



PATIENT

Molly Blaney

SPECIES

Canine

BREED

Newfoundland

SEX

Spayed Female

AGE

6 Years

WEIGHT

80 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Ackmann

HOSPITAL NAME

Buffalo Veterinary
Clinic

REFERRING VET

Dr. Ackmann

INVOICE

14204

DATE

03/10/26

PRESENTING CLINICAL SIGNS

- Anorexia and 25-pound weight loss over 3 weeks
- Progressive decrease in appetite over 3 weeks, initially decreased interest in food
- Now complete anorexia for approximately 1 week
- Last real meal approximately 1 week ago
- Only consumed chicken noodle soup broth last night
- Previous diagnostics by referring veterinarian included chest and abdominal radiographs (multiple sets), barium study, and blood work
- Previous blood work showed low potassium and sodium, attributed to not eating
- Previous course of enrofloxacin 68 mg: 1.5 tabs PO BID x10 days
- Current medications: prednisolone 20mg BID x5 days, then SID (restarted yesterday after previous 10-day tapered course), famotidine 20mg BID

Abnormal PE/Chem/CBC/UA Results: 3/10/26: - Abdominal radiographs: discospondylosis; possible mild thickening of pylorus in one view - Chest radiographs: slightly enlarged sternal lymph node - CBC: MCV- mildly low, MCHC- mildly high, WBC- mildly low characterized by decreased lymphocytes and eosinophils -Chem 17: BUN- low (likely due to muscle mass loss), electrolytes- low (likely from not eating), amylase- mildly low - Blood smear: toxic degranulation of neutrophils

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Small urinary bladder 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, architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident. The left kidney measured 6.8 cm in length. The right kidney measured 6.4 cm in length. Normal color flow pattern was evident in both kidneys.

Adrenal Glands

Not clearly visualized but appear to be of normal shape, echogenic appearance and size.

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 1.4 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

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

Gastrointestinal

Normal appearance of the 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. Diffuse thickening of the gastric wall measuring up to 1.2 cm with some loss of layering with the lumen containing a small amount of fluid.

Pancreas

Not clearly visualized but 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

Normal mesenteric lymph nodes.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

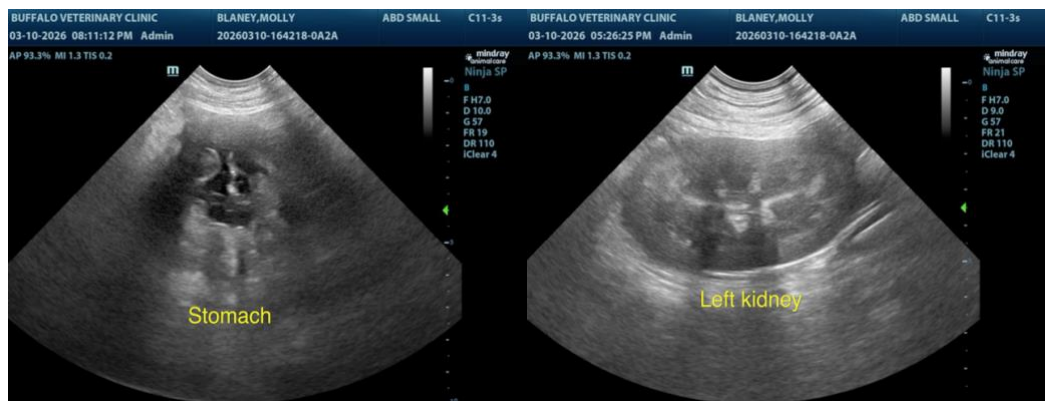
- Gastric thickening.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Likely etiologies for the gastric thickening would be neoplasia and granulomatous disease. Ulcerative disease, severe helicobacter gastritis and gastric hyperplasia would be less likely differential diagnoses.

Further assessment would be FNA cytology of the gastric wall and possibly gastroscopy with biopsies.

Specific therapy would be dependent on an etiological diagnosis.





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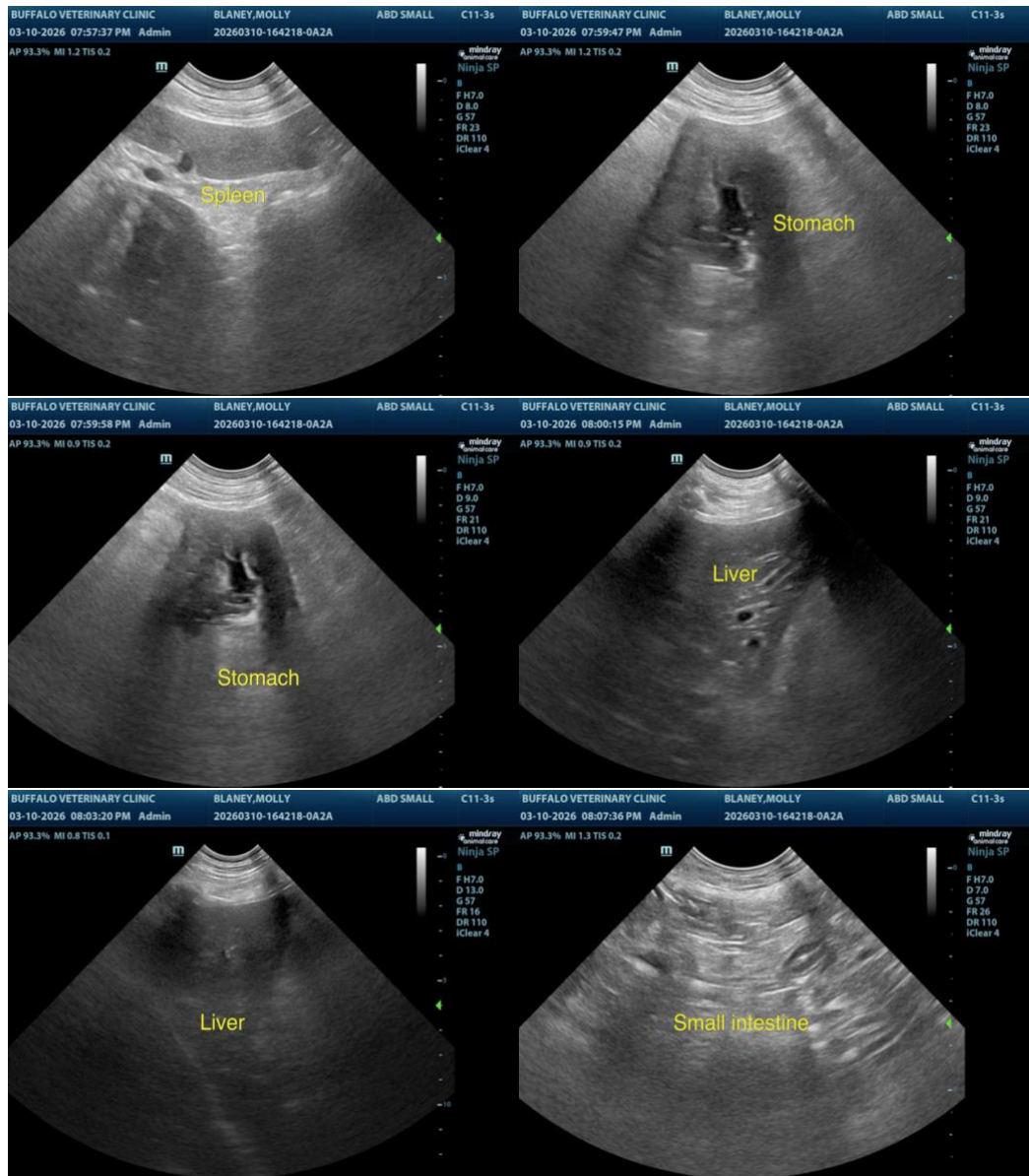
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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