

**PATIENT**

Pixie Joyce Lamb

SPECIES

Canine

BREED

Miniature Pinscher

SEX

Female Spayed

AGE

5 Years 5 Months

WEIGHT

7.24 kg

INTERPRETED BYR. McKenzie Daniel,
DVM, DABVP
(Canine and Feline)**IMAGING PERFORMED BY**

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Dr. Maller

INVOICE

20954

DATE

2/3/23

PRESENTING CLINICAL SIGNS

History: Pixie Joyce presented to the MVS Emergency Service on Feb 02, 2023, at 5:27pm, for evaluation of lethargy, pale gums. Pixie has not eaten since Sunday and has been lethargic since that time as well. Owner brought her to pcDVM yesterday where they did rads, bloodwork and SQF. Today, owner noticed Pixie was breathing abnormally - shallow breaths - and her gums were pale. She called pcDVM and they recommended bringing her in to us. Pixie had an episode of hematemesis on Tuesday night and has potentially been experiencing hematochezia over the last week as well.

Abnormal PE/Chem/CBC/UA Results: pDVM bloodwork from 2/1 and 2/2 4DX negative Neutrophilia Monocytosis Platelets - 71,000 Chemistry panel normal 6:15 pm - PCV 12% TS - 5.8 g/dl Patient given 125 ml of DEA negative pRBCs over 4 hours. She vomited a large blood clot Platelet estimate - ~45,000 Post transfusion PCV/TS 31%/5.0 CBC 2/3 HCT 20.5 Retic 200.3k WBC 39.4k Neu 15.65k Lym 17.72k Mono 5.9k Plt

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. Mild nondependent particulate sediment was present, which may indicate cellular debris/protein, crystalline debris or mucus, 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. No evidence of bladder tumors.

No evidence of medial iliac or sublumbar lymphadenopathy.

Normal size and margination were 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 4.5 cm in length. The right kidney measured 4.85 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 0.50 cm width at the caudal pole and 0.46 cm width at the cranial pole.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.48 cm.

Spleen

The spleen was normal in size Potential for borderline enlargement. Areas of mild medial capsule asymmetry were present. Mild parenchyma heterogeneity with mild decreased parenchyma echogenicity. No evidence of splenic masses or nodules. Splenic vascularity was normal.

Liver

The liver exhibited subjective borderline to mild enlargement. 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

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mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

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The gallbladder was non-distended in size with primarily anechoic content and mild nonorganized echogenic luminal debris. No evidence of gallbladder or peripheral gallbladder inflammation. The cystic and common bile ducts were normal.

Gastrointestinal**BREED**

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The stomach presented intact sonographically normal wall layering. The lumen of the stomach contained a mild amount of focally shadowing ingesta. No evidence of mechanical pyloric outflow obstruction. The pylorus wall measured 0.38 cm.

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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 0.36 cm. The jejunum wall measured 0.29 cm.

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

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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.

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Free Abdomen

Several, mildly prominent to enlarged mid abdominal mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example measured 2.2 cm x 0.5 cm. Small pocket of scant perisplenic free fluid was noted. No omental masses were present.

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ULTRASONOGRAPHIC FINDINGS**IMAGING PERFORMED BY**

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- Minor urinary bladder sediment
- Mild heterogenous to hypoechoic spleen, scant perisplenic free fluid
- Subjective borderline hepatomegaly- overtly benign
- Mild gallbladder debris (non-mucocele)
- Intact overtly normal gastrointestinal wall layering with mild nonspecific gastric ingesta
- Intermittent benign/reactive mesenteric lymphadenopathy

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The spleen was nonspecific with considerations including primary or secondary hyperplasia, hematopoiesis, splenitis, while the possibility of early infiltrative neoplasia cannot be excluded. If normal clotting status, screening splenic FNA cytology, using a 25-gauge needle, is suggested, primarily to ensure only benign changes are present and to rule out potential for infiltrative neoplasia as a contributing factor to the anemia. Expanded infectious disease serology, if clinically indicated, may be considered. No overt evidence of gastrointestinal mural pathology, i.e., significant mural thickening, masses, definitive ulceration, etc. Potential for nonobvious or microulceration is possible given the

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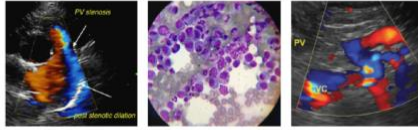
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reported hematemesis. Gastroprotectant protocol and as needed gastrointestinal support is warranted.

Empirically, some or all of the following protocol is suggested.

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IMHA/Infectious Anemia/Thrombocytopenia/Evans Syndrome

(Note: ensure no underlying neoplasia as IMHA/Evans syndrome can occur as paraneoplastic manifestation especially in lymphoma/round cell neoplasia)

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Anemia +/- thrombocytopenia with spherocytes/autoagglutination in dogs and hyperbilirubinemia, bilirubinuria. *(NOTE: cats do not get spherocytes in IMHA)*

Consider Onion/Garlic derivative ingestion if Heinz bodies present.

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Prednisone (K9) Prednisolone (Feline): 2 mg/kg Sid/Bid initially x 3 weeks then attempt taper

Aspirin 0.5 mg/kg Sid owing to hypercoagulable state

Sucralfate 0.5-1 g po tid dogs, 0.5 g bid cats in slurry

Doxycycline if infectious suspected clinically or based on CBC path review:

Dogs, Cats: 10 mg/kg p.o. q24h with food or water bolus in cats

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Long-term management dogs: Azothiaprine 2 mg/kg Sid or Cyclosporine 10mg/kg po sid bid

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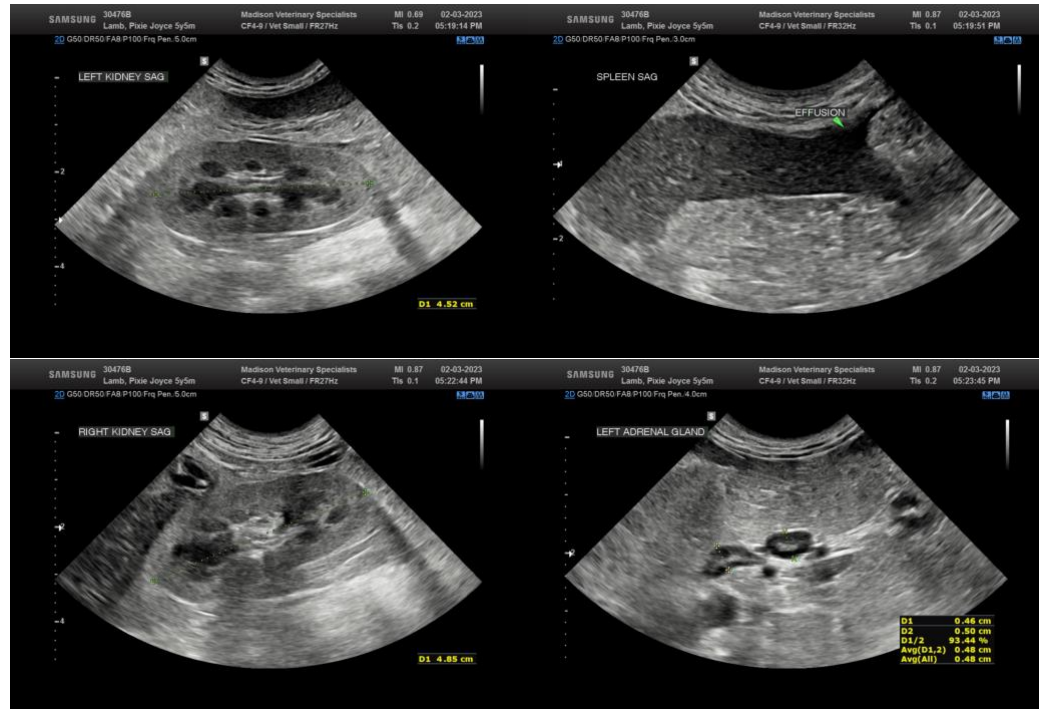
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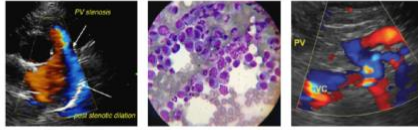
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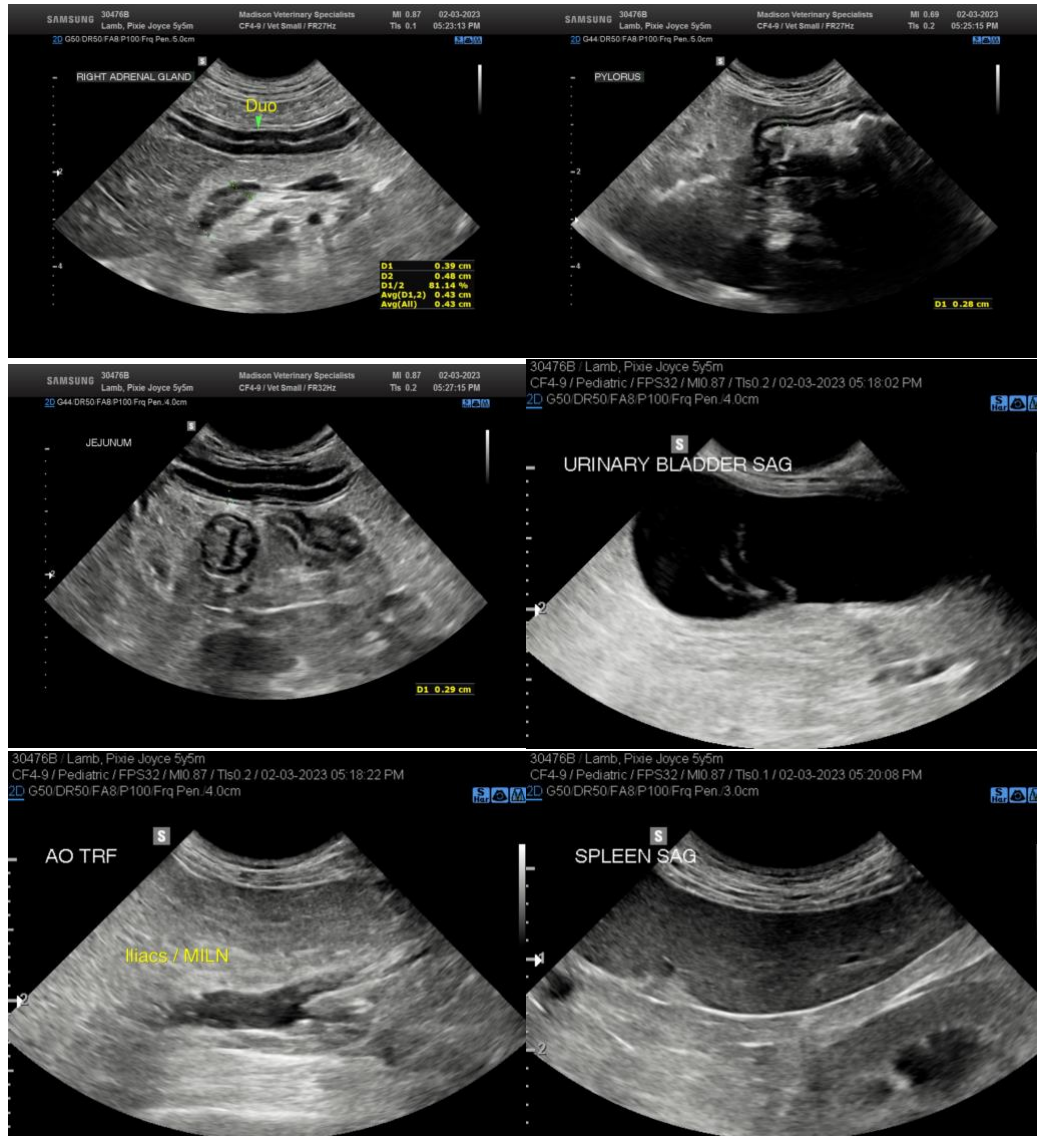
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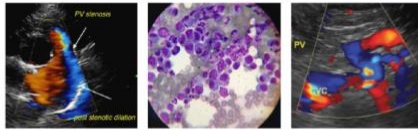
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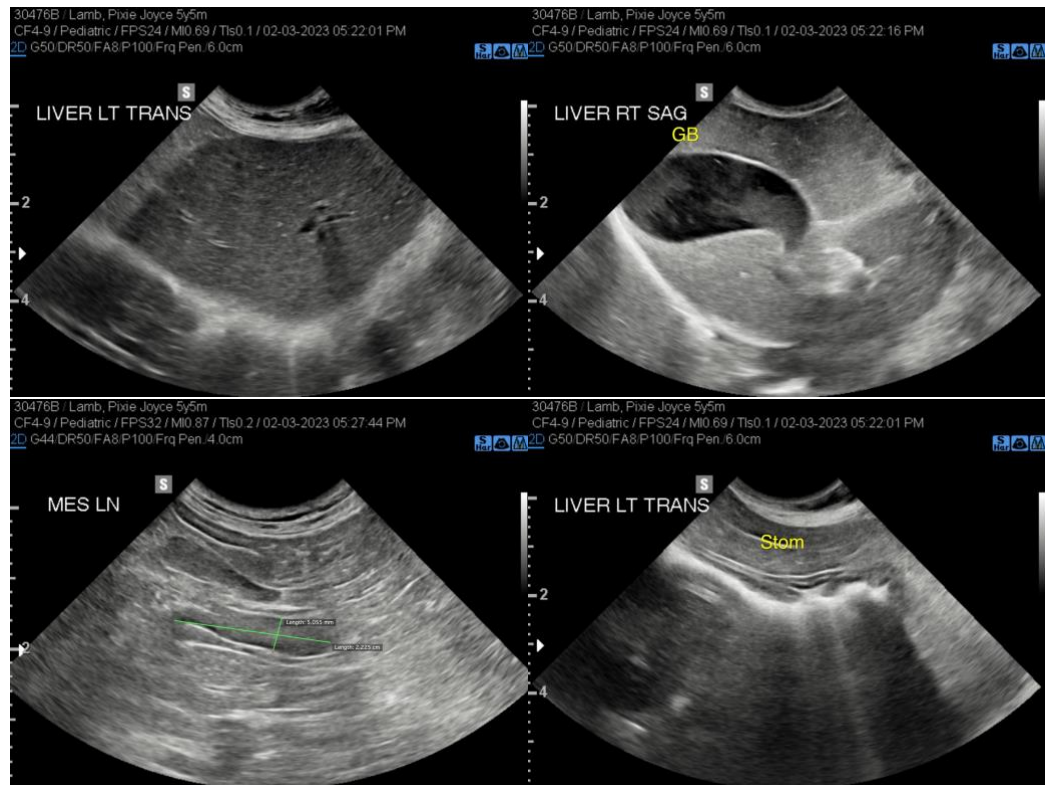
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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