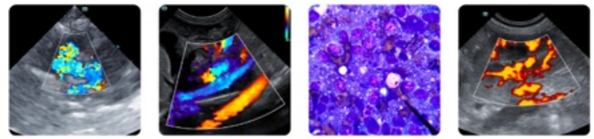
- Mesenteric lymphadenomegaly.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiologies for the mesenteric lymphadenomegaly would be reactive hyperplasia, lymphadenitis and possibly infiltrative neoplasia.

Although the GI tract appears ultrasonographically normal, with the presenting clinical signs an underlying enteropathy such as parasitic enteritis, dietary hypersensitivity and inflammatory bowel disease should still b considered.

Further assessment would be based on the pending cytology results and if the cytology is consistent with reactive hyperplasia, then fecal analysis, cobalamin and folate assay and endoscopy of the upper GI tract would be indicated.



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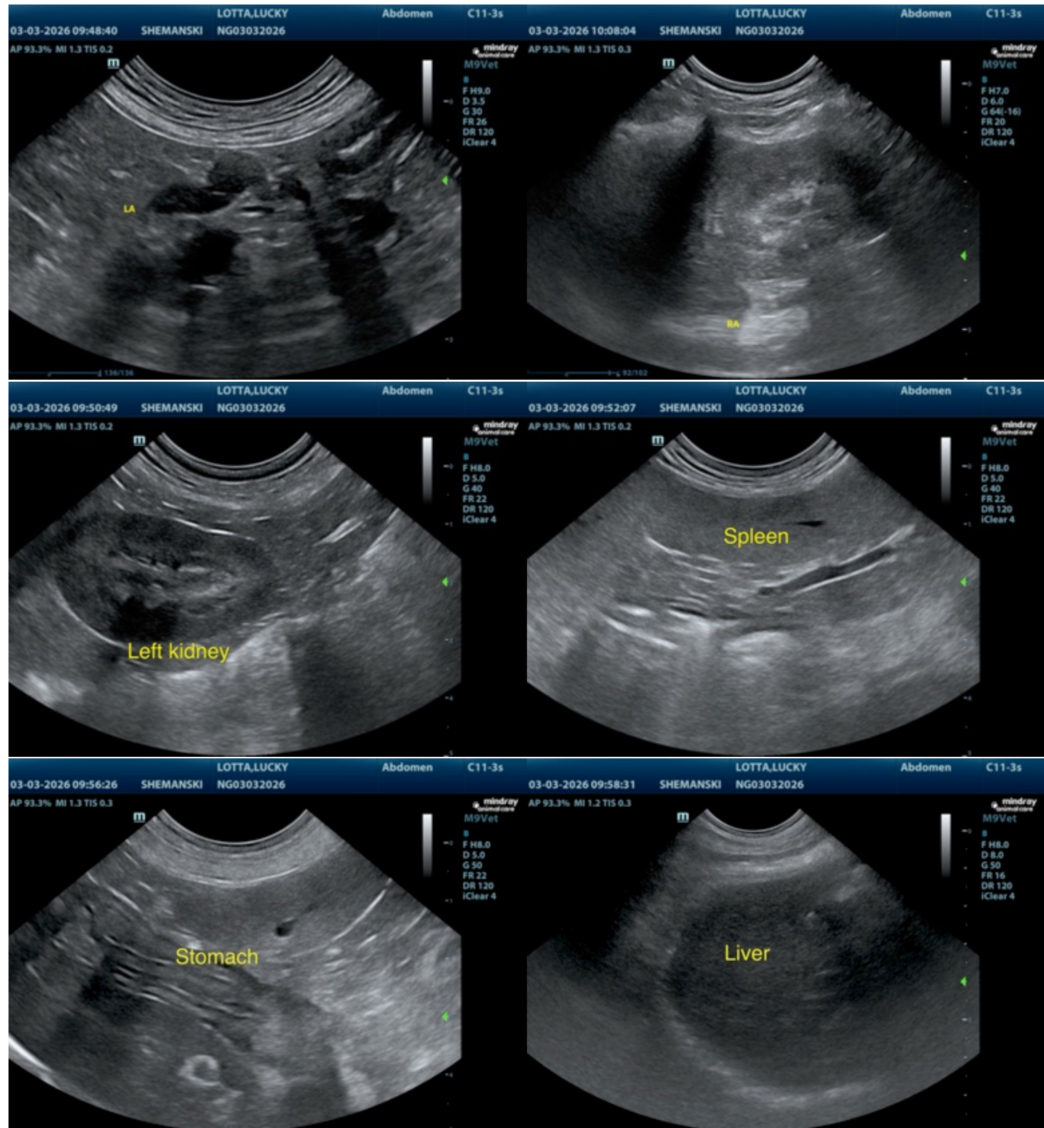
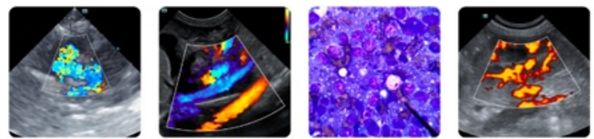
Specific therapy would be dependent on an etiological diagnosis.





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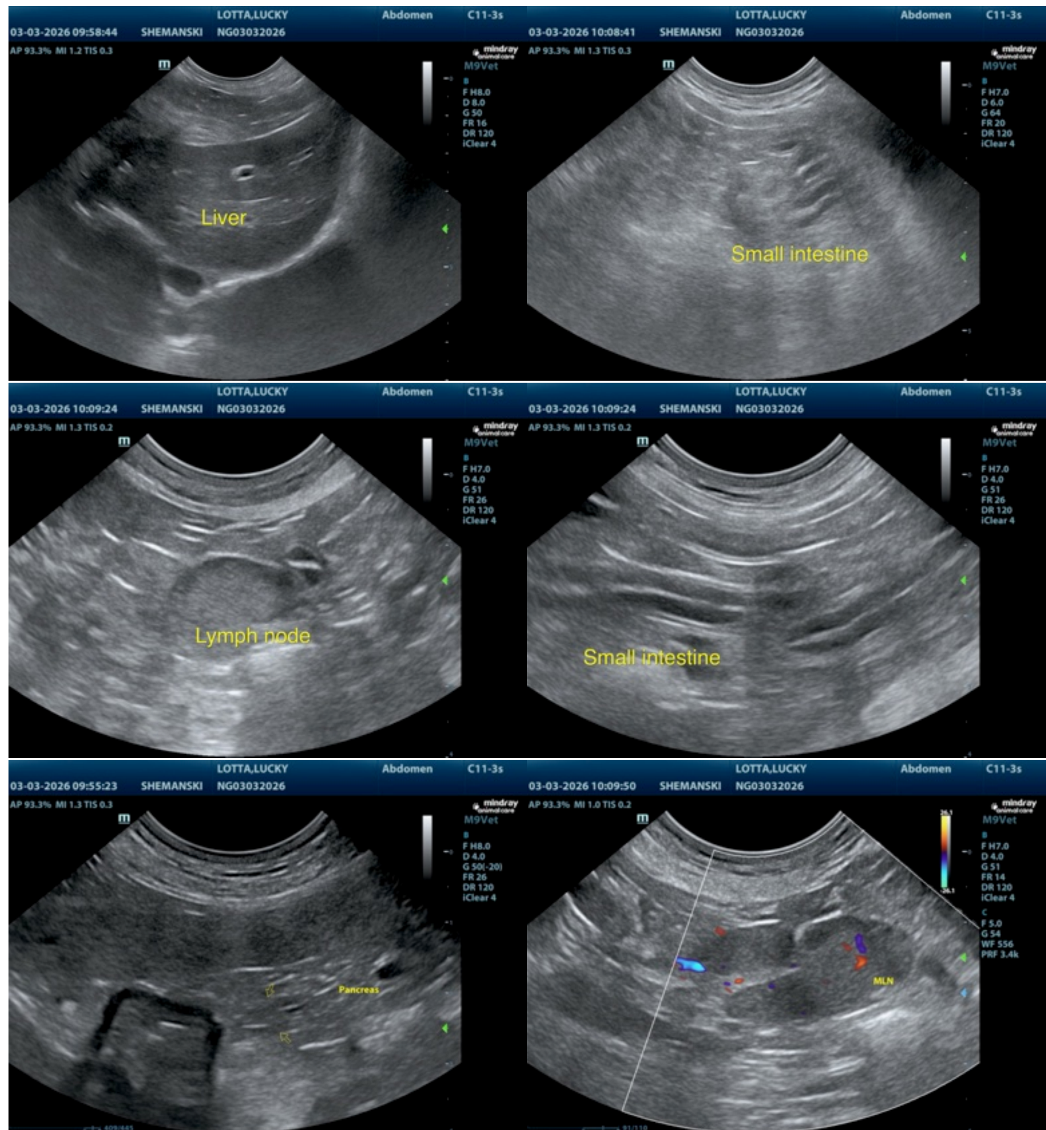

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)

info@sonopath.com