



PATIENT

Charlie Faci

SPECIES

Canine

BREED

Maltese Mix

SEX

MN

AGE

8 years 9 months

WEIGHT

6.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Mariusz
Chmielinski

HOSPITAL NAME

Apex Veterinary
Services Ltd.

REFERRING VET

Alpine 24/7 – ER
Doctor

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DATE

2/24/2026

PRESENTING CLINICAL SIGNS

- Chronic vomiting, inappetence, and progressive weight loss. Vomiting bile/acid, primarily early morning.
- Recent recurrence with 3 vomiting episodes in one day.
- Recent diarrhea 48-hour anorexia Drinking normally.
- Temporary improvement with maropitant (Cerenia.)
- No response to omeprazole, sucralfate, or clindamycin.
- Clinical Course.
- Initial visit ~10 days prior for similar GI signs.
- Weight loss progression from ~8–9 kg to 6.4 kg.
- Significant ongoing weight loss (approx. 1.6–2.6 kg total.)

Abnormal PE/Chem/CBC/UA Results: Mentation: BAR Mild dehydration initially (<5%), normal at recheck Tachycardic when stressed Cranial abdominal discomfort on palpation

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

The prostate is normal in size (0.68 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (4.27 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.

The right kidney has a normal shape and size (4.21 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.

Adrenal Glands

The left adrenal gland is plump in size measuring 0.56 cm at the cranial pole and 0.59 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 plump in size measuring 0.53 cm at the cranial pole and 0.6 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.

Spleen



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The spleen is subjectively normal in size (1.12 cm) and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

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Liver

The liver is normal in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is mildly heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There are numerous poorly defined, hypoechoic nodules in the parenchyma, typically measuring between 0.25 cm and 1.0 cm.

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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. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible. There is a small, hyperechoic non-shadowing structure visualized in the dependent portion of the gallbladder, most consistent with adhered debris or a small polypoid lesion. Recommend continued monitoring.

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Gastrointestinal

The stomach has significant fluid distension. Some of the areas of the gastric wall appear normal, measuring at 0.4 cm with intact wall layering. The region of the pylorus appears severely thickened measuring up to 1.4 cm. There is severe thickening of the gastric wall in the region of the pylorus. Wall layering is visible but somewhat diminished. The pyloric lumen is narrowed, likely resulting in a partial outflow tract obstruction.

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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured as normal (0.3 in wall thickness) and the jejunum measured as normal (0.24 cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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.

Pancreas

The pancreas is prominent and hypoechoic in the left limb. 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

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. There is significant reactive mesentery around the pyloric region of the stomach.

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ULTRASONOGRAPHIC FINDINGS

- Bilaterally plump adrenals. Findings could be consistent with anatomic variation, mild hyperplasia, etc.
- Pancreatic changes consistent with chronic pancreatitis remodeling +/- chronic pancreatitis.

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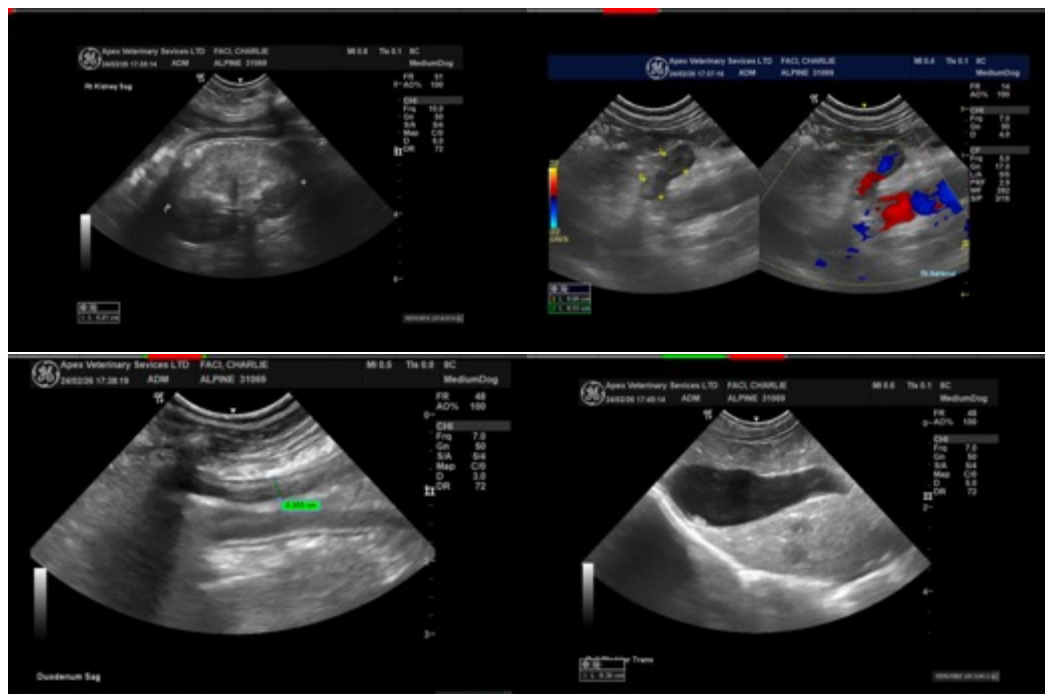
- Heterogenous liver with hypochoic nodules. The nodules visualized could be consistent with regenerative nodules or similar. Metastatic nodules cannot be ruled out.
- Fluid distended stomach with severely thickening pyloric wall with reduced detail wall layering. Findings are concerning for gastric neoplasia (round cell neoplasia, carcinoma, other.) Although acquired pyloric hypertrophy cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach is significantly fluid distended and the pyloric wall is thickened resulting in a narrowed pyloric lumen/outflow tract. The hypochoic appearance of the gastric wall is concerning for possible infiltrative neoplasia (primary differential), although other causes such as severe gastritis, edema, hypertrophy etc.. are possible. If a safe window for sampling is available, consider a fine needle aspirate of the gastric wall as this could potentially diagnose round cell neoplasia. Otherwise, full thickness surgical biopsies may be necessary (+/- pylorotomy at the same time?)

There are numerous ill-defined hypochoic nodules in the liver. These could represent regenerative nodules, small metastatic lesions, etc. If a safe window for sampling is available, consider a fine needle aspirate.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.





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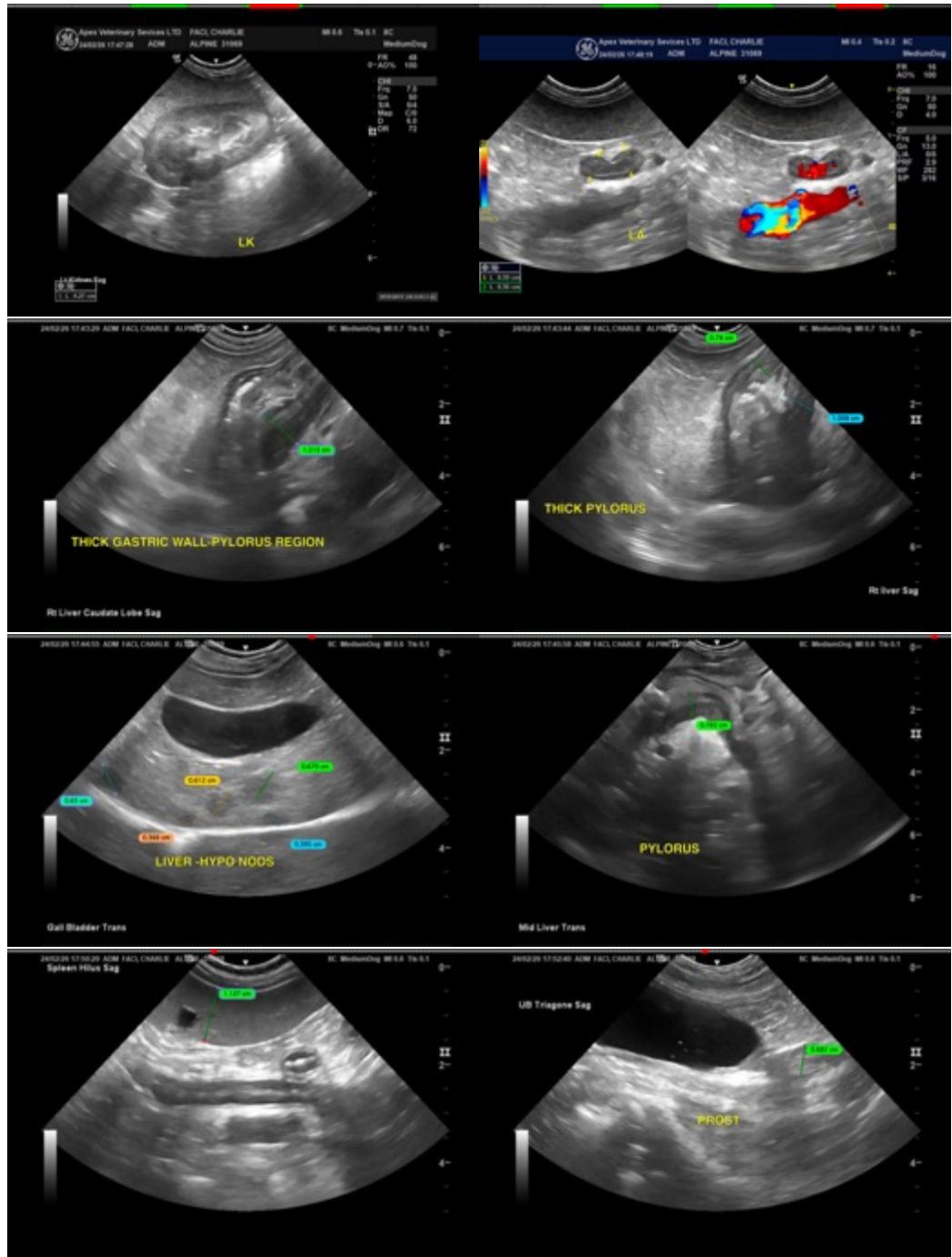
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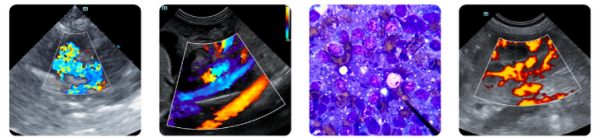
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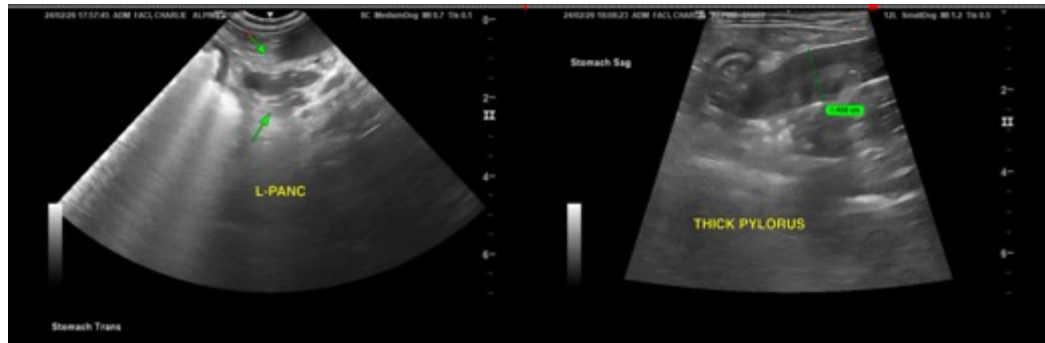
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

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