



PATIENT

Luna Middleditch

SPECIES

Canine

BREED

Great Pyrenees Mix

SEX

Spayed female

AGE

6 ½ years

WEIGHT

30.5 kg

INTERPRETED BY

Remo Lobetti, BVSc,
MMedVet (Med),
PhD, Dipl. ECVIM

IMAGING PERFORMED BY

Dr. Mariusz
Chmielinski, DVM

HOSPITAL NAME

Apex Veterinary
Services, Ltd.

REFERRING VET

Alpine 24/7/ ER Doctor

INVOICE

69185

DATE

12/2/25

PRESENTING CLINICAL SIGNS

Luna has a long-standing history of chronic intermittent vomiting, diarrhea, and anorexia. The owner reports trying multiple diets, medications, and management strategies without sustained improvement. Over recent months, Luna has experienced significant weight loss and progressive decline despite supportive care. She presented today for an abdominal ultrasound to further investigate her chronic GI signs.

Mentation: Bright, alert, responsive but anxious, Temperature: 38.0°C, Heart Rate: 122 bpm, HR:Pulse Ratio: 1:1, Respiratory Rate: Panting, Respiratory Effort: Normal (0), Mucous Membranes: Pink, moist, CRT: < 2 sec, Hydration: Adequate, Body Condition Score: 2/5 (markedly underweight) Abdominal Palpation: Tense, reactive; General: Poor body condition, evidence of chronic weight loss

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is small with a normal thickness and smooth appearance of the wall. Normal anechoic urine with no sediment or uroliths evident.

Normal appearance of the trigone area, proximal urethra, and iliac blood vessels.

Normal appearance and size of the iliac lymph nodes. Ureters not visualized, which can be considered a normal finding.

Normal renal size (left measured 6.3 cm, right measured 6.4 cm), architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident.

Adrenal Glands

Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 0.48 cm and 0.43 cm in width. The right adrenal gland measured 0.65 cm in width.

Spleen

Normal size and echogenic appearance. Smooth homogenous parenchyma and regular curvilinear capsule. Normal volume of the splenic vasculature without any overt congestion or thrombosis evident. No inflammatory, neoplastic, infarction, or infiltrative changes evident. The spleen measured 2.0 cm in width.

Liver

Normal size, echogenic appearance, portal markings, and regular curvilinear capsule. No nodules or masses evident. Normal appearance of the hepatic and portal vasculature.



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Gallbladder

The gallbladder is full containing normal anechoic bile. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.

Gastrointestinal

Thickening of the gastric wall (up to 1.5 cm) showing loss of layering, but with no pyloric obstruction present. A small amount of fluid accumulation was noted within the stomach. Normal appearance of the stomach, duodenum, small intestine, ileo-cecal junction, and colon with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen.

Pancreas

The visible sections of the pancreas are of normal size and echogenic appearance with a regular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Focal mesenteric lymphadenomegaly measuring up to 0.7 x 1.7 cm in size with a slightly rounded shape and a hypoechogenic appearance.

A small amount of ascites is present.

ULTRASONOGRAPHIC FINDINGS

- Gastric thickening.
- Focal mesenteric lymphadenomegaly.
- Ascites.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most likely etiology for the gastric thickening would be neoplasia, with chronic gastritis, ulcerative disease and granulomatous gastritis a less likely differential diagnosis.

Etiologies for the focal mesenteric lymphadenomegaly would be reactive hyperplasia, infiltrative neoplasia and possibly lymphadenitis.

The ascites can be ascribed as secondary to the gastric thickening of the mesenteric lymphadenomegaly.

Further assessment would be three view thoracic radiographs and FNA cytology of the gastric wall and mesenteric lymph nodes.



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Specific therapy would be dependent on an etiological diagnosis.

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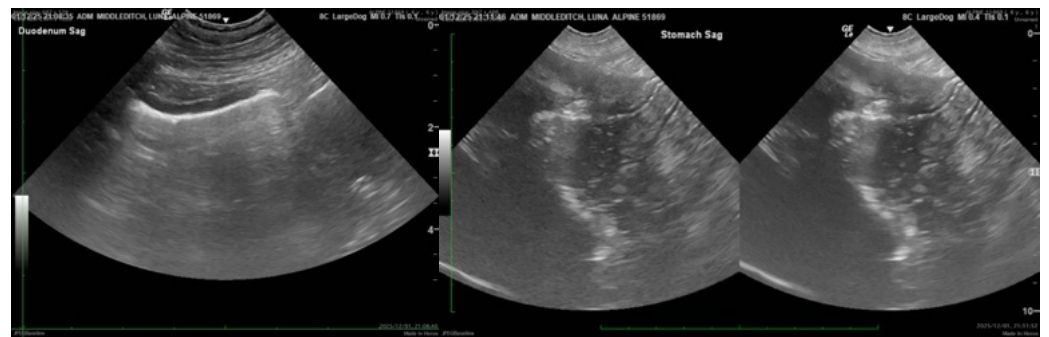
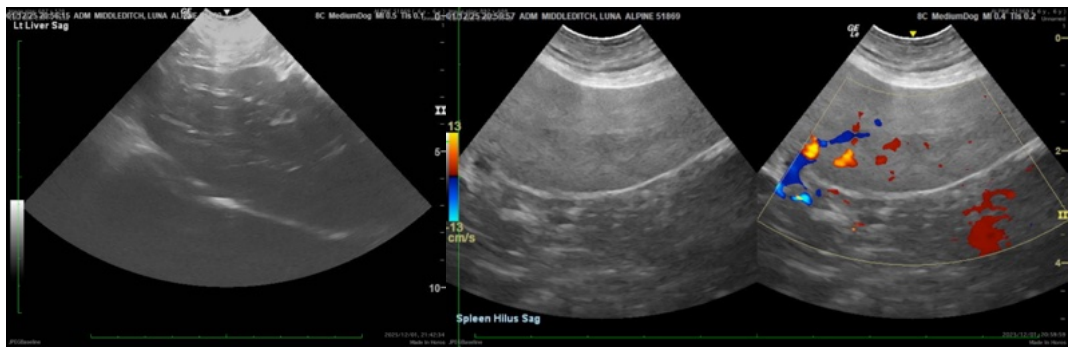
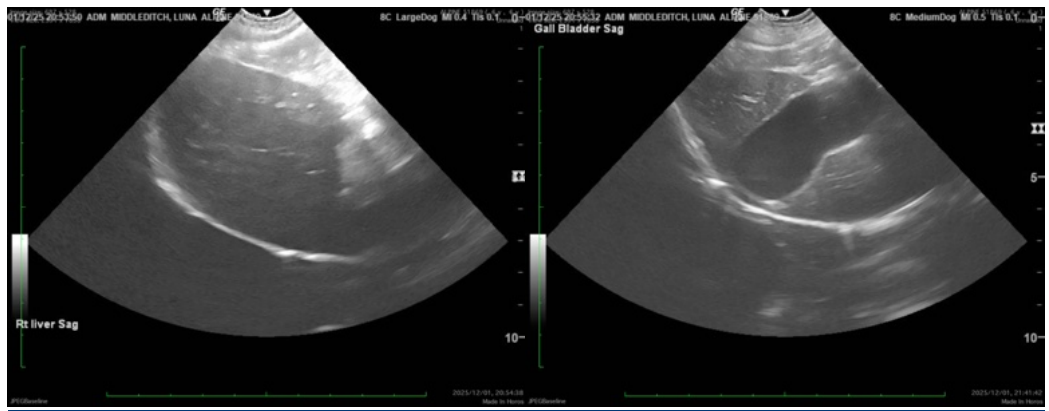
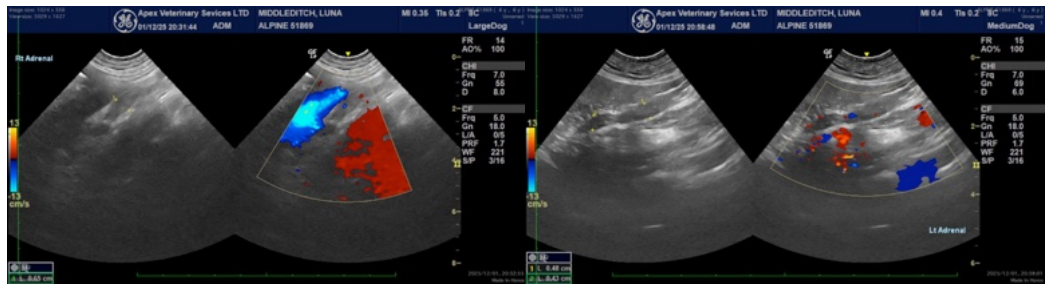
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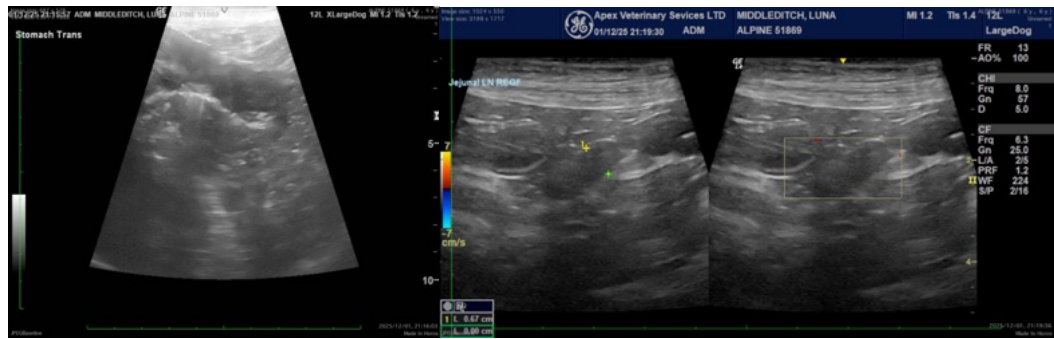
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)

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