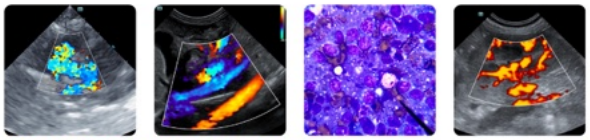


PATIENT

Ruthie Rose Cable

SPECIES

Canine

BREED

Terrier Cross

SEX

Spayed female

AGE

10 years

WEIGHT

50.8 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Brandi Barry

HOSPITAL NAME

Bluegrass Ah

REFERRING VET

Dr. Disney

INVOICE

73960

DATE

3/31/26

PRESENTING CLINICAL SIGNS

- Patient presented for decreased appetite on 3/20/26. Owner reports that patient has been skipping her morning meal lately. Patient stopped eating dry food 6 months ago, but is now eating a mix of dry and canned food.
- Dewormed with a 3 day course of Panacur beginning 3/20/26 after a mild regenerative anemia was noted on CBC.
- Anemia unchanged on recheck CBC 3/27/26. A focal hypoechoic splenic nodule was noted on A-FAST, so a sedated abodominal ultrasound with splenic aspirates was recommended. A blood film was submitted to Idexx for path review.
- Patient has lost ~6 lbs since August 2025.
- Mild tartar. Few SQ and cutaneous masses. CBC/Chem17/Lytes 3/20/26: HCT L 36.4 %, RETIC H 395, PLT L 106 K (manual count 120 K); all else WNL CBC 3/27/26: CBC: HCT L 36.8 %, RETIC H 385.4, PLT L 115K Radiographs performed 3/27/26: Only able to obtain lateral films without out sedation. Thoracic rads: Cardiac silhouette WNL, lung parenchyma WNL Abd rads: Good serosal detail, no obvious masses, GIT, liver and spleen appear normal CBC path review (see attached): Erythrocyte density is decreased with moderate anisocytosis and polychromasia, and morphology is unremarkable overall. Nucleated erythrocytes are noted (0-3/100wbcs) and represented by metarubricytes. Platelets adequate. Obtained US guided splenic aspirates today- cytology pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

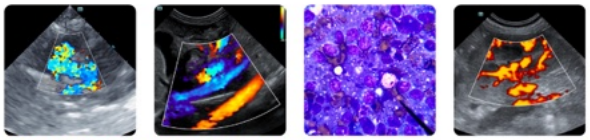
The urinary bladder is underdistended, and the wall appears mildly thickened. Due to underdistension, wall thickness may be overestimated. The urine is anechoic. The bladder neck and proximal urethra appear normal. No calculi or evidence of inflammatory or neoplastic changes are identified.

The left kidney is normal in shape and size (5.71×2.91 cm), with a cortical thickness of 0.53 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Doppler color evaluation shows a normal perfusion pattern.

The right kidney is normal in shape and size (5.29×3.22 cm). Cortical thickness is not recorded. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Doppler color evaluation shows a normal perfusion pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.46 cm at the cranial pole and 0.44 cm at the caudal pole. The right adrenal gland measures 0.50 cm at the cranial pole and 0.45 cm at the caudal pole.



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Spleen

Splenic thickness is 2.41 cm. The parenchyma demonstrates normal echogenicity. A well-defined, homogeneous hypoechoic nodule measuring 0.74×1.06 cm is present in the ventral aspect of the spleen, without capsular distortion. Additional smaller, subtle hypoechoic foci are noted in the dorsal spleen. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder is normally distended. The wall is thin, and the contents include a mild amount of biliary sludge. No dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and folded, with a wall thickness of 2.39 mm and preserved layering.

Pylorus: 6.08 mm. Duodenum: 3.01 mm. Jejunum: 3.54 mm. Wall layering is preserved throughout. No evidence of inflammation, ileus, or foreign material is identified.

Colon: 1.28–1.33 mm, with formed feces in the descending segment.

Pancreas

The evaluated pancreatic areas do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

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

PRIMARY FINDINGS

- Splenic hypoechoic nodule (0.74×1.06 cm).
- Additional subtle hypoechoic splenic foci.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The spleen contains a well-defined, homogeneous hypoechoic nodule, along with additional smaller hypoechoic foci. In isolation, this ultrasonographic appearance is most commonly associated with

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benign processes, such as nodular hyperplasia or extramedullary hematopoiesis, particularly in the context of regenerative anemia. The lack of capsular distortion, homogeneous echotexture, and absence of additional abdominal findings are mildly reassuring features.
However, overlap with infiltrative or neoplastic disease exists, and definitive differentiation is not possible with ultrasonography alone.

No ultrasonographic evidence of abdominal effusion or lymphadenomegaly is identified at this time.

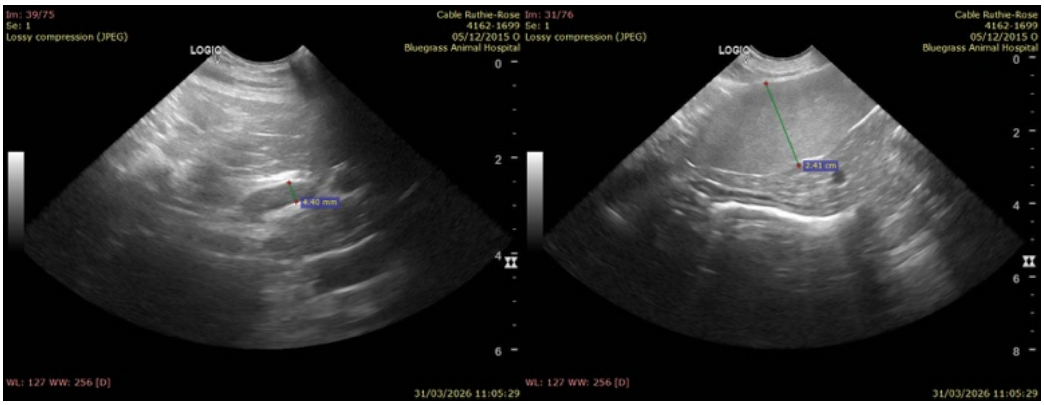
The clinical relevance of the splenic findings should be interpreted in conjunction with the reported subcutaneous masses. Cytologic characterization of these lesions is recommended, as certain neoplastic processes (mast cell tumor) may involve the spleen and could account for both the splenic and hematologic abnormalities.

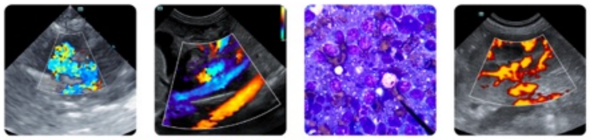
Recommendations

- Await and correlate with splenic cytology results, which will be critical for further characterization.

- Correlate with CBC trends and blood smear/pathologist review, particularly given regenerative anemia and thrombocytopenia.
- Given the hematologic abnormalities, consider underlying infectious etiologies (vector-borne diseases), as these may account for both the splenic findings and clinical presentation

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status





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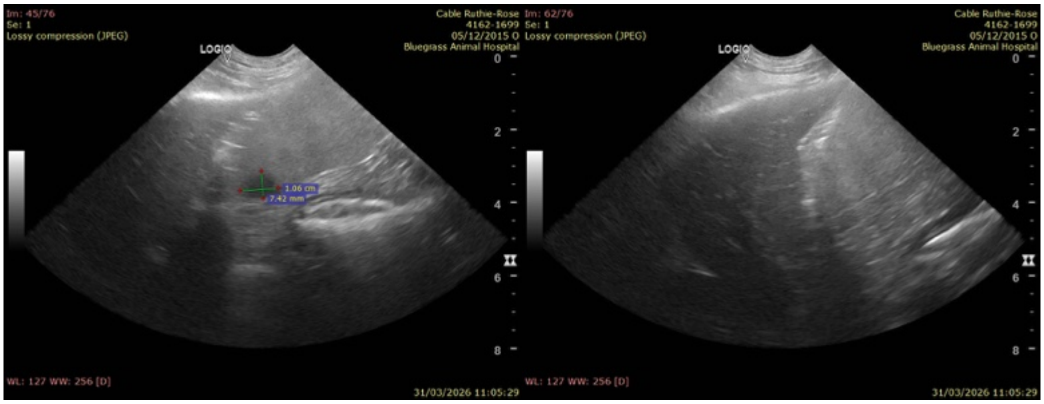

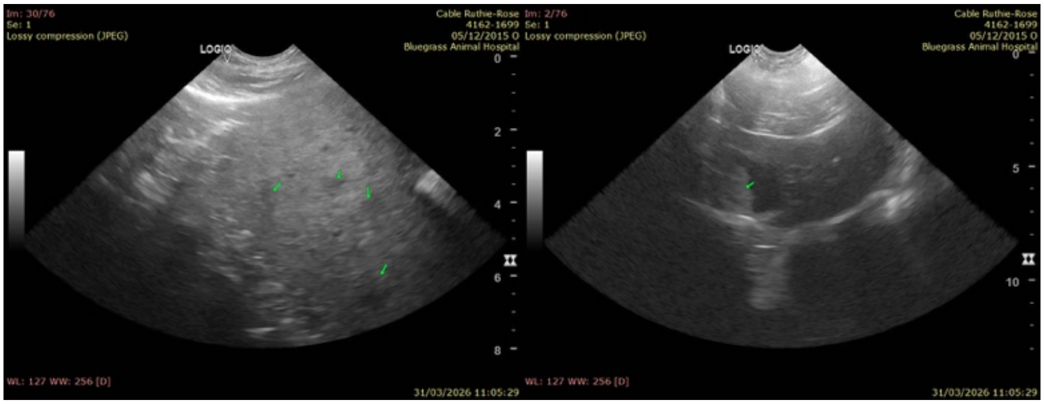

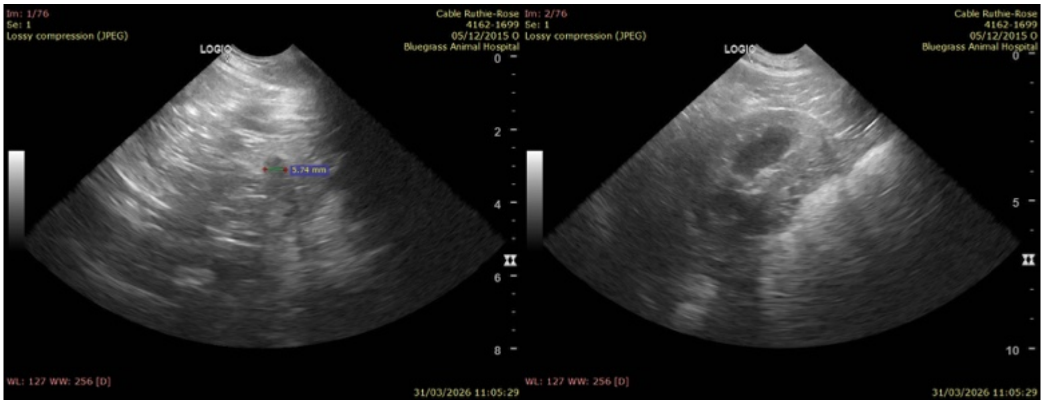

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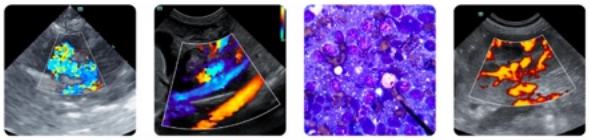

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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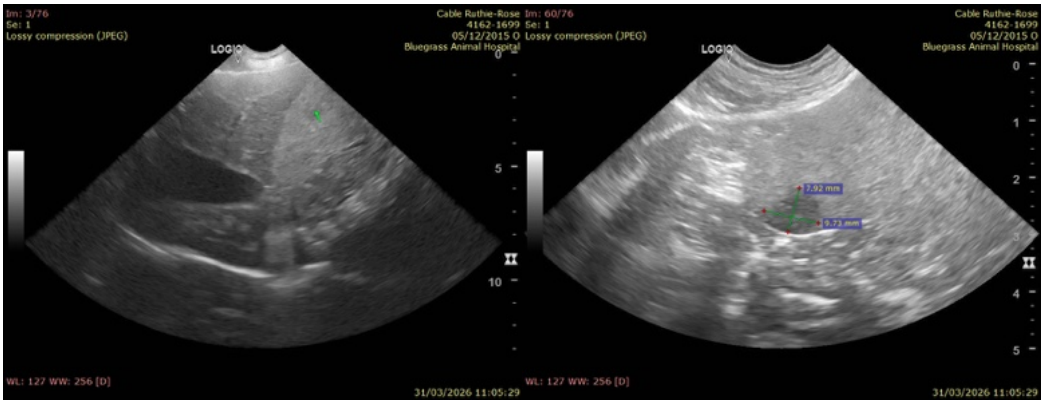

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com