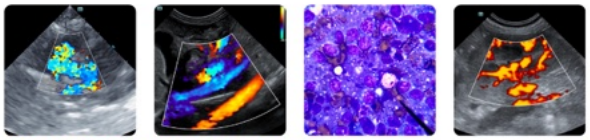


PATIENT

Chyna Raymond

SPECIES

Canine

BREED

Pitbull Mix

SEX

Female

AGE

10 years

WEIGHT

73.5 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Striano Kaplan

HOSPITAL NAME

Ramsey VH

REFERRING VET

Dr. Kaplan

INVOICE

72037

DATE

2/27/26

PRESENTING CLINICAL SIGNS

- History decreased appetite x1 week, panting at night x 1 week, lethargic not herself x 2weeks, no vomiting or diarrhea
- PE: tense painful abdomen, lethargic, pale pink mm Radiology Report: splenomegaly on Rads, hypovolemia and poor serosal detail Labs: SDMA 26, AMYL 449, MCV 60.3, MCHC 38.1, WBC 94.11, NEU 85.62, MONO 3.01, EOS 2.58, PLT *131, MPV 14.8, PDW *21.1

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is underdistended. The caudal bladder wall, near the vesical neck, appears subjectively thickened. Due to underdistension, wall thickness may be overestimated. The lumen contains scant suspended echoes, which may represent a small amount of mineral sediment. No discrete uroliths or masses are identified.

The left kidney is normal in shape and size: 5.92 x 3.50 cm, with a cortical thickness of 0.45 cm in the sagittal plane. The cortex is isoechoic relative to the liver parenchyma. Corticomedullary definition and ratio are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified.

The right kidney is normal in shape and size: 6.30 x 3.86 cm, with a cortical thickness of 0.48 cm in the sagittal plane. The cortex is isoechoic relative to the liver. Corticomedullary definition and ratio are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified.

Caudal to the left kidney, an ovoid structure measuring 1.86x2.96 cm is identified, compatible with the left ovary. Within this structure, several small anechoic rounded foci (approximately 0.97x1.34 mm) are present, most consistent with ovarian follicles or small cystic structures.

Reproductive status (intact vs spayed) was not specified. The right ovary and uterine horns are not visualized in the provided video material.

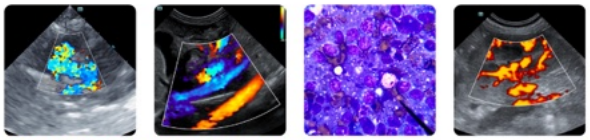
Adrenal Glands

Adrenal glands are not visualized in the submitted study.

Spleen

Splenic thickness ranges from 3.52–4.33 cm, with rounded margins. The parenchyma is diffusely hypoechoic with a fine, homogeneous echotexture. No focal splenic nodules are identified. The splenic capsule is smooth and regular.

Liver



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The liver is subjectively normal in size, with sharp margins and regular contour. The visualized parenchyma is homogeneous and isoechoic relative to surrounding fat, with normal echotexture. No focal hepatic lesions or lymphadenopathy are identified.

The gallbladder is normally distended. The wall is thin. A moderate amount of biliary sludge is present. No evidence of biliary obstruction is identified.

Gastrointestinal

The stomach is empty and folded. Gastric mural thickness measures 3.03 mm, with preserved layering. The pylorus measures 5.87 mm.

Duodenum: 3.68 mm, Jejunum: 4.23 mm, Ileum: 2.67 mm. Wall layering is preserved throughout. No evidence of obstruction, mural loss of layering, or foreign material is identified.

Colon: 1.49 mm, empty with gas.

Pancreas

Visualized pancreatic regions do not show ultrasonographic evidence of overt inflammation.

Peritoneal Cavity

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified in the submitted material. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Diffuse splenomegaly (3.52–4.33 cm thickness) with rounded margins
- Diffusely decreased splenic echogenicity

SECONDARY FINDINGS

- Possible mild bladder wall thickening (likely secondary to underdistension).
- Left ovary with small anechoic structures: follicles vs cysts.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is marked, diffuse splenomegaly characterized by rounded margins and a homogeneous, hypoechoic parenchymal pattern. No discrete splenic mass is identified in the submitted material; however, the degree of enlargement is substantial and should be considered clinically significant.

Color Doppler evaluation of the spleen was not performed in the submitted study. However, grayscale imaging did not demonstrate ultrasonographic features typically associated with splenic torsion, such as marked parenchymal heterogeneity, peripheral hypoechoic infarcted regions, a “lacy” or reticular echotexture, capsular distortion with a twisted vascular pedicle, or the characteristic diffuse

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enlargement with mottled echogenicity often described in torsed spleens. No peritoneal effusion suggestive of acute vascular compromise was identified in the provided material.

Diffuse splenic enlargement may be seen in reactive conditions, including tick-borne disease and systemic inflammatory processes. However, in this patient, the severity of leukocytosis, pronounced neutrophilia, abdominal pain, and pale mucous membranes raise concern that the splenic changes may represent more than a simple reactive response.

While infectious or inflammatory causes remain possible, the magnitude of the leukocytosis warrants strong consideration of an underlying hematologic disorder, including leukemic or other infiltrative processes involving the spleen. Diffuse infiltrative neoplasia can produce uniform splenic hypoechogenicity without discrete mass formation, particularly in early or systemic stages.

At this time, the imaging findings are most compatible with either:

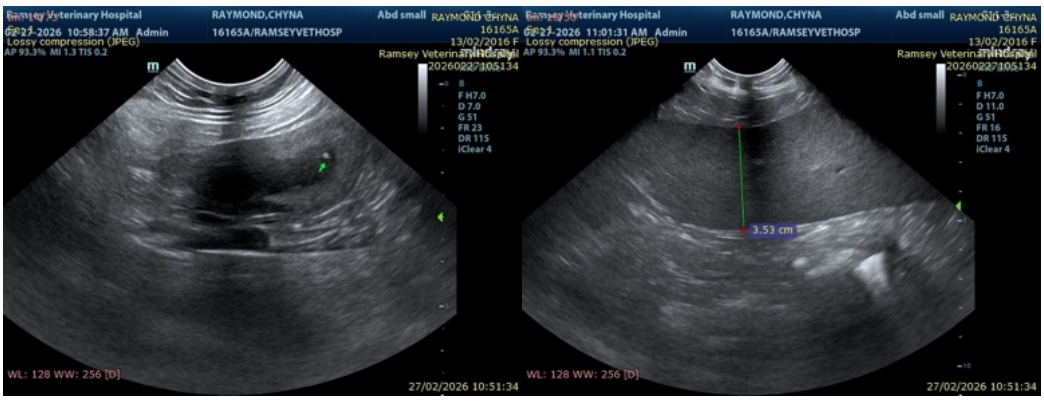
- Severe reactive splenic hyperplasia or splenitis secondary to systemic inflammatory or infectious disease.
- Diffuse infiltrative splenic involvement associated with hematologic malignancy.

No alternate intra-abdominal source of the patient's clinical signs is identified on the study.

The ovarian cysts are mild and unlikely to account for the severity of the systemic abnormalities described.

Recommendations

- CBC review with manual differential and blood smear evaluation to assess for blasts or toxic change.
- Splenic fine-needle aspiration (if the patient is hemodynamically stable).
- Thoracic imaging.
- Coagulation profile prior to invasive procedures.



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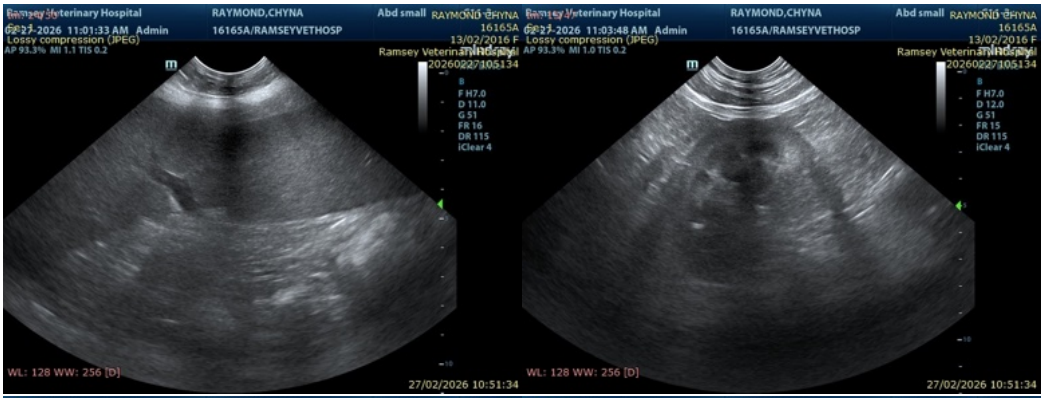

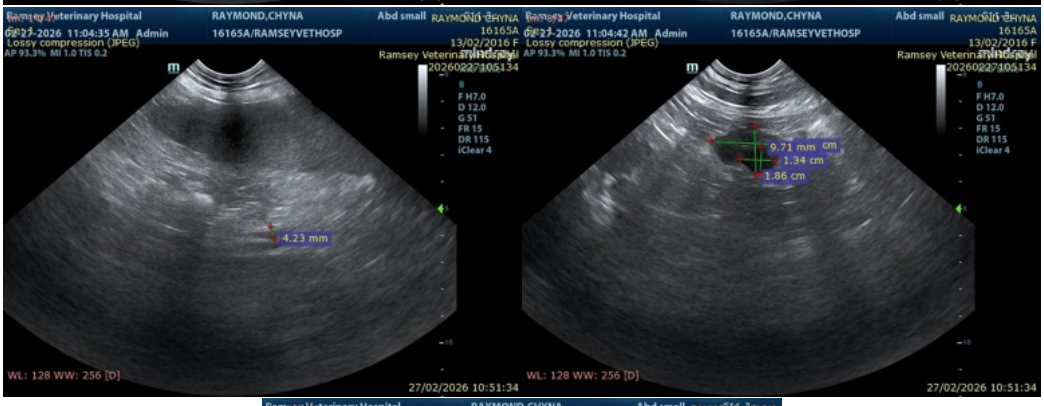

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

info@SonoPath.com