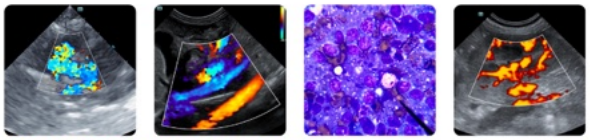


PATIENT

Russell Gragert

SPECIES

Canine

BREED

Pit Bull

SEX

Neutered male

AGE

12 years

WEIGHT

30 kg

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Patti Mayfield, DVM

HOSPITAL NAME

Pawtown VC

REFERRING VET

Dr. Stayer

INVOICE

75259

DATE

5/6/26

PRESENTING CLINICAL SIGNS

History: - Regurgitation, occasional vomiting, decreased appetite, mild lethargy.
- Occasional loose, dark & tarry stool. Some weight loss (~2-3kg over the past year).
- Trial on cerenia & omeprazole showed slight
improvement but signs have returned in the past 5-7 days.
Abnormal PE/Chem/CBC/UA Results: CBC/Chem performed April 21, 2026 - Albumin low (2.2), but otherwise NSF. - Exam unremarkable. - No xrays or further diagnostics performed.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended. The urinary bladder wall is thin and smooth. The urine is anechoic. The bladder neck and proximal urethra are unremarkable. No cystoliths or sonographic evidence of inflammatory or neoplastic urinary bladder disease are identified.

The left kidney is normal in shape and size, measuring 5.89×3.36 cm. Cortical thickness measures 0.50 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. Corticomedullary ratio and corticomedullary distinction are preserved. No pyelectasia, hydronephrosis, or nephrolithiasis is identified. Color Doppler evaluation demonstrates a subjectively normal vascular pattern.

The right kidney is normal in shape and size, measuring 4.68×3.44 cm. Cortical thickness measures 0.49 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. Corticomedullary ratio and corticomedullary distinction are preserved. No pyelectasia, hydronephrosis, or nephrolithiasis is identified.

Adrenal Glands

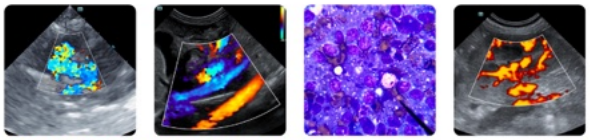
Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.43 cm at the cranial pole and 0.55 cm at the caudal pole. The right adrenal gland measures 0.46 cm at the cranial pole and 0.51 cm at the caudal pole.

Spleen

Splenic thickness is 2.67cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.



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The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic with a small amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal Tract

The stomach is empty and folded, with mural thickness measuring approximately 2.98 mm and preserved wall layering throughout part of the evaluated stomach. However, a large region of the gastric wall demonstrates severe diffuse mural thickening measuring approximately 1.39–1.41 cm, with complete loss of normal mural layer definition.

The pyloric wall measures 5.99 mm. The duodenum is not confidently visualized. Jejunal wall thickness measures approximately 3.02 mm with preserved mural layering. No evidence of obstructive ileus or gastrointestinal foreign material is identified.

Colonic wall thickness measures approximately 1.16 mm, with formed fecal material present within the descending colon.

Pancreas

The evaluated pancreatic regions do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

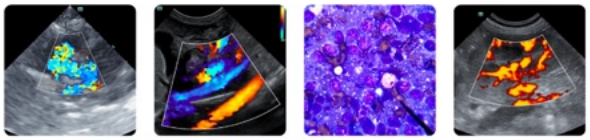
No abdominal effusion or sonographic evidence of peritonitis is identified. Cranial mesenteric lymph nodes are not confidently visualized; however, two rounded hypoechoic left gastric lymph nodes are identified measuring approximately 0.94×1.03 cm and 1.11×1.71 cm. The iliac trifurcation region is unremarkable.

PRIMARY FINDINGS

- Focal severe gastric mural thickening (1.39–1.41 cm) with loss of mural layering.
- Left gastric lymphadenopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A large infiltrative region of severe gastric mural thickening with complete loss of normal mural layering is identified together with regional left gastric lymphadenopathy. These findings are highly concerning for infiltrative gastric neoplasia, with primary differential considerations including lymphoma, gastric adenocarcinoma, or less likely other infiltrative gastric wall neoplasms. Severe focal granulomatous or inflammatory disease is considered less likely based on the degree of mural architectural disruption and associated lymphadenopathy.



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The reported melena, weight loss, hyporexia, vomiting/regurgitation, and hypoalbuminemia are likely explained by the identified gastric lesion. Ulceration associated with the lesion is possible and could contribute to chronic gastrointestinal blood loss and hypoalbuminemia.

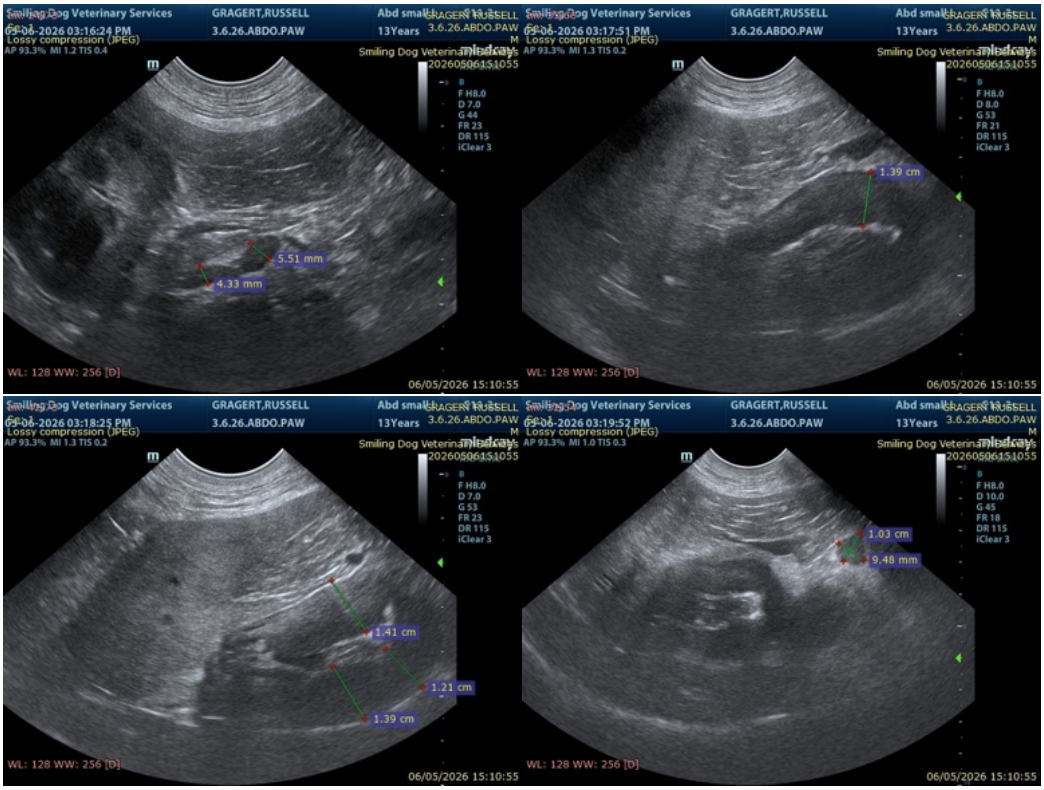
No sonographic evidence of abdominal metastatic disease, abdominal effusion, or overt disseminated abdominal involvement is identified on the current examination, although microscopic or early metastatic disease cannot be excluded sonographically.

The absence of diffuse intestinal abnormalities makes severe diffuse protein-losing enteropathy less likely as the primary explanation for the hypoalbuminemia.

Recommendations

- Endoscopic evaluation with gastric biopsies is strongly recommended if clinically feasible.
- Ultrasound-guided cytology of the enlarged gastric lymph nodes could also be considered for further characterization and staging.
- Thoracic imaging is recommended for staging purposes if neoplasia is pursued diagnostically.
- Supportive management for suspected gastric ulceration, nausea, and nutritional support should be considered clinically pending definitive diagnosis.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.



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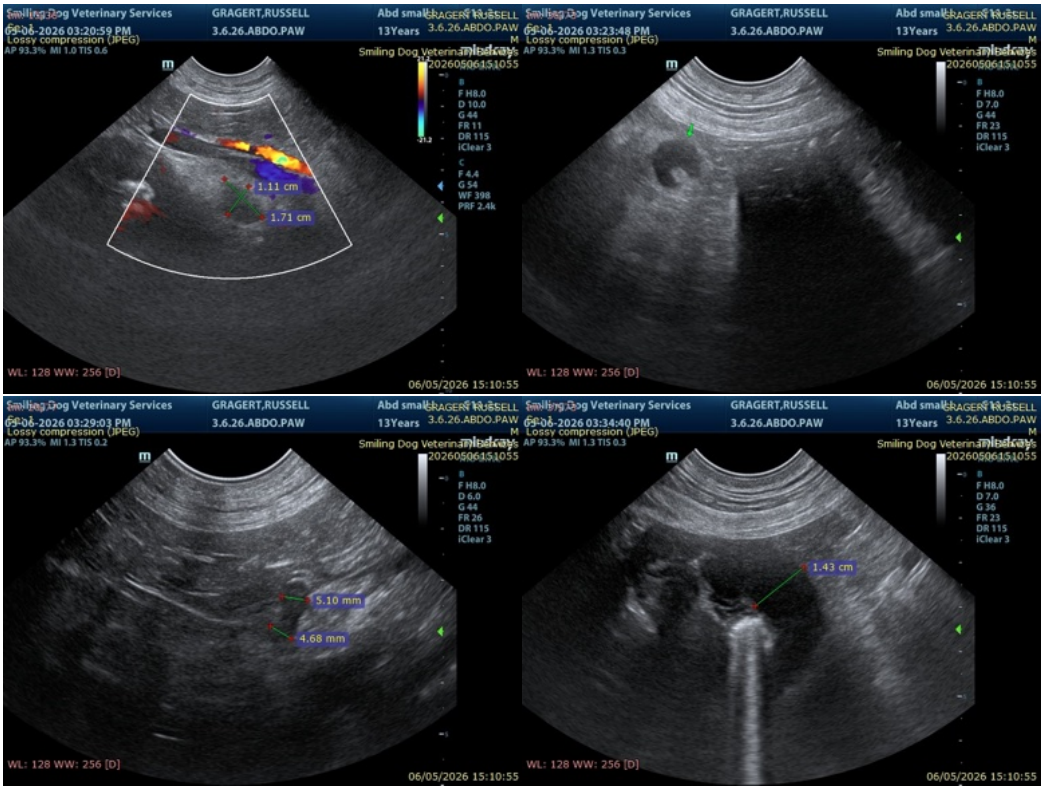

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

info@SonoPath.com