



PATIENT

Lucky Monjar

PRESENTING CLINICAL SIGNS

SPECIES

Canine

BREED

Border Collie

SEX

Neutered Male

AGE

11 Years 5 Months

Chief Concern: Lucky is presenting for anorexia, inappetence, regurgitating and dark tarry stool. O reports he regurgitates even small amounts of food or treats anywhere between 5-60mins post eating. This has been going on for about a week. O said that Lucky has been getting into the trash more lately but hasn't really had much energy the past 5-7 days. Diagnosis: ddx: gastritis vs FB vs pancreatitis vs neoplasia History and Physical Findings: Mentation: QAR BCS:4/9 Hydration status: 10-15% dehydrated MM Pink, capillary refill time less than 2 seconds. Heart auscultates normally, no murmur or arrhythmia noted. Lungs auscultate normally. Hair coat appears healthy. OU appear normal. AU are clean in visible ear canal. Nose appears normal. Mouth appears to have grade 2/4 periodontal disease. LN are WNL. Abdomen palpates mildly tense, no obvious mass on palpation. No signs of lameness. Radiographic Abnormalities: On lateral radiograph appreciated an enlarged stomach and a thickening in the pylorus region. Mild loss of detail throughout the intestines. Liver and spleen appear to be displaced caudally. Summary of Laboratory Abnormalities: Mild elevation in ALT and mild hypokalemia on chemistry. Mild lymphopenia on CBC. No other Page 1 of 2 significant findings. Current Therapy and Medications: Rx: 1g Sucralfate and Cerenia SQ Discussed sending owner with 10g Prednisone (1 tab SID/BID) continuing sucralfate and cerenia as needed. O has not started this therapy.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

WEIGHT

52 Pounds

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

INTERPRETED BY

Kathleen Sennello DVM,
MS, Diplomate ACVIM
(Small Animal Internal
Medicine)

The visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

IMAGING BY

Loetitia Saint-Jacques,
LVT

The left kidney has a normal shape and size (7.42 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

HOSPITAL NAME

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The right kidney has a normal shape and size (7.05 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

REFERRING VET

Dr. Anna Lopez

Adrenal Glands

The left adrenal gland is normal in size measuring 0.65 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

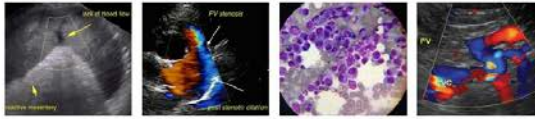
The right adrenal gland is normal in size measuring 0.43 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

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Spleen

The spleen is subjectively normal in size, echotexture is homogenous. The blood flow through the hilus and splenic parenchyma appears normal. There is a mixed echogenic, somewhat moth eaten appearing, hypoechoic nodule visualized measuring 1.69 cm x 2.46 cm, deviating the splenic capsule.

SPECIES

Canine

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There are numerous hyperechoic nodules visualized within the parenchyma. Examples measure 1.81, 1.09, and 1.23 cm in diameter. A larger hyperechoic nodule measures 1.76 cm x 2.44 cm. Additionally, there is a hypoechoic nodule measuring 1.35 cm in diameter on the left side of the liver.

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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

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Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material, most consistent with normal ingesta and fluid. The gastric wall appears somewhat thickened, measuring 1.17 cm in thickness with reduced detail of wall layering. This appears to involve the area of the pyloric antrum and pylorus primarily. Findings are concerning for infiltrative disease, but other differentials are possible.

WEIGHT

52 Pounds

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is mildly/moderately increased. Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Jejunum wall measures 0.42 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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Kathleen Sennello DVM,
MS, Diplomate ACVIM
(Small Animal Internal
Medicine)

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

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Pancreas

The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

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Free Abdomen

There is a scant to small amount of free abdominal fluid. There are enlarged mesenteric lymph nodes measuring 1.0 cm and 0.91 cm in width. There is a gastric lymph node that is enlarged and hypoechoic, measuring 1.07 cm x 1.43 cm. The omentum is hyperechoic around the enlarged lymph nodes.

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ULTRASONOGRAPHIC FINDINGS

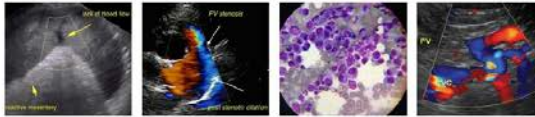
- Mixed echogenic/moth eaten appearing, hypoechoic splenic nodule – There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid

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hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

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- Heterogeneous liver with numerous hyperechoic nodules and a hypoechoic nodule – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. The nodules visualized are most consistent with benign lesions, although underlying neoplastic lesions cannot be excluded as possibilities.

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- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.

SEX

Neutered Male

- Gastric wall thickening with decreased detail of wall layering – Findings are concerning for infiltrative disease such as neoplasia, although edema and severe gastritis are possible differentials.

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- Moderately thickened small intestine – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia.

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- Scant free abdominal fluid

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- Moderate cranial abdominal mesenteric lymphadenopathy – The moderate mesenteric lymphadenopathy is most concerning for a neoplastic process, although you can see significant lymphadenopathy in some cases of autoimmune/inflammatory disease, infectious disease (tick born disease-such as bartonella, fungal infections, FIP (cats)) etc. A fine needle aspirate with cytology is recommended for further evaluation.

IMAGING BY

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastric wall appears abnormal in that it is thick with reduced detail of wall layering. Additionally, there are some prominent mesenteric and gastric lymph nodes visualized. Consider a fine needle aspirate of a mesenteric or gastric lymph node. If a cytologic diagnosis cannot be obtained, then biopsies must be considered. Endoscopic biopsies are less involved, but there is a chance that full thickness biopsies may be necessary to obtain a diagnosis. Additionally, you could sample lymph nodes, liver, and remove the spleen. If this is too much, consider 3-view thoracic radiographs, a fine needle aspirate of the liver, spleen, and a mesenteric lymph node to start.

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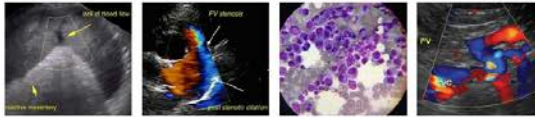
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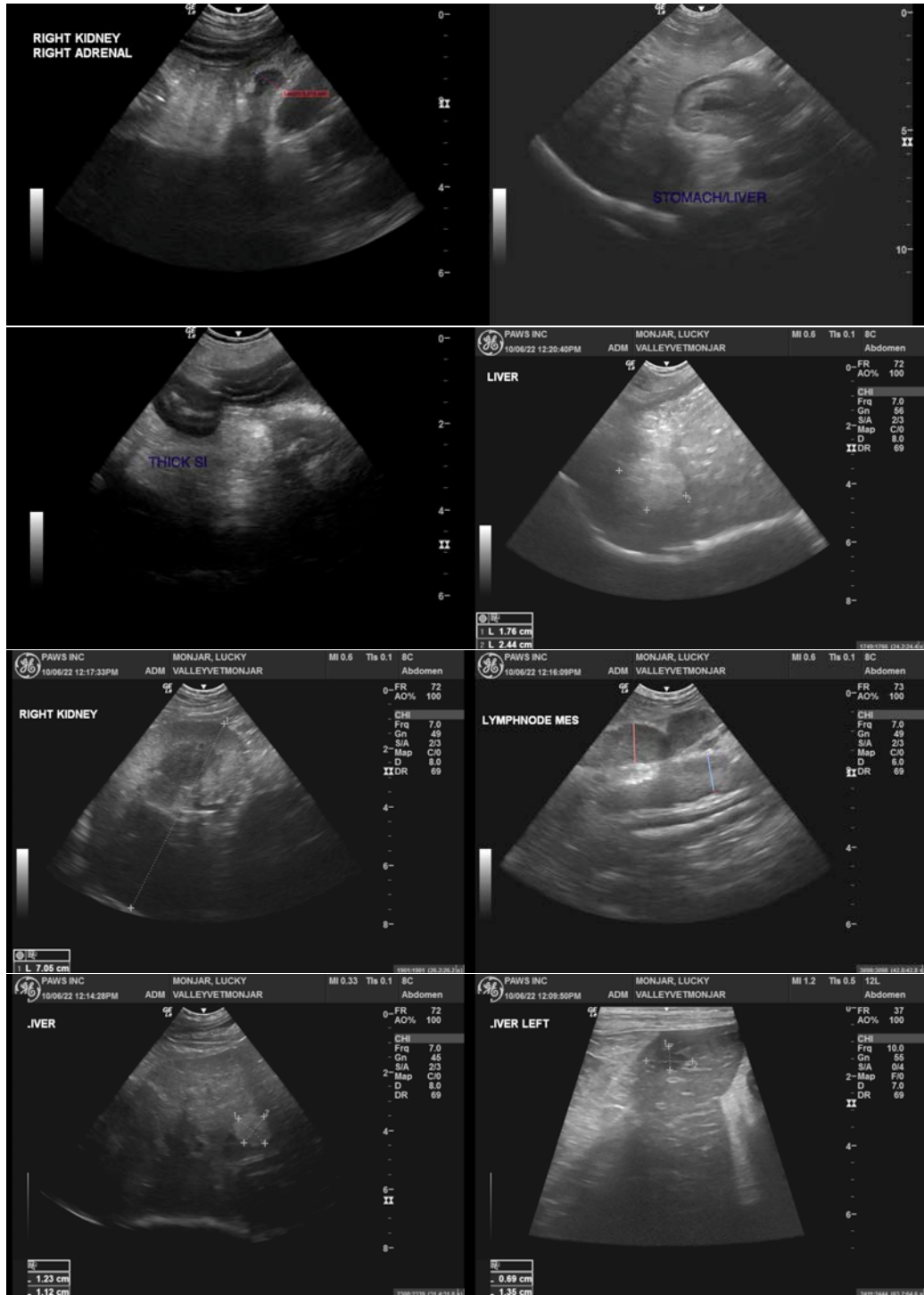
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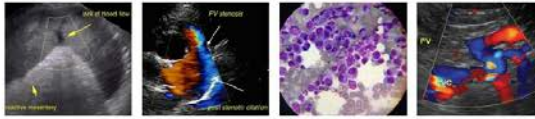
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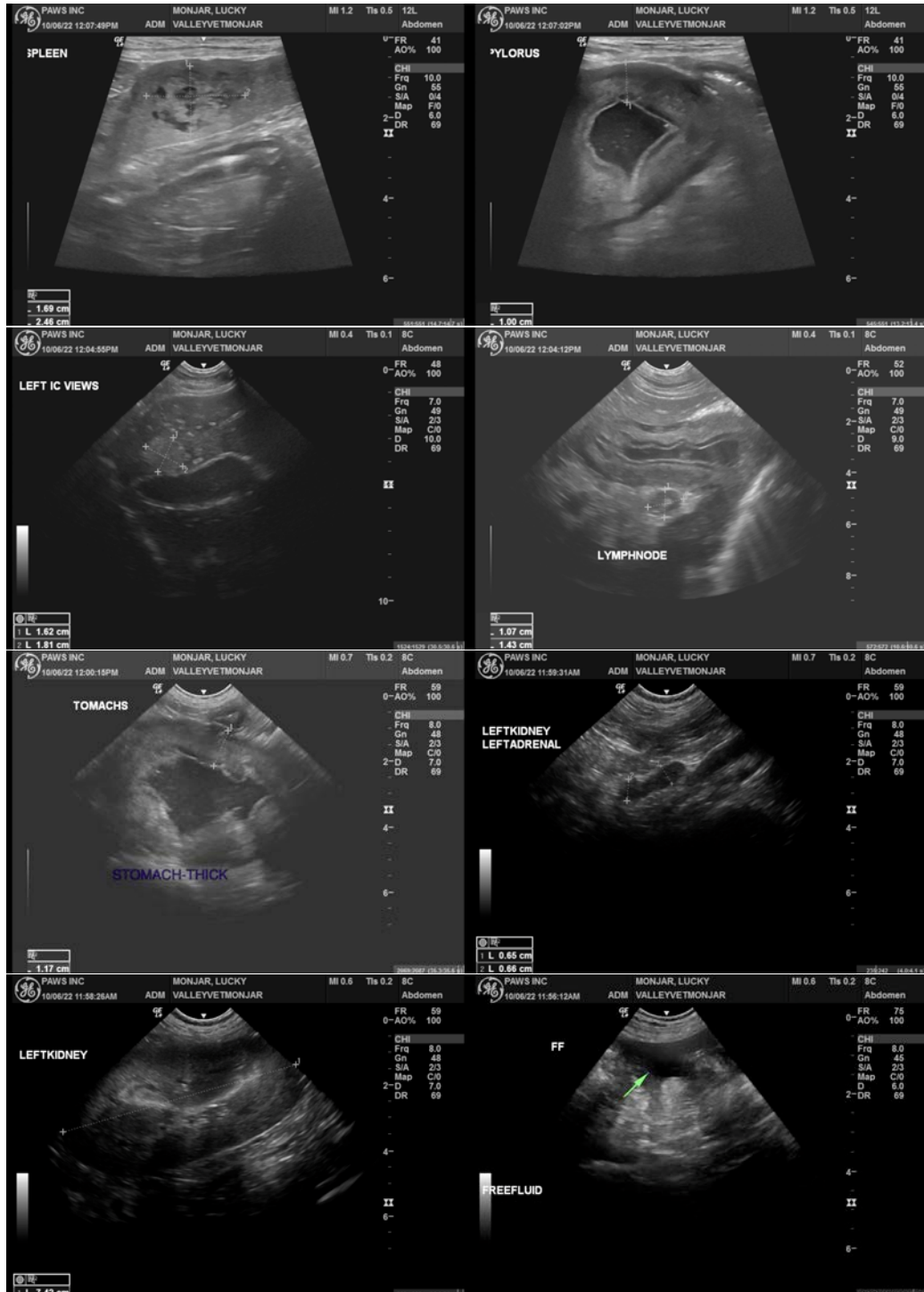
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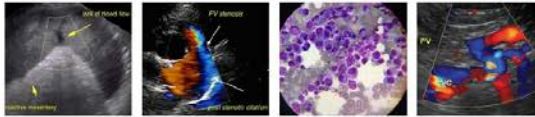
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Portable Animal Wellness Sonography, Inc.

IMAGING PERFORMED BY

pawsonography@gmail.com  530-786-8340

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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.

SPECIES

Canine

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.

BREED

Border Collie

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)
kathleen.sennello@sonopath.com

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