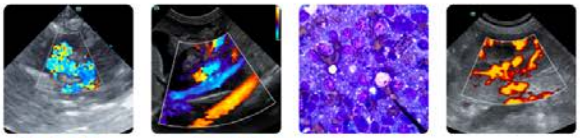


PATIENT

Bella Marchese

SPECIES

Canine

BREED

Labradoodle

SEX

Spayed Female

AGE

9 Years

WEIGHT

54.4 lbs

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Pet Care Clinic of the High Country

REFERRING VET

Dr. Watson

INVOICE

72331

DATE

12/4/25

PRESENTING CLINICAL SIGNS

P has glaucoma and is managed by ophthalmologist. Rec Enucleation. P presented today for surgery, preanesthetic bloodwork showed platelet machine count at 25,000. Manual count showed 46,000 with No clumping seen, 4dx neg x 4. rdvm requested US to screen for cause of thrombocytopenia and postponed surgery. No swelling or bruising from blood draw site

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The Bladder wall largely appears of normal thickness with a smooth mucosal surface. In the trigonal region in the ventral wall near the cystourethral junction, there is a small wall irregularity measuring 0.55 cm x 0.33 cm. Additionally, deep in the region of the cystourethral junction there is a soft tissue structure with somewhat polypoid like appearance, measuring 0.48 cm x 0.66 cm. The proximal urethra appears normal with no evidence of any significant lesions.

The left kidney has a normal shape and size (6.22 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.57 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.55 cm at the cranial pole and 0.58 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

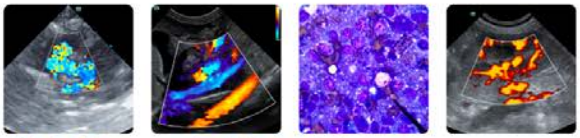
The right adrenal gland is normal in size measuring 1.01 cm at the cranial pole and 0.49 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is normal in size but irregular in shape. The blood flow through the hilus and splenic parenchyma appears normal. There is a large, hypoechoic, mixed echogenicity mass effect visualized associated with the mid cranial region of the spleen, which deforms the splenic capsule, measuring 1.96 cm x 2.31 cm.

Liver

The liver is large in size and rounded. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There are occasional, somewhat poorly defined hypoechoic nodules visualized throughout the parenchyma. Examples measure 1.34 cm x 1.43 cm and 0.69 cm x 1.11 cm.



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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains mild/moderate fluid/ingesta. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.45 cm. Jejunum wall measures 0.38 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The right limb of the pancreas is prominent and focally hypoechoic adjacent to the duodenum with mild to minimal surrounding inflammation. Findings could be consistent with mild focal pancreatitis or pancreatic remodeling.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no evidence of a diffuse lymphadenopathy. There is a prominent lymph node near the tail of the spleen measuring 0.77 cm x 1.55 cm. The omentum is generally of normal echogenicity/slightly reactive near the right pancreas.

Other

The right auricle and pericardium were visualized and were unremarkable. No obvious pathology is visualized. If cardiac function evaluation is desired a full echocardiogram is warranted.

ULTRASONOGRAPHIC FINDINGS

- Small bladder wall irregularity near the trigone, and a larger elongated soft tissue structure visualized near the cystourethral junction – Findings could be consistent with a polypoid lesion and cystitis or an early transitional cell carcinoma.
- Mixed echogenicity hypoechoic splenic mass lesion –Differentials include : benign lesions (lymphoid hyperplasia, hemangioma etc..) or cancerous lesions (hemangiosarcoma, lymphoma, histiocytic sarcoma etc..)
- Focal areas of hypoechoic prominent pancreas in the right limb – Findings are most consistent with mild pancreatitis/pancreatic remodeling.

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- Heterogeneous, rounded liver with ill-defined hypoechoic nodules – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. The nodules observed trend toward a more benign process but underlying neoplasia cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a mixed echogenicity hypoechoic mass effect visualized associated with the spleen. This alters the splenic margins. This could represent a benign or neoplastic lesion. Typically, I would recommend a splenectomy with samples for histopathology, as a benign or neoplastic lesion can have implications in the future (rupture, etc.). If platelet count is in a safe range this could be considered, or a fine needle aspirate could be considered.

There is mild irregularity and a polypoid looking lesion near the trigone region of the urinary bladder. Correlate with urinalysis and culture. If no infection is present, consider either a urine BRAF test or a traumatic catheterization at the level of the cystourethral junction. A positive urine BRAF test would increase the likelihood of a neoplastic lesion but is not definitively diagnostic. A negative urine BRAF test is non-diagnostic and would require further evaluation. If an infection is present, recommend treatment and reevaluation of this region after a prolonged course of antibiotics and negative urine culture (likely 2-4 weeks with concurrent probiotic therapy).

The right limb of the pancreas is prominent. The significance of this is uncertain. In the absence of GI signs, correlate with a PLI level and consider empirical treatment for pancreatitis if clinically appropriate.

The liver is large and slightly heterogeneous with some ill-defined hypoechoic nodules. The appearance of the nodules trend towards a benign process. If liver enzyme elevations are present, consider a liver function test and a fine needle aspirate of the liver.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).

Obviously, invasive diagnostics may need to be delayed until the thrombocytopenia is further evaluated. Recommend a pathologist review of the blood smear, screening for vector borne diseases, evaluation for any lymphadenopathy, etc. If a platelet count is safe enough for splenectomy, this could be considered, as it could be a trigger for thrombocytopenia, or if no other cause is identified, conservative treatment for ITP could be considered so that further diagnostics could be performed.

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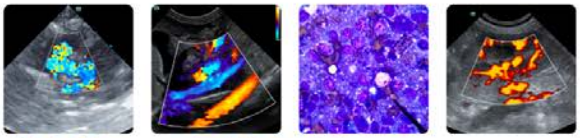

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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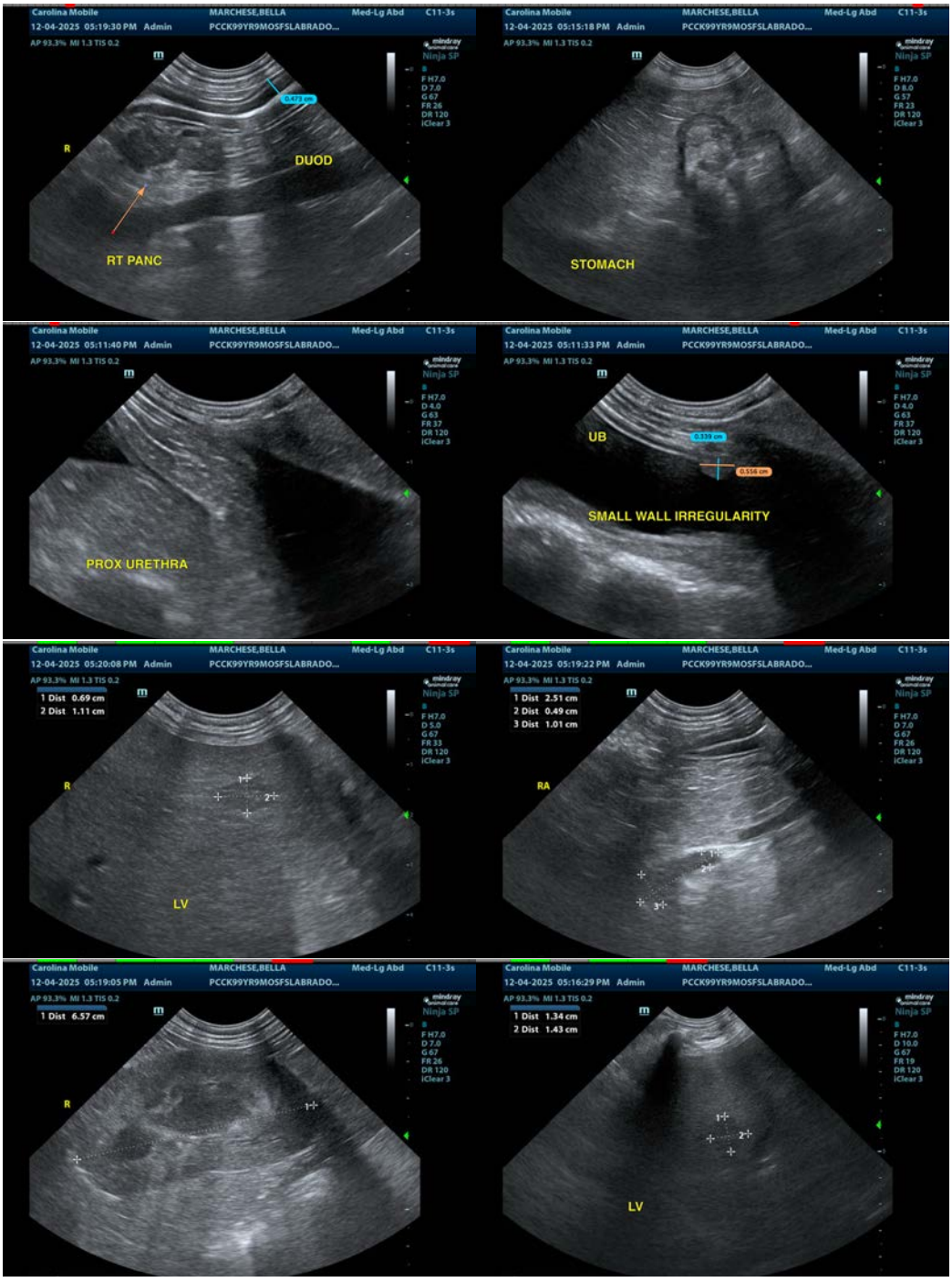

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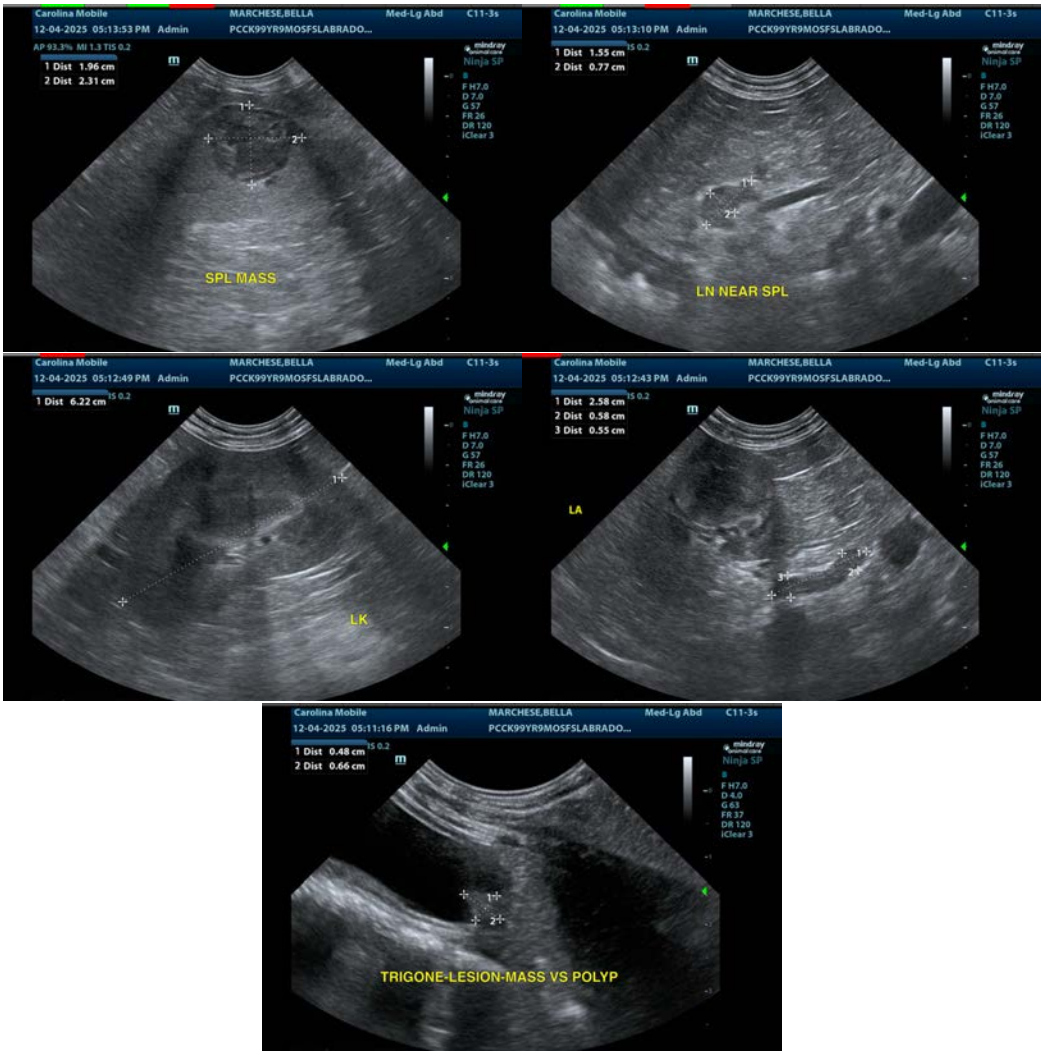

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

info@sonopath.com