



PATIENT

Pam Yaternick

SPECIES

Canine

BREED

Chihuahua

SEX

Spayed Female

AGE

11 Years

WEIGHT

3.8 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Nigel Gumley

HOSPITAL NAME

Cedarview AH

REFERRING VET

Dr. Nigel Gumley

INVOICE

45463

DATE

2/23/23

PRESENTING CLINICAL SIGNS

Seen for dental pain and periodontal disease. Pre-anesthetic blood work showed severe thrombocytopenia. Normal WBC and RBCs. Repeat CBC's show persistent thrombocytopenia after starting prednisolone therapy. Some petechiae on ventral abdomen resolved. No other signs of bleeding

Abnormal PE/Chem/CBC/UA Results: Pathology report suggests marginal anemia, moderately responsive, marked decrease platelets, no clumping. Non-toxic neuts, mature. Mild leukocytosis and moderate neutrophilia and monocytosis. Tick panel at NC Tick Vector lab negative. Chest rads normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately 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 in size (3.93 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 in size (3.38 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 right adrenal gland is normal in size (0.36 cm at the cranial pole and 0.44 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.44 cm at the cranial pole and 0.55 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. Several small hypo- to anechoic non-capsule disrupting nodules are present, one measuring 0.20 cm x 0.50 cm and one measuring 0.50 cm x 0.80 cm. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as mild suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.



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Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with 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 (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with 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 observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

PRIMARY FINDINGS

- **Hyperechoic hepatomegaly** - This appearance is non-specific and most consistent with a benign steroid (endocrine) or vacuolar hepatopathy or reactive or idiopathic hepatopathy. Inflammatory and/or infiltrative disease (such as round cell neoplasia) are also possible, but considered less likely.
- **Scalloped spleen** - can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.
- **Hypo to anechoic splenic nodules** - likely represent benign lesions such as cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.

SECONDARY FINDINGS

- **Mild gallbladder debris** - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- **Pancreatic age-related remodeling** - Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.



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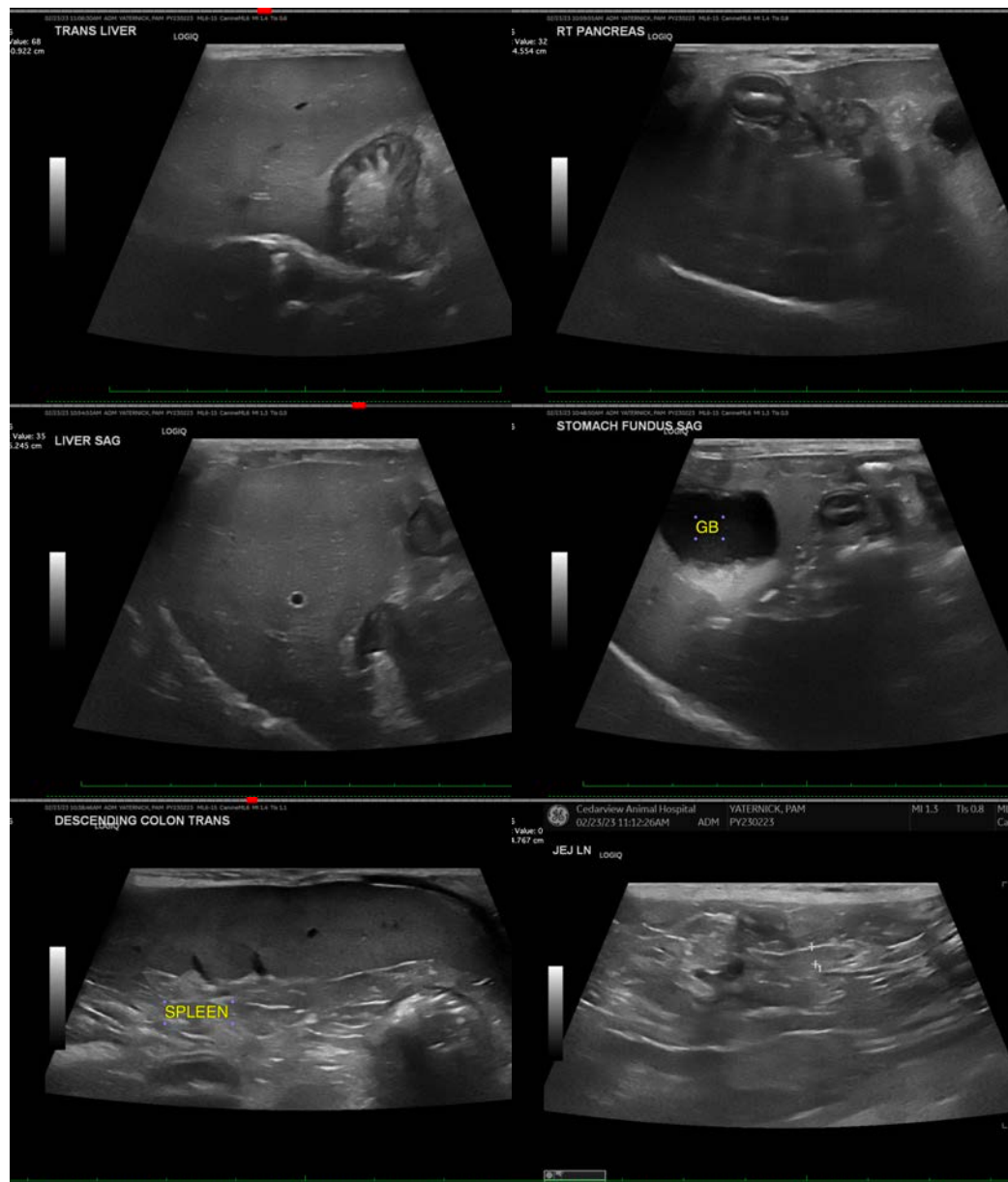
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no definitive ultrasonographic underlying reason for this patient's reported thrombocytopenia. The splenic changes trend in appearance toward benign and most likely represent immune stimulus. If/when patient's coagulation status returns to normal, a fine needle aspirate of the spleen could be considered. However, this should not be pursued in the face of marked thrombocytopenia.

Since comprehensive infectious disease testing is reportedly negative, recommendations at this time include management of presumed immune mediated thrombocytopenia. If the patient is not responding adequately to Prednisone, a 2nd immunosuppressant added to the Prednisone such as modified Cyclosporin versus other may need to be considered.





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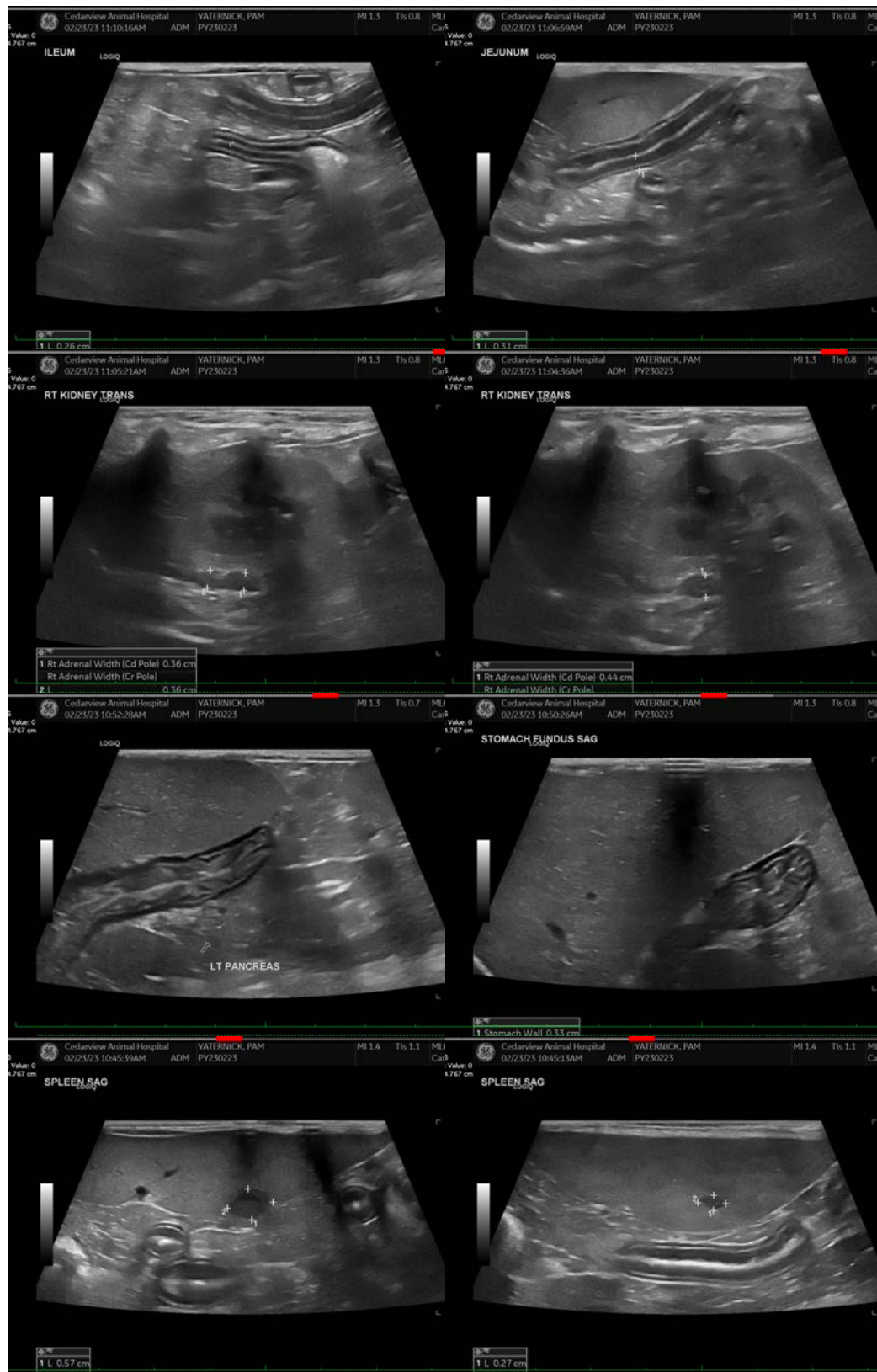
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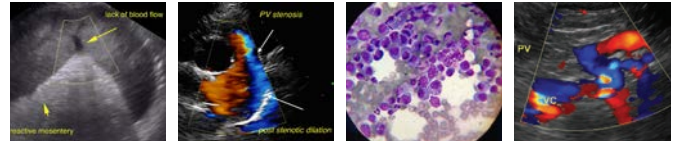
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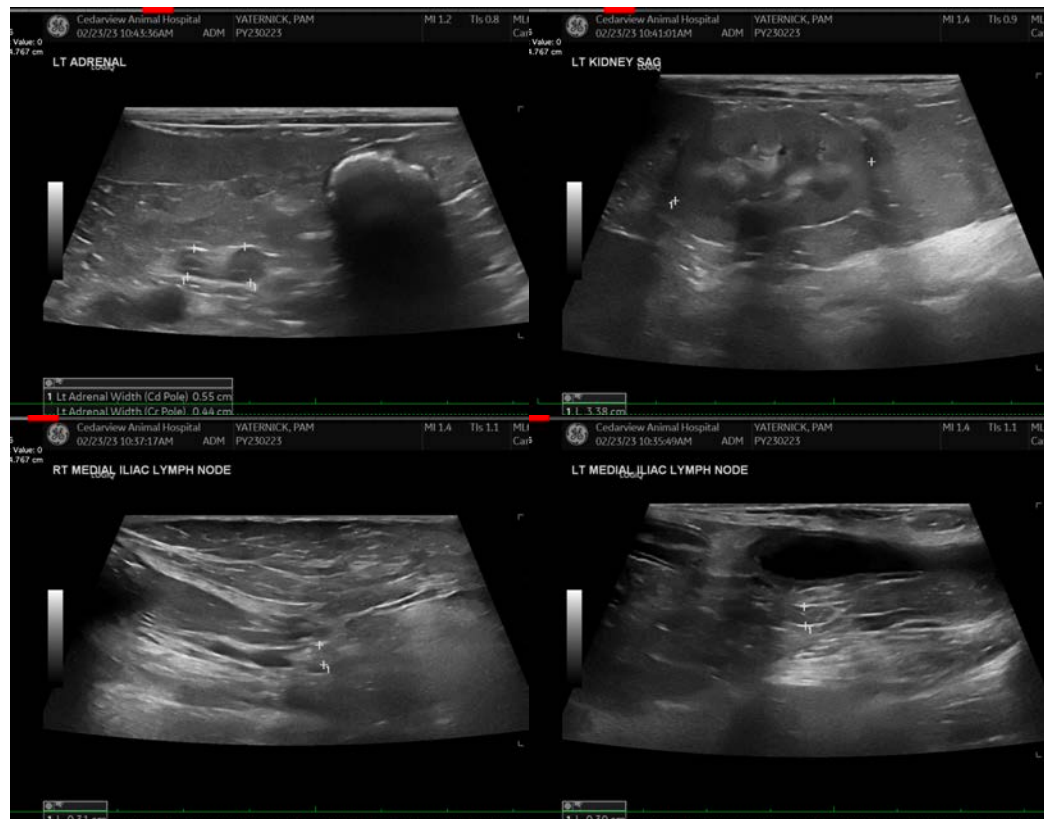
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
Beth.Johnson@sonopath.com