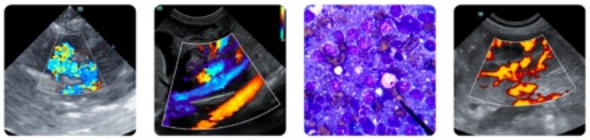




**PATIENT**

Bella Allgyer

**SPECIES**

Canine

**BREED**

Corgi

**SEX**

Spayed female

**AGE**

8 years

**WEIGHT**

24.4 lbs

**INTERPRETED BY**

Alicia Angosto Guerrero, DMV, PgDip, MSc.

**IMAGING PERFORMED BY**

Justin Eckenrode DVM

**HOSPITAL NAME**

Carlisle Small Animal VC

**REFERRING VET**

Dr. Eckenrode

**INVOICE**

75258

**DATE**

5/6/26

## PRESENTING CLINICAL SIGNS

History: Several weeks ago Gi upset, owner treated symptomatically. About 10 days ago presented for vomiting. Exam overall non-remarkable. Maropitant injection and vomiting stopped. She has been eating on/off. Mild weight loss. Today presented for repeat vomiting w/ generalized jaundice/pale. Palpation of spleen noted irregular/lobular and discomfort noted with palpation. Afebrile 102.4F. She is eating but less, lethargic but has moments of being more alert. Agglutination negative. No peripheral lymphadenopathy. Concerns of underlying infiltrative disease - splenic lymphoma, histiocytic sarcoma. Abnormal PE/Chem/CBC/UA Results: RBC 3.09; HCT 24.6% Retic 377.9 WBC 10.64 Neut 6.3; Lym 3.88; Eos 0.05; Plt 75,000 Glu 77 SDMA 11; Creat 0.6; BUN 8 ALT 907; ALKP 1802; GGT 29; Tbil 5.1 Alb 2.7 Chol 320 T4 1.1

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder lumen is incompletely distended. The urinary bladder wall measures approximately 2.17 mm in thickness and remains smooth and regular in appearance. Due to underdistension, urinary bladder wall thickness may be mildly overestimated. The urine is anechoic. The bladder neck and proximal urethra are unremarkable. No cystoliths or sonographic evidence of inflammatory or neoplastic urinary bladder disease are identified.

The left kidney is normal in shape and size, measuring 4.60×2.54 cm. Cortical thickness measures 0.44 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. Corticomedullary ratio and corticomedullary distinction are preserved. No pyelectasia, hydronephrosis, or nephrolithiasis is identified. Color Doppler evaluation demonstrates a subjectively normal vascular pattern.

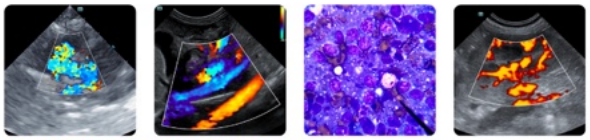
The right kidney is normal in shape and size, measuring 5.91×2.64 cm. Cortical thickness measures 0.28 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. Corticomedullary ratio and corticomedullary distinction are preserved. No pyelectasia, hydronephrosis, or nephrolithiasis is identified. Color Doppler evaluation demonstrates a subjectively normal vascular pattern.

### *Adrenal Glands*

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.40 cm at the cranial pole and 0.42 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.

### *Spleen*

Marked splenomegaly is present, with splenic thickness ranging from approximately 2.55–3.05 cm. The spleen demonstrates a markedly irregular contour with multifocal mass-like regions deforming the splenic capsule. The splenic parenchyma is severely heterogeneous, containing mixed cavitary and solid-appearing regions of variable echogenicity. Increased vascularity is identified within the more solid-appearing portions of the lesions on Doppler interrogation.





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## *Liver*

The liver is subjectively normal in size, with sharp margins and regular contour. The hepatic parenchyma is predominantly homogeneous and isoechoic relative to the falciform fat, with preserved overall echotexture. On limited submitted cine loops, a few questionable nodular foci are intermittently suggested within the hepatic parenchyma, although these findings could not be consistently reproduced throughout the remainder of the hepatic examination. Therefore, the presence of hepatic metastatic disease cannot be confidently confirmed or excluded sonographically. No hepatic lymphadenopathy is identified.

The gallbladder is normally distended. The gallbladder wall is thin and regular. A small amount of biliary sludge is present. No evidence of cystic duct or common bile duct dilation is identified.

## *Gastrointestinal Tract*

The stomach contains a small amount of partially digested ingesta. Gastric wall thickness measures 2.71 mm with preserved mural layering. The pyloric wall measures 5.61 mm. Duodenal wall thickness measures 3.05 mm. Jejunal wall thickness measures 2.93 mm with preserved mural layering. No evidence of obstructive ileus or gastrointestinal foreign material is identified. Colonic wall thickness measures approximately 2.27 mm, with scant soft fecal material present within the descending colon.

## *Pancreas*

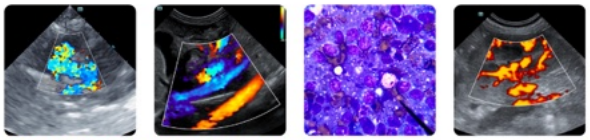
The pancreas measures approximately 1.47 cm in thickness and appears diffusely hypoechoic. The surrounding peripancreatic fat is markedly hyperechoic and expanded, with associated regional inflammatory change involving the adjacent mesenteric/peritoneal tissues, including the peri-duodenal region.

## *Free Abdomen*

Mild to moderate abdominal effusion is present, predominantly surrounding the spleen and between the hepatic lobes. Marked regional peritoneal reaction/inflammation is also identified in the peripancreatic and peri-duodenal regions. No definite abdominal lymphadenomegaly is identified, although subtle nodal involvement cannot be completely excluded sonographically given the degree of regional inflammation and abdominal complexity. The iliac trifurcation region is unremarkable.

## PRIMARY FINDINGS

- Marked irregular cavitary and solid splenic masses with severe splenomegaly and increased vascularity.
  Mild to moderate abdominal effusion.
- Diffuse pancreatic enlargement and hypoechogenicity with marked surrounding peripancreatic inflammatory change.
- Hepatic nodular foci/metastatic disease not definitively confirmed sonographically.
- Regional peritonitis/peritoneal reaction centered on the splenic and pancreatic regions.





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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Marked aggressive splenic disease is present, characterized by severe splenomegaly with multiple irregular cavitary and solid vascularized mass-like regions deforming the splenic contour. In the context of the patient's regenerative anemia, thrombocytopenia, hyperbilirubinemia, and abdominal effusion, the ultrasonographic appearance is highly concerning for malignant splenic neoplasia. Differential considerations would include histiocytic sarcoma, lymphoma, hemangiosarcoma, or other aggressive splenic infiltrative/neoplastic processes.

Mild to moderate abdominal effusion may reflect reactive inflammatory effusion and/or hemorrhagic leakage associated with the splenic lesions. Cytologic evaluation of the effusion may be clinically useful if safely obtainable.

Questionable hepatic nodular changes are intermittently suggested on limited portions of the hepatic examination; therefore, early metastatic hepatic involvement is suspected, although definitive hepatic metastases are not conclusively demonstrated sonographically at this time.

Additionally, marked pancreatic and regional peritoneal inflammatory change is present, compatible with concurrent pancreatitis and regional peritonitis. Whether this represents secondary reactive inflammation adjacent to the splenic disease, concurrent primary pancreatitis, vascular compromise, or neoplastic involvement cannot be definitively determined ultrasonographically.

Recommendations

- Ultrasound-guided cytology of the splenic lesions and/or abdominal effusion should be considered if clinically appropriate and hemostatically safe.
- Coagulation assessment is recommended prior to invasive sampling given the thrombocytopenia and severity of splenic disease.
- Surgical consultation may be warranted if the patient is considered a candidate for splenectomy and stabilization.
- If clinically pursued, thoracic imaging may be useful for staging purposes.
- Continued monitoring for progression of anemia, hemorrhage, hemodynamic instability, and worsening abdominal pain is strongly recommended.

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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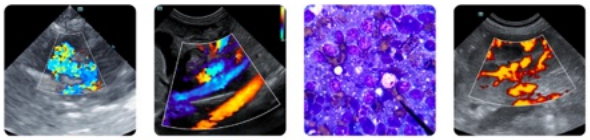

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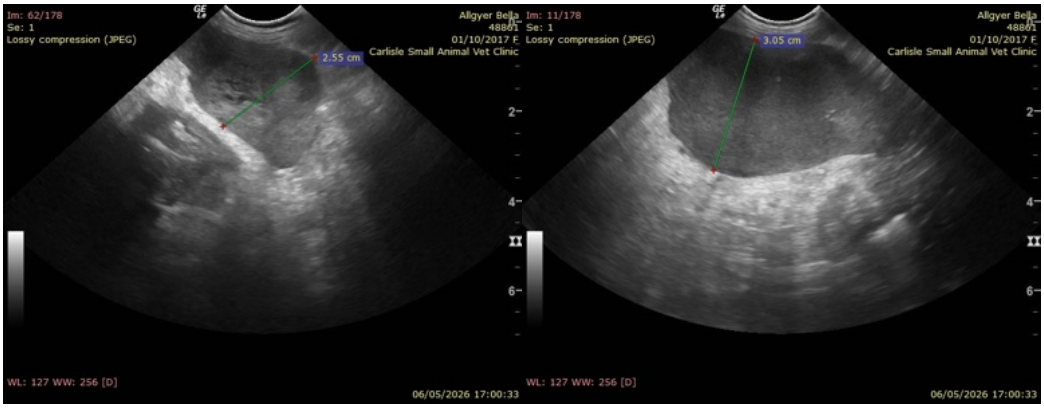


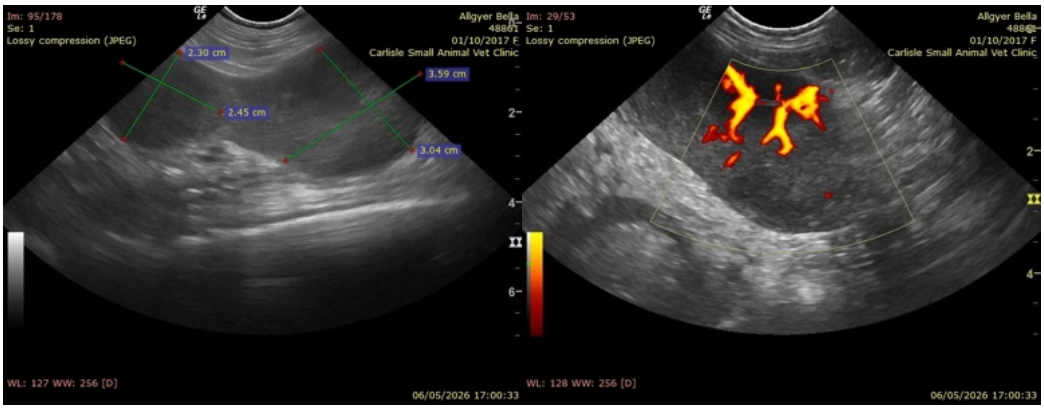


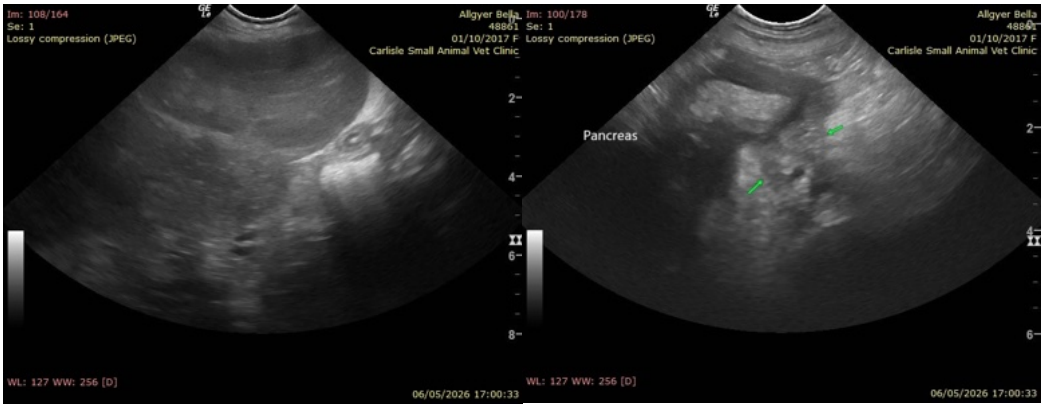

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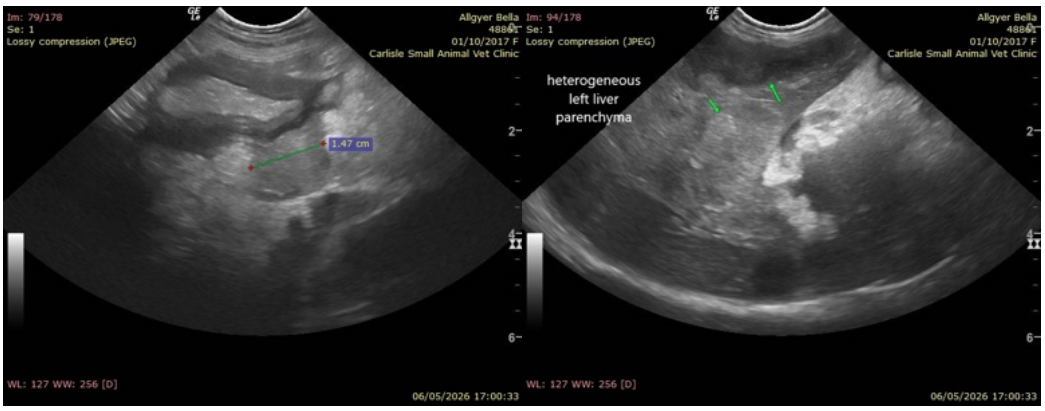


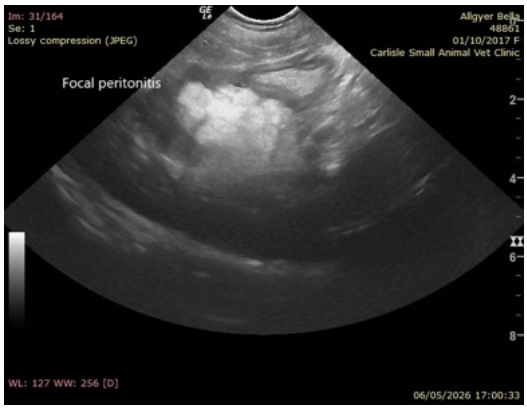


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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