



**PATIENT**

Tippy Icenhour

**SPECIES**

Canine

**BREED**

Lab Mix

**SEX**

Spayed Female

**AGE**

9 years

**WEIGHT**

53 lbs

**INTERPRETED BY**

Tam Mengine, DVM,  
 DABVP (canine/feline  
 practice)

**IMAGING PERFORMED BY**

Kathleen Byrnes

**HOSPITAL NAME**

Aloha

**REFERRING VET**

Dr. Rouco

**INVOICE**

11208

**DATE**

1/30/2026

**PRESENTING CLINICAL SIGNS**

- P previously at ER for vomiting blood and blood in stool, frank blood on rectal exam, not eating as well. Bloodwork at ER- ALKP 231.
- Rads: possible splenic mass.
- Meds: Metronidazole, omeprazole, carafate, cerenia.
- Did CPL after US- elevated at 292.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is minimally distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted. Urethra visualized to 4.0 cm.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal). Left kidney measures 5.9 cm, and the right kidney measures 6.4 cm.

**Adrenal Glands**

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. Left adrenal measures 4.2 mm at the cranial pole and 4.8 mm at the caudal pole. Right adrenal measures 8.3 mm at the cranial pole and 5.3 mm at the caudal pole.

**Spleen**

The spleen is of appropriate size with a normal smooth capsular surface. There are 2.5 cm well circumscribed regions at both the tail, and head of the spleen, which are hypoechoic and lacking blood flow on Doppler interrogation. The splenic vasculature is otherwise normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal. The splenic parenchyma is otherwise normal.

**Liver**

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

**Gastrointestinal**

The stomach is mildly distended with gas. The gastric wall is 4.2 mm with normal deviations due to rugal folds, and exhibits appropriate wall layering. The pylorus is of normal appearance.

The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. Intestinal motility appears normal.



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The visible portions of the colon are of normal thickness, 1.5 mm, with intact wall layering. The ileocecal junction is visualized and appears normal.

**SPECIES**

Canine

***Pancreas***

Both limbs of the pancreas is swollen and hypoechoic, surrounded by hyperechoic mesenteric fat. The pancreatic duct appears normal.

**BREED**

Lab Mix

***Free Abdomen***

There is no evidence of free fluid within the peritoneal cavity. The mesenteric lymph nodes were moderately enlarged, up to 4.9 cm, with normal short to long axis ratio and appropriate echogenicity. There is hyperechoic omental fat surrounding both the pancreas and the abnormal portions of the splenic parenchyma. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

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***Other***

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The visualized portion of the heart exhibits appropriate systolic function with no masses or effusions noted.

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**PRIMARY FINDINGS**

- Hypoechoic pancreas with steatitis, consistent with pancreatitis.
- Reactive mesenteric lymph node.
- Hypoechoic regions within the spleen, consistent with splenic infarcts.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The appearance of the pancreas, along with the elevated CPL level, are consistent with acute pancreatitis, which is deemed the most likely cause of the patient's clinical signs. The concurrent mesenteric lymphadenopathy suggests there may be concurrent enteritis, despite the normal sonographic appearance of the intestines.

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The presence of splenic infarcts suggests the presence of a hypercoagulable state. This may be secondary to pancreatitis, particularly if no other underlying pathology, such as hypoalbuminemia, or sepsis, has been identified to explain it.

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Additional recommendations include:

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- Coagulation testing, to rule out the possibility of DIC, given the presence of splenic infarcts. Thromboelastography should be considered if available.

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- A highly digestible, low fat intestinal diet should be encouraged as soon as vomiting can be controlled.

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- Complications such as hypoalbuminemia, hyperglycemia and hypokalemia should be managed as they arise.

- If the patient is not responding to medical management, fine needle aspiration with a 25G needle for cytology could be considered after first checking a coagulation profile.



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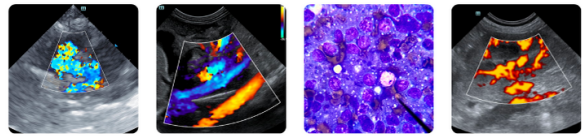
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- Although antithrombotic therapy with Clopidogrel might be considered given the presence of infarcts, the concurrent presence of hematochezia makes me reluctant to recommend this, lest it worsen GI bleeding.





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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.

**Tam Mengine, DVM, DABVP (canine/feline practice)**

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