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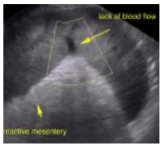
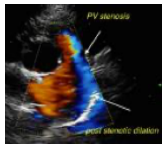
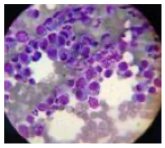
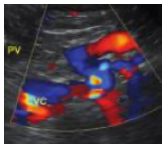

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1-800-838-4268 info@sonopath.com

**PATIENT**

Boomer Anderson

**SPECIES**

Canine

**BREED**

American Staffordshire Terrier

**SEX**

Neutered Male

**AGE**

6 years, 5 mos

**WEIGHT**

73 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Amanda Lacey-Crook SDEP Cert Sonographer

**HOSPITAL NAME**

Rivers Edge Pet MC

**REFERRING VET**

Dr. David Gray

**INVOICE**

13415

**DATE**

6.19.23

## PRESENTING CLINICAL SIGNS

History: Treating for IMHA last 6 months, now potential ITP case; recent increase 4 days ago in prednisone to 40mg BID dosing (from 20mg BID); currently on Famotidine as well.

Abnormal PE/Chem/CBC/UA Results: See attached - CBC from today (6/19): RBC 5.59, HCT 36.7, HGB 12.7, WBC 18.23, Neu 16.11, Eos 0.00, PLT 111 (prev less than 25) 4DX neg CBC 6/14: Eos 0.05, PLT less than 25, MPV 14.8, PCT 0.04 See attached previous CBCs for historical marker.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is moderately distended with anechoic urine. The bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The left kidney has a normal shape and size (3.67 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 (6.45 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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/borderline small in size (0.34 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/borderline small in size (0.52 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 subjectively normal in size The spleen echotexture is heterogenous and mildly mottled, the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

### *Liver*

The liver is subjectively large in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

### *Gastrointestinal*

The stomach contains minimal luminal contents. 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.

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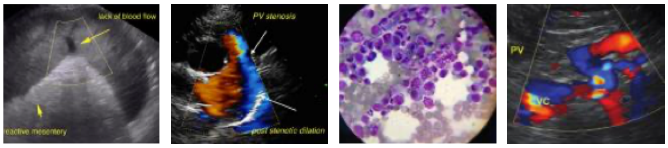

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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured as normal (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. 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 pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

***Free Abdomen***
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity. ‘

***Other***
A brief view of the heart was submitted. No pericardial effusion was seen.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

- Mildly mottled spleen - The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

- Large heterogenous liver – 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. This could be consistent with steroid hepatopathy.

### Secondary Findings

- Borderline small adrenals – This is likely due to chronic steroid therapy.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized on today’s exam to explain the anemia reported. The spleen is slightly mottled. This could be secondary to a regenerative response. A fine-needle aspirate could be considered to look for evidence of active phagocytosis, evidence of Babesia, underlying neoplastic change, etc.

If not already done, consider screening for haemoparasites, which may become more apparent with immunosuppression. Additionally, I’d hesitate to increase the prednisone dose, as the patient is already on an immunosuppressive dose. If more immunosuppression is desired, I would consider adding in an additional immunosuppressant, with the hopes of tapering the prednisone down. Additionally, you could consider measuring iron and B12 levels. If this has been a longstanding regenerative anemia, you can see depletions in some of these areas.

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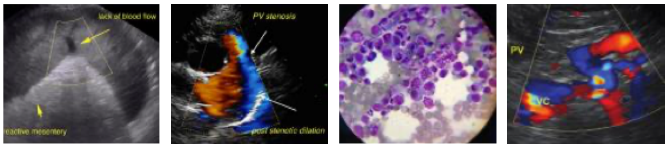

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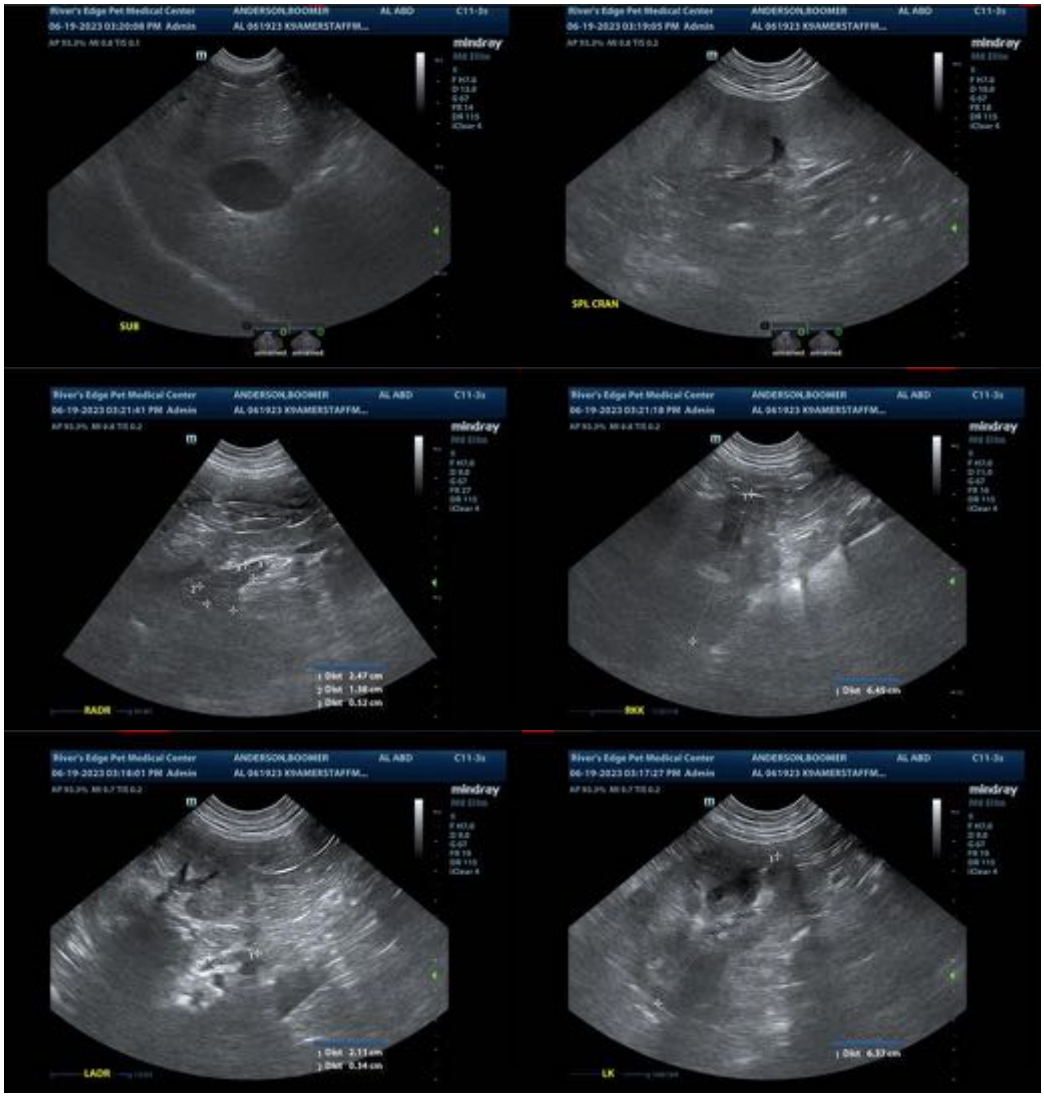

**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

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