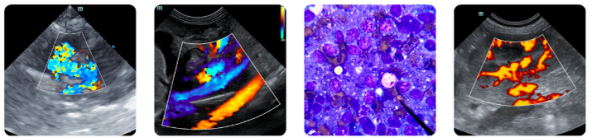


PATIENT

Happy Baker

SPECIES

Canine

BREED

Staffordshire Terrier Mix

SEX

FS

AGE

7 years 2 months

WEIGHT

82 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Heather

HOSPITAL NAME

Animal Care Clinic of Flanders

REFERRING VET

Dr. Hallihan

INVOICE

10870

DATE

12/5/2025

PRESENTING CLINICAL SIGNS

12/5/25: Seen today for not acting like normal self. Severe anemia - acute onset Abdomen distention Depressed, gums pale, non-painful distended abdomen Grade 2-3/6 systolic heart murmur anorexia Chest and abdominal radiographs NSF Medication: Torbugesic 1.2ml IV for scan - very uncomfortable for scan.

Abnormal PE/Chem/CBC/UA Results: HCT 17.4% Platelet 97,000 ALK PHOS 201 Rads are attached.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is 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 3.0 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 6.9 cm, and the right kidney measures 6.8 cm.

Adrenal Glands

The left adrenal gland is identified in its normal location. It is of normal size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The left adrenal gland height is 5.7 mm at the caudal pole. The right is not distinctly visualized, but the region appears unremarkable.

Spleen

The splenic parenchyma is mottled with several small hypoechoic nodules (up to 5.0 mm in diameter). The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.

Liver

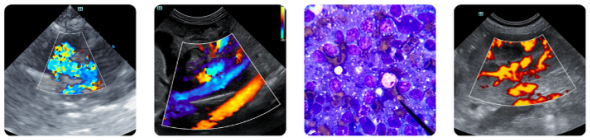
The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

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 moderately distended with gas and ingesta. The gastric wall is 3.8 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, up to 1.8 mm, with intact wall layering. The ileocecal junction was not visualized.

Pancreas

The areas of the limbs and body of the pancreas are isoechoic to the surrounding mesenteric fat, with normal capsular appearance. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

Free Abdomen

There is no evidence of free fluid within the peritoneal cavity. The omentum and intra-abdominal fat are of appropriate echogenicity. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Hypoechoic splenic nodules, typical of benign extramedullary hematopoiesis or nodular regeneration, with neoplastic etiology deemed less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no apparent cause identified for the patient's anemia. From the clinical history, it is unclear whether the anemia is regenerative or non-regenerative.

There is no apparent cause identified for the anemia. If the anemia is non-regenerative, then this may be secondary to renal disease, iron deficiency, precursor-targeted immune-mediated anemia (PIMA) or primary bone marrow disease, including myelophthisis and neoplasia.

Additional recommendations:

- CBC with pathologist review to screen for neoplastic cells.
- Three view chest radiographs
- If there is evidence of renal failure, then treatment with erythropoietin or darbepoetin, with concurrent iron supplementation, may be beneficial.
- Serum erythropoietin and iron levels can also be checked, to determine whether a deficiency in either is a cause for anemia, which can then be treated accordingly.
- Bone marrow aspiration is recommended to rule out PIMA and primary bone marrow disease.
- A blood transfusion may be needed, depending on the patient's clinical signs and response to initial immunosuppression.

If the anemia is regenerative, this would be more typical of a hemolytic anemia, or a toxin.

Additional recommendations:

- Testing for tick borne infectious disease
- CBC with pathologist review to screen for neoplastic cells and infectious agents.
- Three view chest radiographs
- Empiric treatment with doxycycline (5-10 mg/kg PO BID) and corticosteroids (such as prednisone at 2 mg/kg/day) can be instituted while awaiting infectious disease results.

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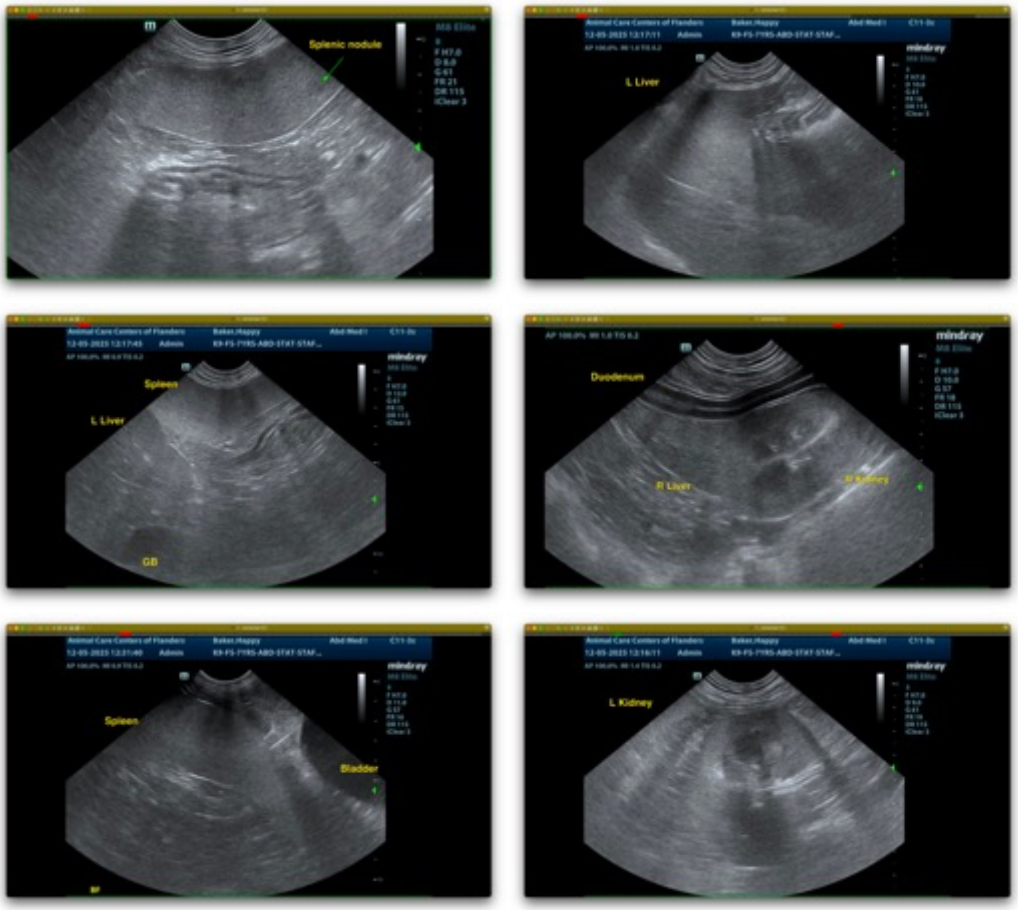
- Treatment with clopidogrel at 2mg/kg PO once daily is recommended until Hct is >25%, unless the patient becomes severely thrombocytopenic as well (platelet count < 30,000/uL).
- Gastroprotectants, such as omeprazole or pantoprazole, may be of benefit in preventing gastric ulcers secondary to corticosteroid use.
- A blood transfusion may be needed, depending on patient's clinical signs and response to initial immunosuppression.
- If a second immunosuppressive agent is needed, options would include azathioprine (2mg/kg PO once daily), cyclosporine modified (5mg/kg PO BID), and mycophenolate mofetil (8 - 12 mg/kg PO BID).



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) info@SonoPath.com