

PATIENT

Chester Heunfeld

SPECIES

Canine

BREED

Welsh Corgi

SEX

Neutered Male

AGE

10 Years 9 Months

WEIGHT

30.5 pounds

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP (Canine
/ Feline Practice)

IMAGING PERFORMED BY

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

Sierra Pet Clinic

REFERRING VET

Dr. Sperka

INVOICE

15056

DATE

04/13/26

PRESENTING CLINICAL SIGNS

P has SOFTissueSarcoma- just staged for sx removal at BP. In addition, P has hypoalbuminemia - with concurrent symptoms including chronic diarrhea/loose stool. Now P has become more lethargic, hyporexic, unsettled at night, eye redness and intermittent coughing when drinking water. BP did chest rads - no mets found but did see bronchointerstitial patterns - either age/body related or bronchitis. O mentioned P has had increased drinking. P originally was doing well on Biome (normal feces and appetite), then switched to wet food, then back to regular kibble and since P appetite has been steadily decreasing. O has been trying blended chicken + rice, P liked this for 3 days then stopped. Now O offering slices of turkey and cheese if P is interested.

Abnormal PE/Chem/CBC/UA Results: Chronic diarrhea, lethargy, hyporexia, weight loss, pyrexia (? - or nervous in clinic) STS, hypoalbuminemia Anemia Low Platelet LABS attached

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

The area of the residual prostate appeared normal and free of pathology.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 5.8 cm in length. The right kidney measured 5.9 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.53 cm width at the caudal pole.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.71 cm width at the caudal pole.

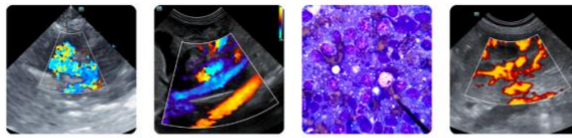
Spleen

Marked asymmetrical splenomegaly exhibiting generalized nonhomogenous hypoechoic parenchyma including indistinctly margined hypoechoic nodules. Normal splenic vascularity. An example of splenic nodules measured 1.8 cm in diameter.

Liver & Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non distended in size with mild nonorganized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.



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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained variably echogenic, mild nonshadowing ingesta without signs of obstruction or foreign material.

Generalized increased intestinal mucosa echogenicity with segmental hyperechoic mucosa speckling to echogenic mucosal striations were present. Intestinal wall layering was maintained with maintained 1:3 muscularis / mucosa ratio. There was no evidence of an obstructive pattern or foreign material. The appearance of the small intestine is most consistent with protein losing enteropathy or lymphangiectasia. There was no evidence of infiltrative or neoplastic intestinal disease which is considered unlikely but cannot be ruled out without full thickness or endoscopic biopsies. Segmental similar appearing intestinal nonshadowing ingesta/chyme and mild nonobstructive intestinal ileus.

Normal visible colon wall layers were present with soft fecal matter.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

Medial iliac lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example of the lymph nodes measured 1.5 cm x 0.45 cm. Regional perisplenic hyperechoic omentum and mild volume of peritoneal effusion were present.

Rapid view of the heart revealed no evidence of pericardial masses or effusion in the visible window.

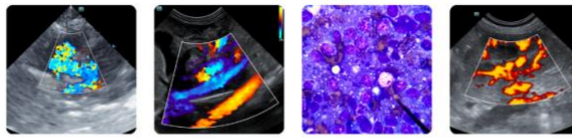
ULTRASONOGRAPHIC FINDINGS

- Marked splenomegaly exhibiting nonhomogenous hypoechoic to nodular parenchyma-consistent with infiltrative neoplastic criteria.
- Sonographically unremarkable normal volume liver.
- Nonorganized gallbladder debris (non-mucocele).
- Intestinal mucosal speckling exhibiting nonshadowing gastrointestinal ingesta and mild nonobstructive intestinal ileus.
- Soft fecal matter in colon.
- Perisplenic hyperechoic omentum and mild volume of peritoneal effusion- effusion may be secondary to splenic disease/hemoabdomen or hypoalbuminemia.
- Medial iliac lymphadenopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

In conjunction with splenic neoplastic criteria, the small intestine in conjunction with gastrointestinal signs and hypoalbuminemia, is consistent with protein losing enteropathy. Concurrent IBD or other inflammatory enteropathy, lymphangiectasia or potential concurrent intestinal neoplasia is possible.

Assuming normal clotting status, further assessment may include splenic FNA cytology using a 25 gauge needle as well as effusion analysis. Three view chest radiographs and consideration for GI panel to include PLI, TLI, cobalamin and folate is recommended. Initial PLE therapy in an attempt to stabilize



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serum albumin level with consideration for some or all of the following protocol is recommended with potential for oncology consult.

Part or all of this protocol may be considered based on your clinical impression of the patient:

OBJECTIVE: keep albumin levels > 2 g/dl, avoid thromboembolism and cavitory effusions, monitor concurrent PLN and liver disease:

Plasma 10 mL / kilogram IV over 4 hours

Or **Human albumin** 2 ml/kg/h over 10 hours. Total daily volume 20.l/kg/day

And Colloids/Hetastarch

10 to 20 mL per kilogram per day and dogs

10 to 15 mL per kilogram per day cats

(Can bolus first 1/3 of dose over 15 minutes)

& maintain on LRS maintenance otherwise.

High colony count probiotic Provable or Visbiome

Famotidine 1 mg/kg Iv Im po dc Sid /bid

Sucralfate 0.5-1 g po tid dogs, 0.5 g bid cats in slurry Or **Misoprostol** 1-5 ug/kg po tid

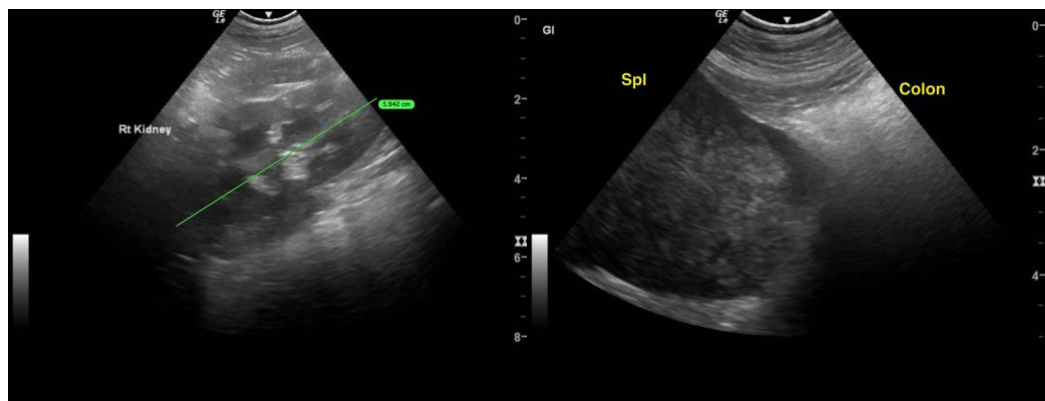
Diet: Highly digestible high quality protein, low fiber, low fat diet (< 15% of dry matter). Hydrolyzed protein or novel protein. Purina HA or Royal Canine HP or similar.

Prednisone or prednisolone 2 mg/kg bid x 3-5 days then 2 mg/kg sid. **Chlorambucil** in refractive severe IBD/alimentary lymphoma cases (monitor cbc for rare bone marrow suppression) 4 mg/m² Q 24-48 hours.

Cobalamin (B12) 250-1500 ug/dog weekly x 6 weeks.

Calcium supplementation if necessary.

Aspirin 0.5-1 mg/kg/day or **Clopidogrel (Plavix)** 1-5 mg/kg/day.



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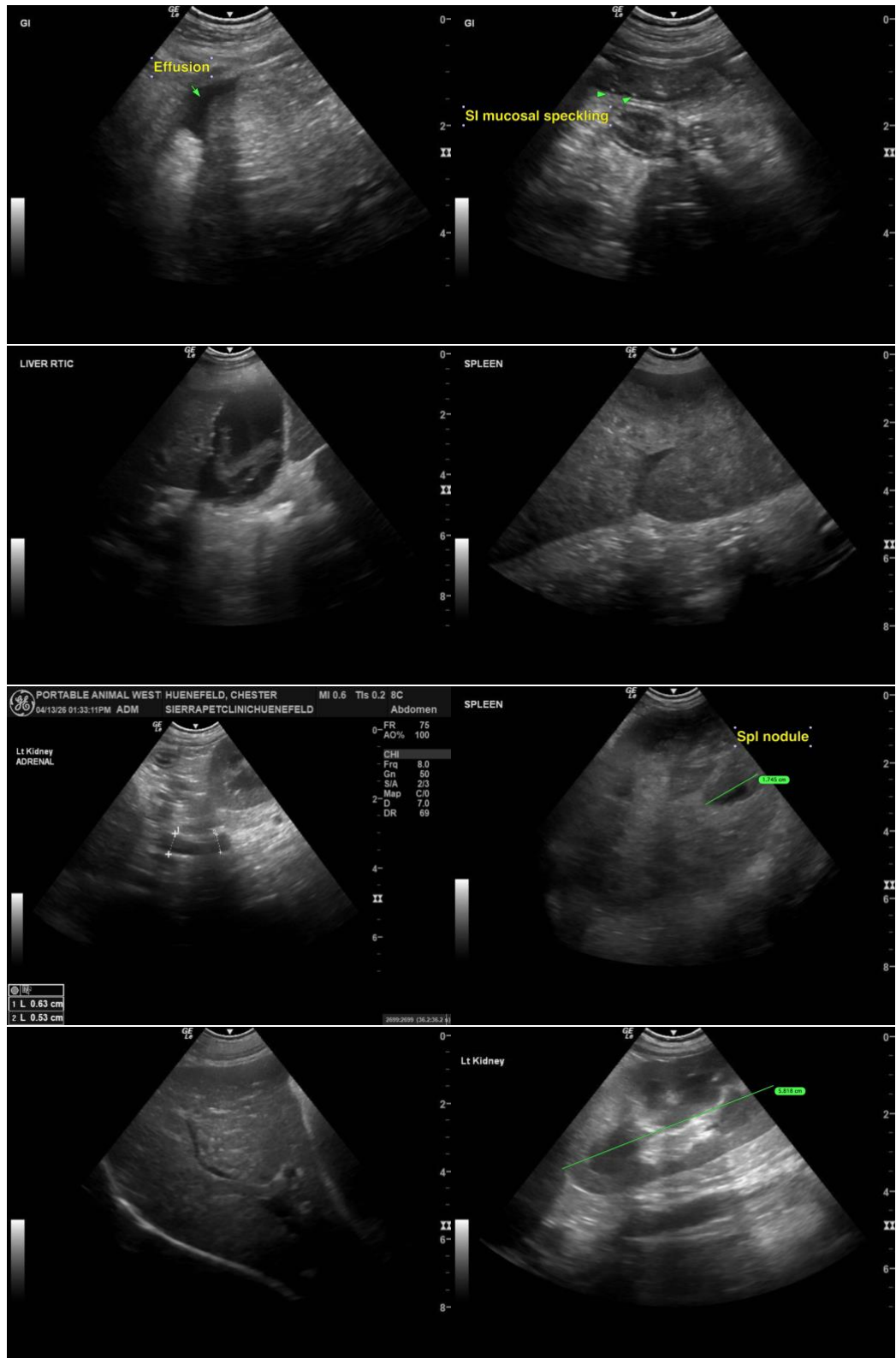
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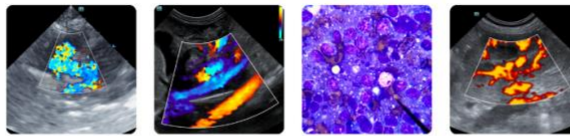
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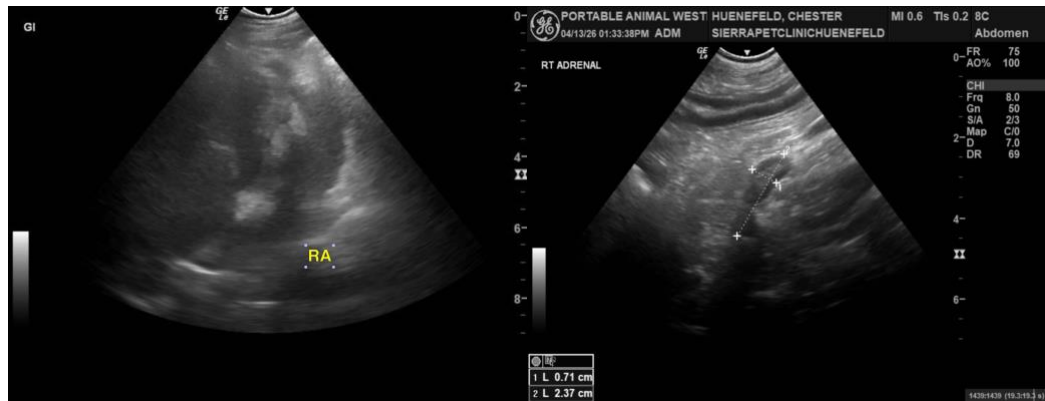
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

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