



PATIENT

Millie Luna

SPECIES

Canine

BREED

Maltese x

SEX

Spayed Female

AGE

9 Years

WEIGHT

9.32 lbs

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Pet Care Clinic of the
 High Country

REFERRING VET

Dr. Sturgill

INVOICE

72470

DATE

12/10/25

PRESENTING CLINICAL SIGNS

P presented for US due to 1 yr history of intermittent hyporexia. P will skip food for 24-36 hours about once per week then resumes normal eating. Occasional vomiting. No diarrhea and stools are normal. weight has been stable Previous US- Sept 2024 Splenic nodule (report says 17.8x 12.8cm but i think probbaly meant mm) a possible pulmonary nodule was seen but thoracic radiographs were declined.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measures 3.36 cm. Right kidney measures 4.15 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.41 cm at cranial pole and 0.36 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.43 cm at cranial pole and 0.44 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen contains an approximately 1.2 cm x 1.7 cm hypo- to anechoic non-capsule disrupting nodule/mass near the cranial aspect of the spleen. I believe there is a 2nd similar appearing density measuring 1.4 cm x 2.3 cm in size noted near the caudal aspect of the spleen. However, I'm unable to see both lesions in any image at the same time. Therefore, the same image being measured twice in different views is a possibility.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.



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The visible small intestine demonstrates areas of moderately thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

Mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

The visible heart base (RA) and pericardium are unremarkable without obvious pathology noted in these images at this time. If cardiac function evaluation is desired, a full echocardiogram is recommended.

PRIMARY FINDINGS

- Moderate inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- Very mild reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- The hypo- to anechoic splenic nodule(s) could represent benign lesions such as cysts, hematomas, nodule hyperplasia, extramedullary hematopoiesis, etc. However, infiltrative neoplasia can mimic benign lesions and can't be ruled out without tissue sampling, especially if there are two lesions now compared to the reported one lesion described in patient's history a year ago.

SECONDARY FINDINGS

- Age related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Fine needle aspirates of the splenic nodule(s) could be considered if patient's coagulation status is appropriate.

Having said that, these findings are of unknown, if any relation to patient's reported gastrointestinal



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history. Therefore, additional gastrointestinal workup may also be warranted, including a routine fecal/giardia exam if not recently evaluated.

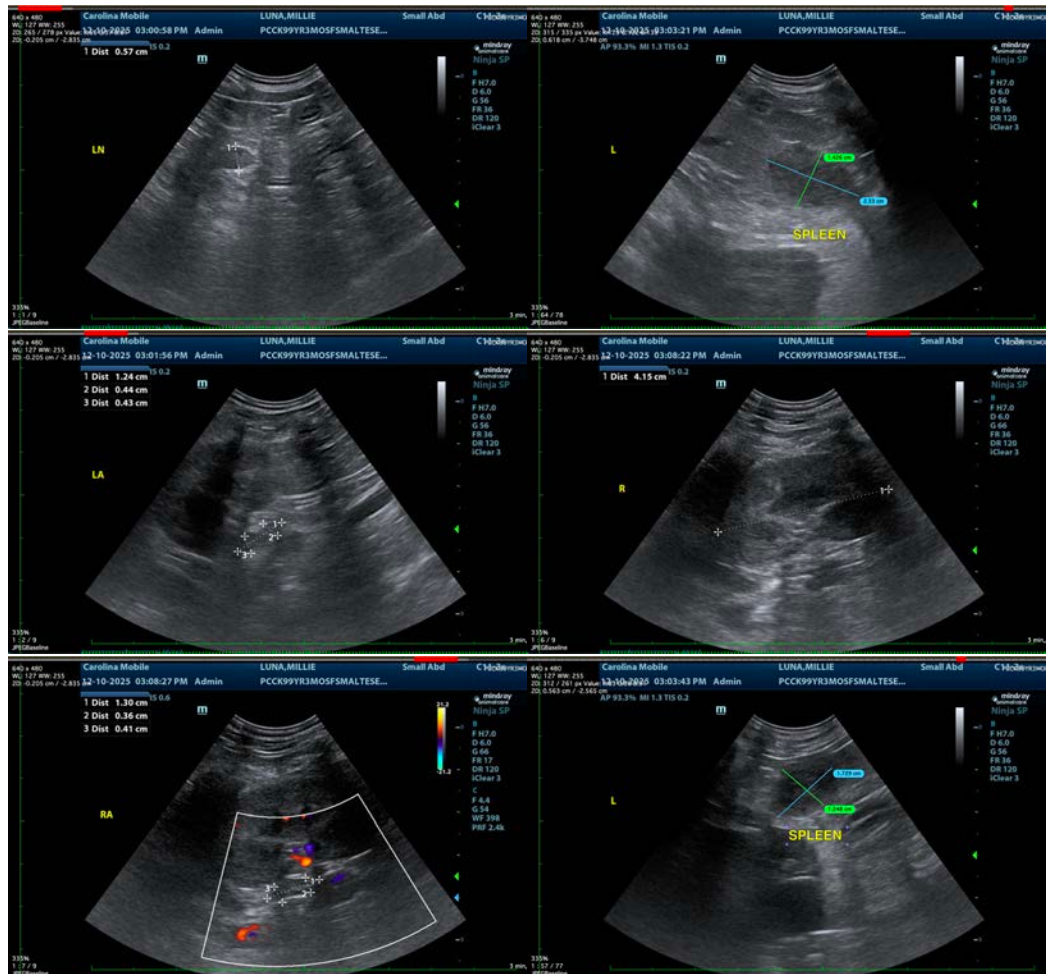
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, gastroprotectants (+/- sucralfate, especially with any history of hematemesis), an appetite stimulant and fluid therapy if indicated, etc.

Additionally, empirical deworming with a 5-day course of Panacur is recommended as is a full course of empirical Helicobacter triple therapy.

Finally, if tolerated, a transition in diet could be considered, based on trial-and-error response with some options to consider including a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs an easy to digest, bland or low-fat diet vs other.





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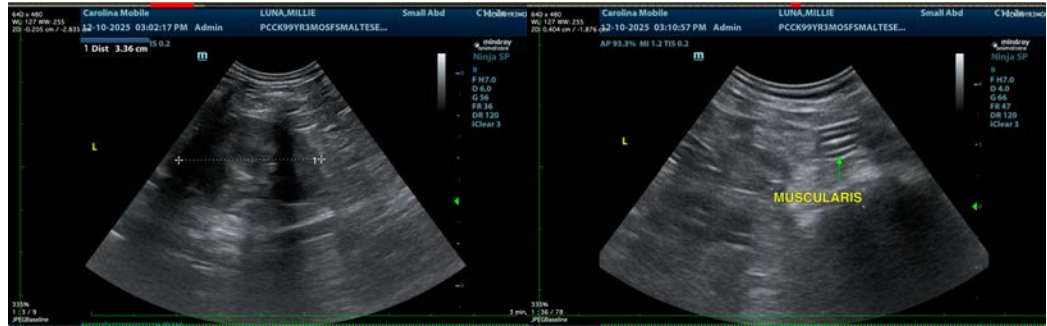
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
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