

PATIENT

Pixie Woodstock
Veterinary Hospital

SPECIES

Feline

BREED

Persian

SEX

FS

AGE

13 years

WEIGHT

2.7 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Michelle DeMelo, RVT

HOSPITAL NAME

Woodstock Veterinary
Hospital

REFERRING VET

Dr. Esther Duschinsky

INVOICE

11784

DATE

4/23/2026

PRESENTING CLINICAL SIGNS

August '24 Pixie was showing clinical signs of a possible FB (she eats scotch tape!) so we took her to surgery. Intra-op, instead of a FB, it was found that her spleen appeared abnormal with poss masses & her spleen had created adhesions within her abdomen which were creating some GIT obstruction. There also appeared to be some abnormal tissue throughout her mesentery (mets vs normal splenic tissue in weird locations?) Splenectomy was performed and an esoph feeding tube was placed - it took her several months to recover, but with time she improved well. Histo of her spleen was inconclusive but was suspected that it was hemangiosarcoma. Blood work has shown progressive anemia and early renal disease. We have been managing her with twice weekly injs of Dexamethasone and Cerenia and added mirtazapine for appetite stimulation in the past 6 mths. In the past week Pixie has developed anorexia, lethargy & intermittent pyrexia. We have been giving her daily 0.3 mg/kg Dexamethasone injections and 1mg/kg Cerenia injections, yesterday we added Pradofloxacin antibiotic (in desperation) and she has been feeling better today. We are looking for an underlying cause of the anemia etc. Is this hemangiosarcoma?

Abnormal PE/Chem/CBC/UA Results: Her bloodwork and U/A showed worse mildly regenerative anemia with a Hct =18 on Monday and Hct =16.1 on Thursday, and an inflammatory leukogram.

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 (3.3 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 (3.8 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 areas of the adrenal glands are examined without evident adrenal gland pathology.

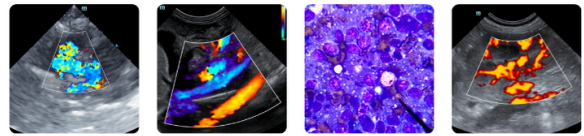
Spleen

The spleen has reportedly been previously removed. *See Free Abdomen*

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 smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.



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Gastrointestinal

The visible stomach wall is normal in thickness 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. 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

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. No pancreatic duct dilation is noted.

Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

However, there are multifocal ill-defined hypo- to anechoic densities/nodules throughout the abdomen. The largest of which measures approximately 2.0 cm x 4.5 cm in size.

ULTRASONOGRAPHIC FINDINGS

- Multifocal hypo- to anechoic densities throughout the abdomen are concerning for metastatic lesions, given patient's history and the concern for previously removed hemangiosarcoma. Having said that, especially without a definitive previous diagnosis, benign lesions including hematomas, abscesses, other inflammatory lesions can't be ruled out without tissue sampling.
- Chronic low grade smoldering pancreatitis is a possibility.

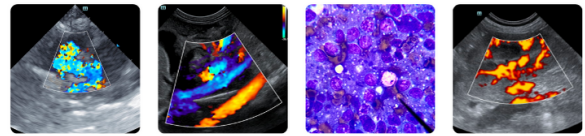
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's history combined with almost anechoic appearance of especially the largest mass like lesion described above, one differential for the anemia is bleeding into the mass. Having said that, there's no definitive free fluid and therefore other causes of the anemia, unrelated to hemorrhage, are also possible.

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.

Fine needle aspirates of the hypoechoic densities, especially the large one described above, could be considered if patient's coagulation status is appropriate.

Additionally, and/or alternatively, if a diagnosis is unable to be obtained, advanced imaging such as an abdominal +/- thoracic contrast CT scan could be considered.



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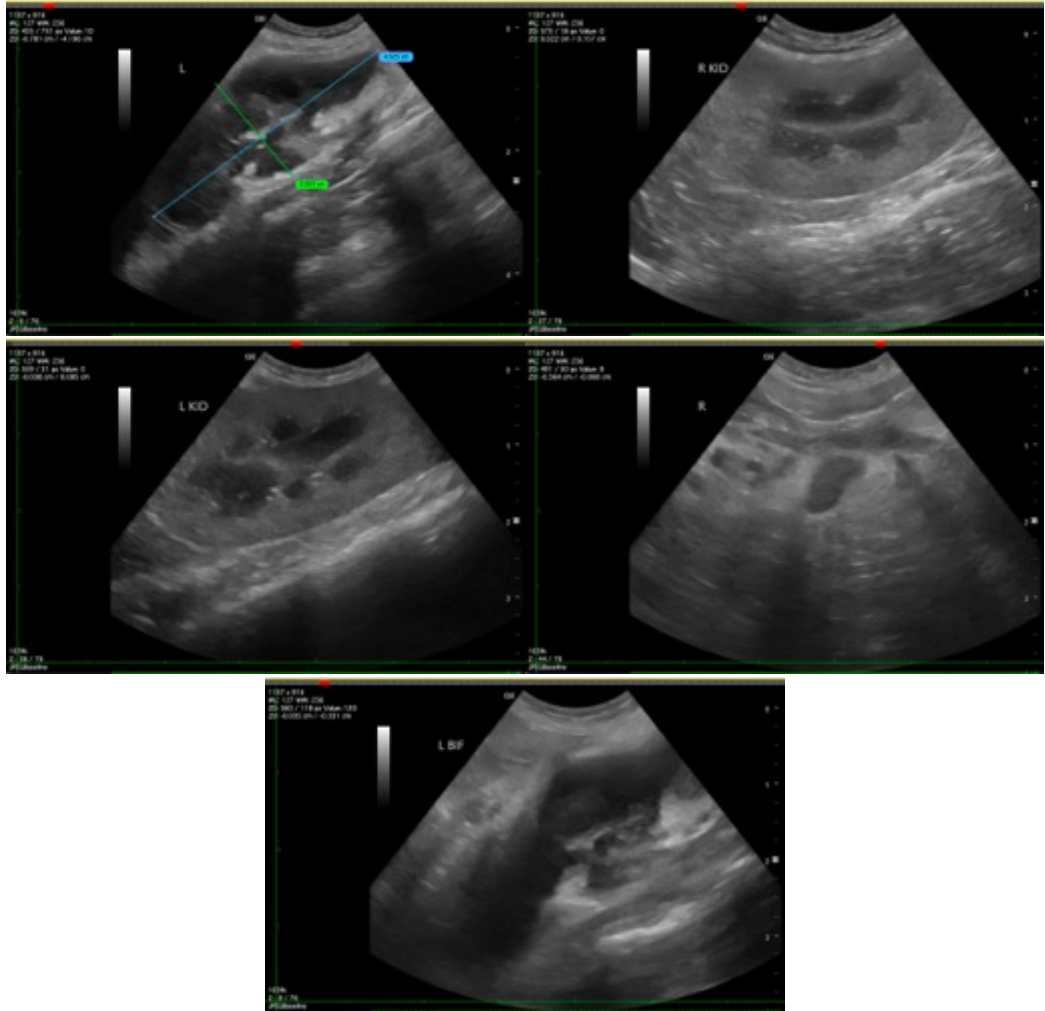
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Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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