PATIENT
Blue Brown

SPECIES
Canine

BREED
Goldendoodle

SEX
MI

AGE
3Y

WEIGHT
57.2lbs

INTERPRETED BY
Beth Johnson, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY
Kathleen Byrnes

HOSPITAL NAME
Shallowford Animal Hospital

REFERRING VET
Dr. Eads

INVOICE
75120

DATE
5-26-26

PRESENTING CLINICAL SIGNS

P presented on 5/21/26 for lethargy, not eating, Rads showed enlarged liver and spleen, mm- pale, anemic, tachypneic, Blood transfusion PCV omcfreased up to 17% Today returned to 11%, P started on Prednisone
Abnormal PE/Chem/CBC/UA Results: 4 dx Neg x 4, PCV 11, HCT 17, slight hypochormiasia, Moderate anisocytosis, Marked polychromasia, nRBC 20, PLT 75 Chem TP 4.4, ALB 2.2, Tbili 0.6, Ca 8.4 CBC Path Review Pending Coag panel- normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

Prostate is normal in size (2.98 cm sagittal view) for an intact male. Parenchyma is diffusely homogenous and relatively hyperechoic. Normal distinct margins and symmetrical bilobed shape are maintained.

Left kidney is normal in size (6.85 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.

Right kidney is normal in size (7.46 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

Left adrenal gland is normal in size (0.47 cm at cranial pole and 0.49 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.54 cm at cranial pole and 0.46 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

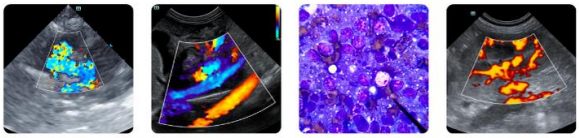
Spleen

Spleen is subjectively large in size with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. No discrete sizable focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The gallbladder 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.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with some fluid, gas, and echogenic nonshadowing content consistent with normal ingesta/chyme. However, in some views, there is some progressively shadowing contents that could still represent normal ingesta, gas, etc., although nonobstructive foreign material, while thought less likely, cannot be definitively ruled out.

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 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 area of the pancreas contains irregular hyperechoic pancreatic remodeling.

Free Abdomen

There is a mild amount of free fluid present in these images.

The medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

Both testicles are visualized without evident testicular pathology.

The visible heart base (RA) and pericardium are unremarkable without obvious pathology noted in these images at this time. If cardiac function evaluation is desired, a full echocardiogram is recommended.

ULTRASONOGRAPHIC FINDINGS

- Coarse splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- Mildly Heterogenous Liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- 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.
- Hyperechoic pancreas – This finding is suggestive of pancreatic fibrosis, possibly secondary to chronic pancreatitis. A TLI is recommended to rule out exocrine pancreatic insufficiency (EPI), especially if clinical signs (weight loss, diarrhea, etc.) are present.

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- Mildly Reactive Medial Iliac lymphadenopathy – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- The mild to moderate amount of free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.
- As described above, while not thought likely, gastric foreign material cannot be ruled out. Reassessment following an additional 12-24 hours of fasting could be considered.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A manual platelet review could be considered to help determine whether or not sampling is a possibility in which case FNA of especially the spleen +/- liver, are recommended.

In the meantime, comprehensive infectious disease evaluation could be considered.

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

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.

Pending results of that workup, especially if the anemia is nonregenerative and remains nonregenerative passed the early regeneration stage, bone marrow sampling may be an option.

If not recently evaluated, urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

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

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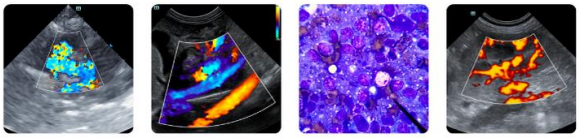

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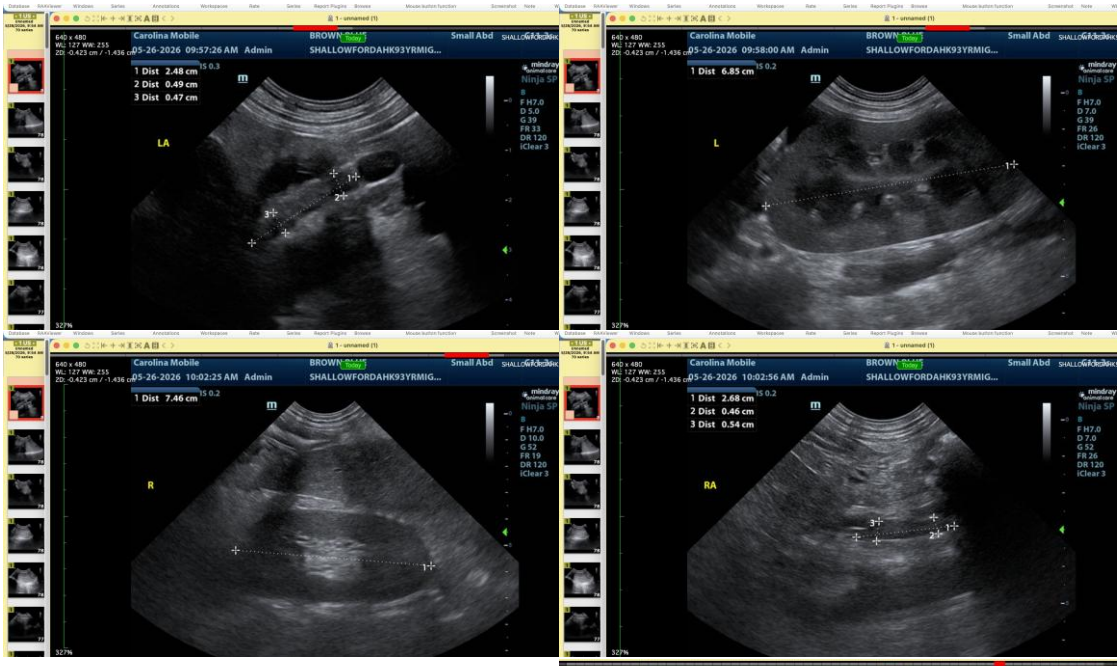

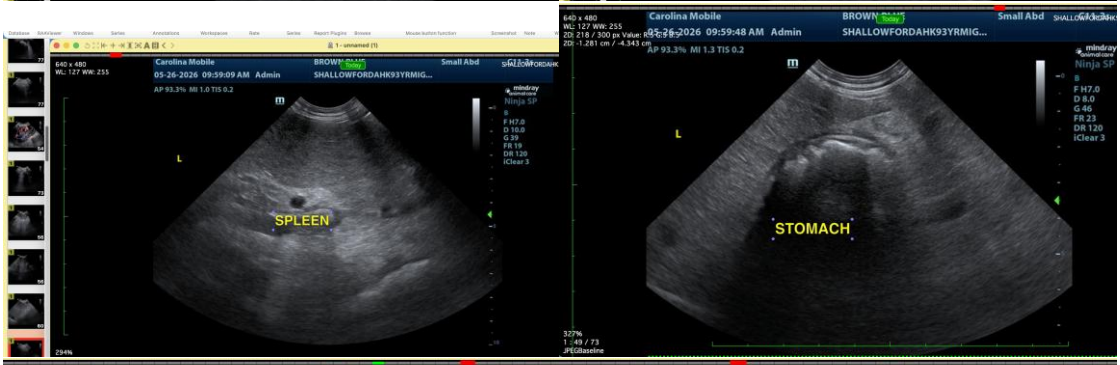

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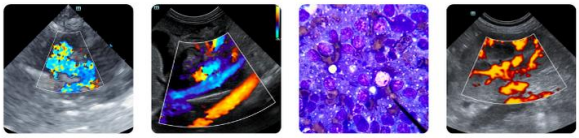

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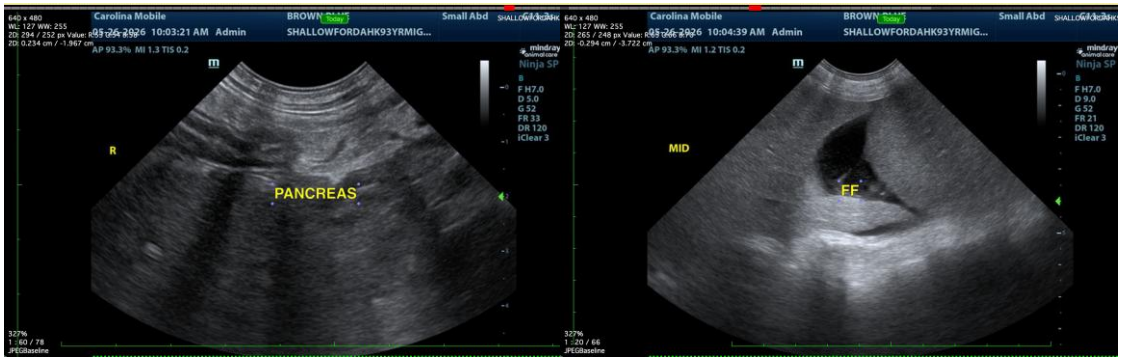

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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