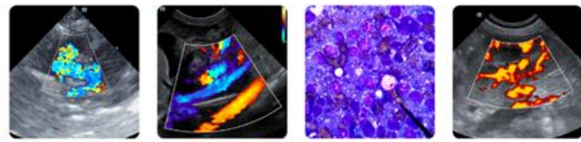


PATIENT
Piggy Sidleck

SPECIES
Canine

BREED
Pitbull

SEX
FS

AGE
8yr

WEIGHT
32kg

INTERPRETED BY
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY
Renee Trionfetti, VMD

HOSPITAL NAME
Blue Pearl Wyomissing

REFERRING VET
Heatherlynn McFarlane, DVM

INVOICE
24103

DATE
03/04/2026

PRESENTING CLINICAL SIGNS

Double cavity further evaluate abdominal effusion. No heart murmur appreciated. Beginning work-up and management with internal med. Noted ~1 month ago when Piggy became tender around her abdomen which seemed distended. Evaluated by pDVM and diagnosed with abdominal effusion. BW was unremarkable with normal albumin and LE (Alb 2.4). Started on furosemide which helped initially but then stopped being effective. Chest radiographs, AUS at pDVM, and abdominal fluid cytology were reported to be unremarkable. Repeat bloodwork 2/14/26 remained normal (Alb 3.3, normal LE/Tbil). Other than the distended abdomen, no other abnormalities or changes have been noted. She is eating well, normal energy, no chronic GI history (vomiting/diarrhea) or ongoing weight loss. No history of coughing or exercise intolerance.

Abnormal PE/Chem/CBC/UA Results: BP: 183, 183, 183 mmHg 1/30/26 Chem: TP 5.4, Alb 2.4, Glob 3, Cr 1.1, BUN 8, normal LES, GGT 0, TBil 0.1, Chol 116, Na 147, K 3.9, Cl 113, Ca 8.6, Phos 2.6, Glu 113 Abd Effusion: TP 3.3 Abd Effusion cytology: Pro 4.1g/dL, RBC <100,000cells/uL, Nucleated Cells 760cells/uL. Interp: Modified transudate. Composed chiefly of blood components mixed w/fewer lg mononuclear cells which are similar in appearance to reactive mesothelial cells or active macrophages. Infrequent lg mononuclear cells have engulfed little nonspecific debris. No erythrophagocytosis. No microorganisms. No cytologic confirmation of sepsis. 2/14/26 CBC: WBC 11.5K, Neut 9.2K, Lymph 1.48K, Eos 0.24K, HCT 55.7%, PLT 391K Chem: TP 6.5, Alb 3.3, Glob 3.2, normal LES, BUN, Cr, TBil 0.2, Na 149, K 3.6 L, Cl 104 L, Ca 10.1, Phos 3.1

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

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 6.1 cm in length. The right kidney measured 6.9 cm in length.

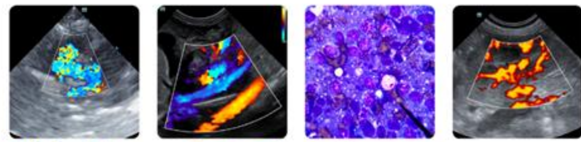
The area of the aortic trifurcation was free of pathology. No evidence of distal aortic or iliac trifurcation thrombus.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.61 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.65 cm width at the caudal pole.

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



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thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. No evidence of splenic vein thrombus.

Liver/Gallbladder

The liver presented mildly enlarged in size with symmetrical yet swollen contour. The parenchyma exhibited conserved uniform parenchyma with normal echogenicity isoechoic to the spleen and falciform fat. Dilated cranial abdomen caudal vena cava to the approximate level of the diaphragm. Within the peri diaphragmatic cranial abdomen caudal vena cava, a soft tissue structure was present, measuring ~ 5 cm x 2 cm.

The gallbladder was non-distended in size with thin walls and mild non-organized debris. No evidence of gallbladder wall edema. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

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 mechanical/metabolic ileus, obstruction or foreign material.

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

Pancreas

The right pancreas was mildly prominent in size with capsule asymmetry exhibiting mild non-homogenous hypoechoic parenchyma.

Free Abdomen

Mild to moderate volume peritoneal effusion.

No visualized significant or swollen mesenteric lymphadenopathy.

Generalized normal omental echogenicity without evidence of peritonitis.

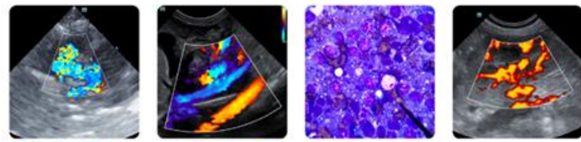
ULTRASONOGRAPHIC FINDINGS

Primary

- Dilated cranial abdomen caudal vena cava with peri diaphragmatic vena cava thrombus vs mass
- Congested liver
- Mild to moderate volume ascites
- Normal bilateral adrenal glands
- Mildly prominent non-homogenous hypoechoic right pancreas -suspect edema, potential for mild inflammation

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Definitive evidence of intra-abdominal pathology as an obvious cause of a hypercoagulable state, i.e. pancreatitis, adrenal disease, etc. was not obvious. Correlation with coagulation profile is recommended. Antiplatelet / anticoagulant therapy may be considered. Correlation with pending



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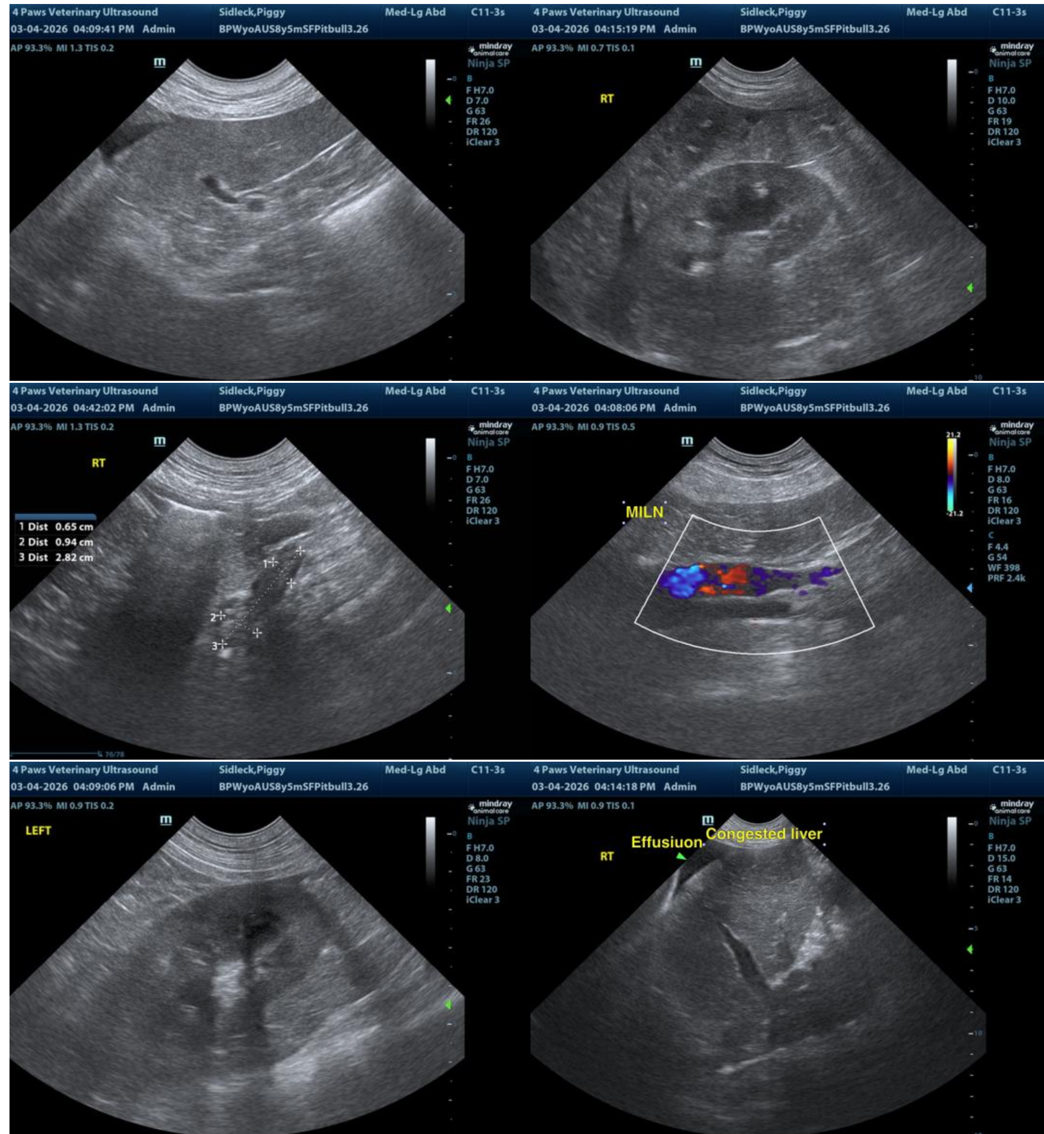
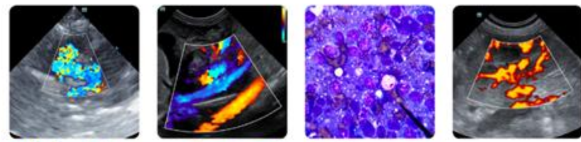
echocardiogram to assess for or rule out cardiomyopathy as a potential contributing factor is recommended. Abdominal CT would be ideal for further clarification.





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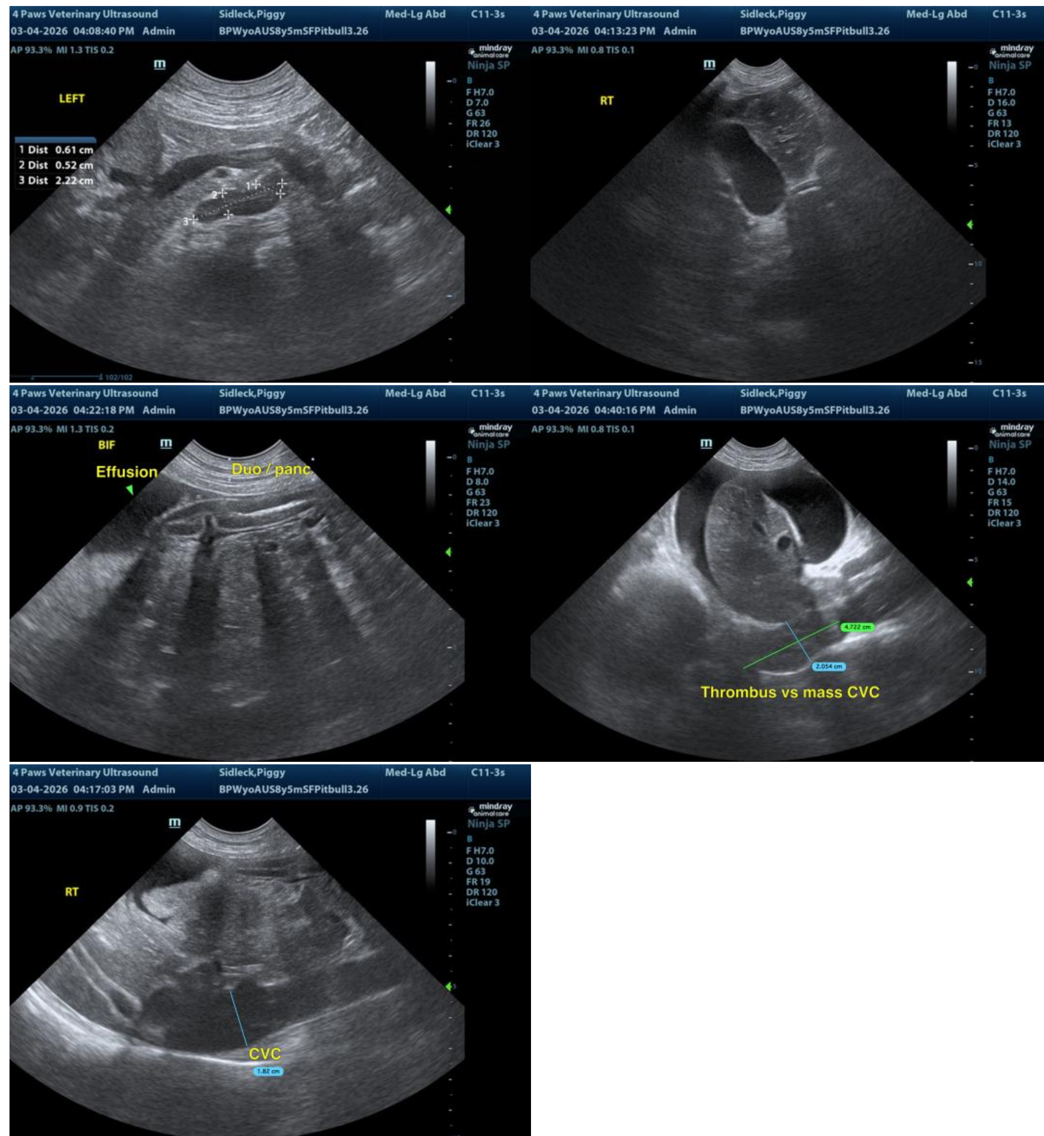

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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