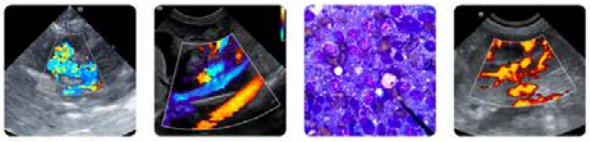


PATIENT

Leia Imboden

SPECIES

Canine

BREED

Havanese

SEX

Spayed Female

AGE

7 Years

WEIGHT

4.6 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Logan Law

INVOICE

72116

DATE

11/26/25

PRESENTING CLINICAL SIGNS

*Patient seen at rDVM today for anorexia, weight loss (11.5# on 8/15/25 to 9.9# today), lethargy, and pallor. Bloodwork showed HCT of 11.6%, no rads done yet. Transferred here for further diagnostics and blood transfusion. Owner noticed patient just was not herself last week, did not want to go for walks and had a decreased appetite. She also looked like she had lost weight. She stopped eating 11/23 and was licking dirt and rusty metal. She vomited once after licking dirt, but has not vomited more and stool is normal. Owner thought she looked pale, so took her to rDVM today. History of allergies. Admitted for blood transfusion. received 62 ml prbc. hospital treatments: dex sp, cerenia, doxycycline, pantoprazole, carafate. *concern for Severe anemia (hct 11.6%) - r/o immune-mediated hemolytic anemia, immune-mediated thrombocytopenia, infectious disease, bone marrow disease; Significant weight loss - r/o underlying systemic disease, chronic illness; Decreased appetite and lethargy - r/o secondary to anemia; other

Abnormal PE/Chem/CBC/UA Results: *PE: dull/depressed, abd tense, hard to palpate *rDVM: RBC 1.46 (5.65-8.87), HCT 11.6 (37.3-61.7), Hgb 3.5 (13.1-20.5), MCV 79.5 (61.6-73.5), MCHC 30.2 (32-37.9), MPV 20.2 (8.7-13.2), Plateletcrit 0.69 (0.14-0.46), Glob 4.8 (2.5-4.5) *CBC Shores: Hct 11.7 (L), HGB 3.5 (L), RBC 1.46 (L), MCV 80.3 (H) *manual PCV: 13, TS 6.4 *rads: Rounded splenic margins may represent a normal patient variant, extramedullary hematopoiesis/lymphoid hyperplasia, splenitis, or infiltrative round cell malignancy (such as lymphoma). Otherwise radiographically unremarkable thorax and abdomen. Comments: Radiographic cause for patient's reported anemia is not identified. *post transfusion: 11/26 5 am pcv 24%, ts 7.0; 11/26 10 am pcv 23%, ts 7.0

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal is size (4.2 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

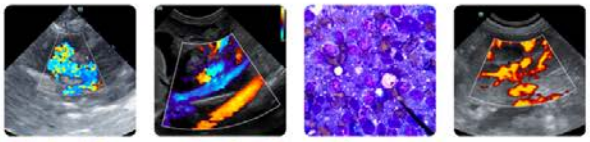
The left kidney is normal is size (3.87 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The adrenal glands are unable to be well visualized in these images.

Spleen

The spleen is subjectively normal in size (1.8 cm thick at the hilus) with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.



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Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is thick and edematous characterized by an intramural hypo to anechoic rim or "double rim effect or halo sign". Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Gallbladder "halo sign" – GB wall edema is a non-specific change and can be seen with any underlying etiology (ie vasculitis, hypoalbuminemia, CHF, other) that results in edema, as well as immune-mediated disease, anaphylactic shock, other. Cholecystitis cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is not a definitive ultrasonographically visible intraabdominal explanation for patient's reported anemia. Further recommendations, therefore, include continued workup of anemia, including determination of regeneration status and potentially comprehensive infectious disease evaluation.

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

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Ultimately, pending patient's response to treatment and workup, bone marrow cytology could be considered.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com