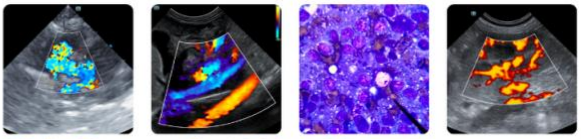


PATIENT

Mazie Guzy

SPECIES

Canine

BREED

Maltese Mix

SEX

Spayed Female

AGE

6 Years 9 Months

WEIGHT

4.9 kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

IMAGING PERFORMED BY

Dr. Sookhoo

HOSPITAL NAME

Calusa Veterinary Center

REFERRING VET

Dr. Holst

INVOICE

13979

DATE

02/27/26

PRESENTING CLINICAL SIGNS

- Mazie presents for continued black stool and declining blood parameters
- Patient History:
- - Previous ER visit with Dr. Rodriguez: normal PCV and TP, black stool attributed to Pepto Bismol administration
- - Visited Monday with Dr. Turkell for persistent black stool
- - CBC on Monday (2-23) showed significant decline in blood parameters:
- - RBC count dropped from 4.4 million to 2 million
- - Values dropped
- - Platelets increased from 0 to 3 (severely low)
- - Non-regenerative anemia
- - Currently on prednisolone 2mg/kg PO q12h since Monday, with initial injection given
- - Client reports patient "acting funky" and not doing well since treatment began
- - Previous week: cried out, brought in for examination, no abnormalities found, received Bordetella vaccine
- - Patient has been eating but overall condition declining

Abnormal PE/Chem/CBC/UA Results: POCUS: No B-lines, No pericardial or pleural effusion, Adequate left ventricular contractility and volume load, LA:Ao 1:1, No peritoneal effusion, Moderate urinary bladder volume. 2 hour post-transfusion PCV/TS: 28%/6.8g/dL iSTAT Chem 8+: Glu 134, BUN 16, Creat 0.5, Na 151, K 4.0, Cl 115, iCa 1.21 cPL: 141.2 ng/mL - normal Thoracoabdominal radiographs: The thorax and abdomen are considered to be radiographically normal. No abnormalities are seen that contribute to the understanding of the thrombocytopenia, melena, and regenerative anemia. There are chronic degenerative changes affecting both hip joints.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Echogenic to particulate nondependent minor sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

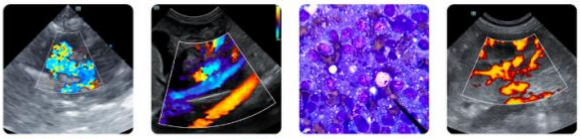
The area of the aortic trifurcation was free of pathology.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 3.7 cm in length. The right kidney measured 3.9 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.37 cm width at the caudal pole.

The right adrenal gland was indistinctly visualized and overtly normal in size, position and shape. The right adrenal gland subjectively measured 0.41 cm width at the caudal pole.



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Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver & Gallbladder

The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended in size. The gallbladder wall was thickened in appearance consisting of an echogenic double rim corresponding to the inner and outer portions of the wall. This is consistent with gallbladder wall edema. Possible causes may include acute inflammation, edema and anaphylaxis. Mild to moderate congealed possibly adhered nonmineralized gallbladder debris was present. The common bile duct was not visualized.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained variably echogenic, mild to moderate nonshadowing ingesta. No evidence of obstruction to pyloric outflow. The pylorus wall measured 0.38 cm wall width.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The duodenum wall measured 0.40 cm wall width. The jejunum wall measured 0.30 cm wall width.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Sonographically normal gastrointestinal tract with nonshadowing gastric ingesta- consistent with food echogenicity.
- Noncongested hepatomegaly.
- Mild edematous gallbladder with congealed gallbladder debris.
- Sonographically normal spleen.
- Mild urine sediment,

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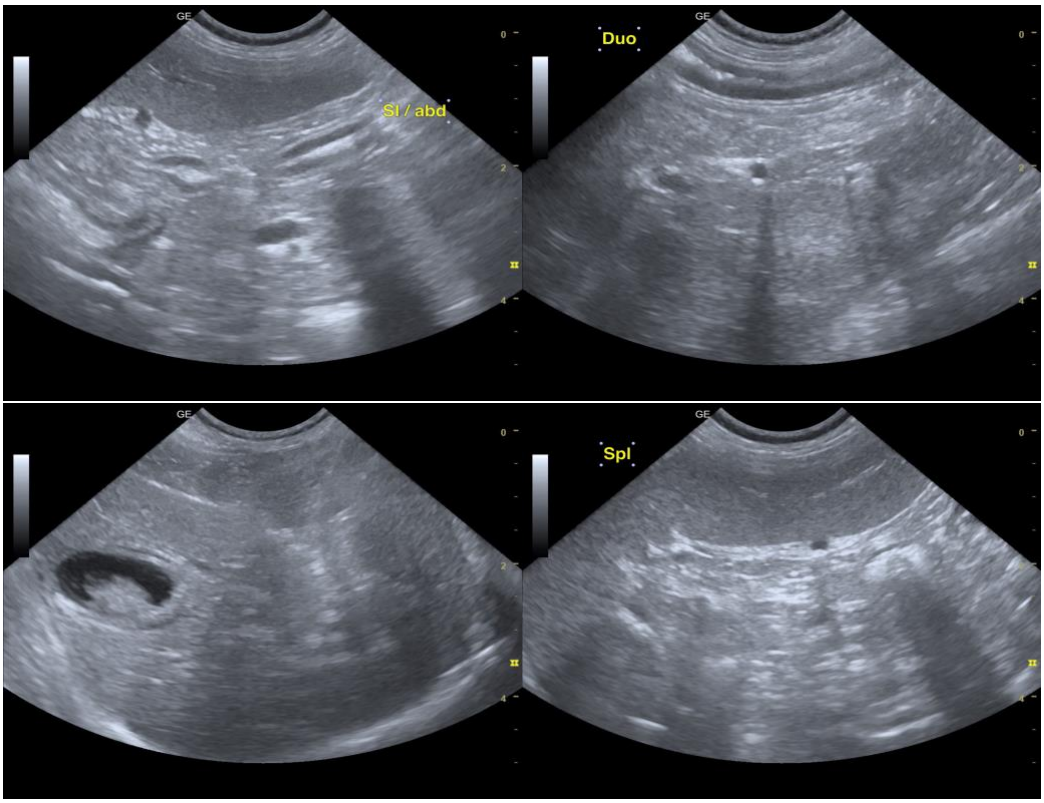
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of significant visceral pathology, i.e. gastrointestinal mural pathology, definitive gastrointestinal ulceration, or abdominal masses as an obvious cause of the patient's clinical signs (anemia and thrombocytopenia). The liver suggests benign criteria, i.e. vacuolar or cholestatic hepatopathy, inflammatory disease, hyperplasia are all potentials with occult hepatic neoplasia thought less likely. The gallbladder wall edema is secondary to inflammation or anaphylaxis possible. Microscopic gastrointestinal pathology, such as micro ulceration, may be difficult to visualize sonographically.

CBC pathology review and infectious disease serology, if clinically indicated, may be considered. Broad-spectrum gastroprotectants with concurrent hepatogastrointestinal support and clinical monitoring would be appropriate. In addition to current empirical steroid therapy, doxycycline trial for infectious disease coverage may prove beneficial.



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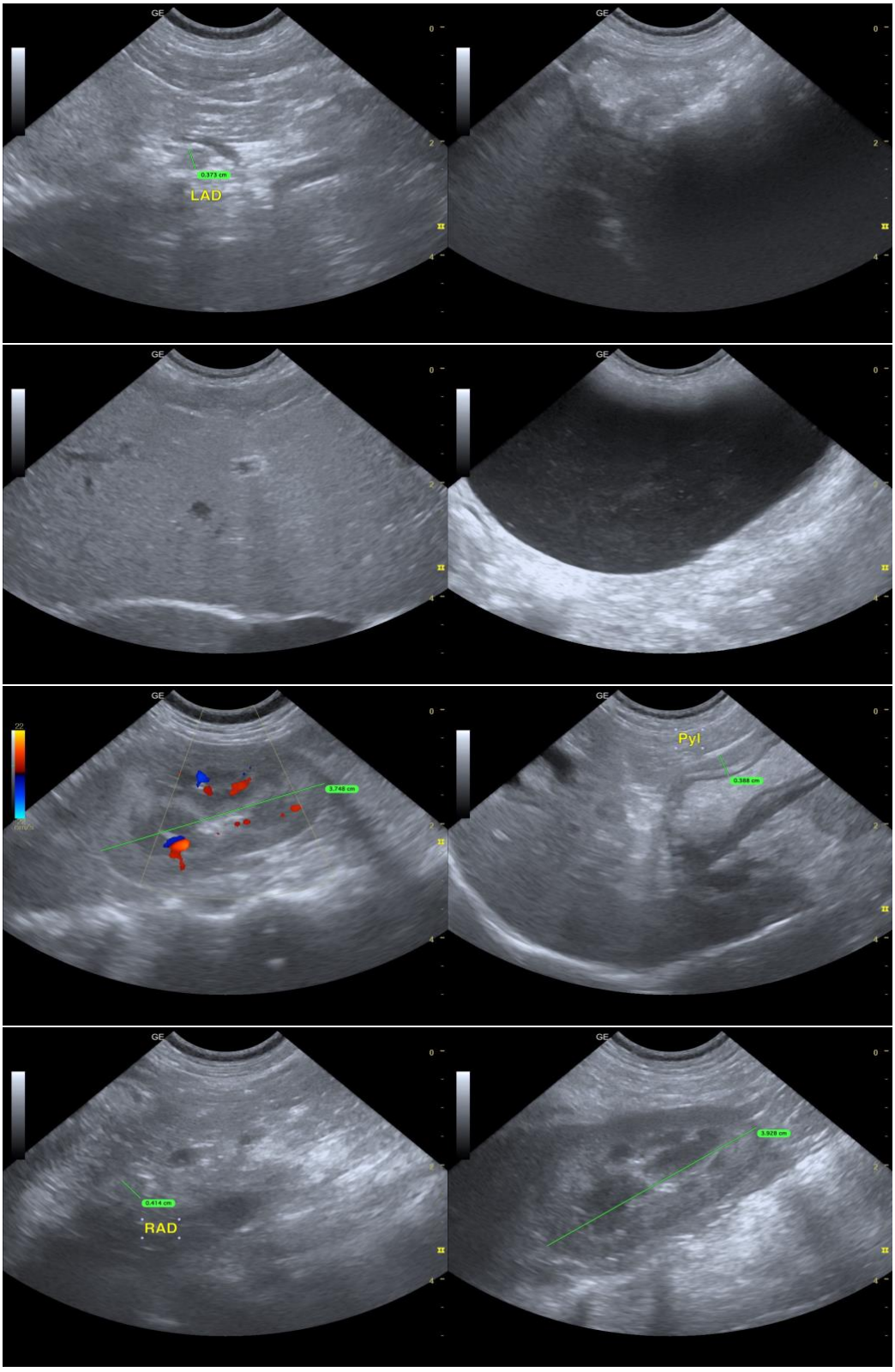

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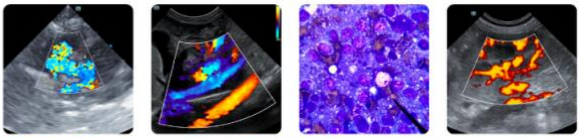

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com