



PATIENT

Jackson Hisey

SPECIES

Canine

BREED

Corgi

SEX

Neutered Male

AGE

11 Years

WEIGHT

11 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jackson

HOSPITAL NAME

Wilvet South

REFERRING VET

Dr. Jackson

INVOICE

75193

DATE

5/16/26

PRESENTING CLINICAL SIGNS

O states pt has been declining over the last 2 weeks, seems more lethargic, not acting like himself, yesterday O noticed pale gums. O found tick on pt nose about a month ago and O flicked it off his nose. pt wears a flea and tick collar new as of 3 weeks ago. Previous Medical Conditions: Dental disease, multiple teeth removed. Diet Type: PPP previously beef just switched to chicken recently

Abnormal PE/Chem/CBC/UA Results: Hydration: Slightly dehydrated Eyes: Abnormal: Slightly icteric sclera Oral Cavity: Abnormal: Extremely pale MM Respiratory: Lungs auscultate clear bilaterally; trachea clear. Slightly increased respiratory effort. FAST scan: No pleural, pericardial, or abdominal effusion noted. No obvious masses in spleen or liver. CBC: Hct 7.7%, retic WBC 7.35k (N), PLT 198k (N) Chem17: Glob 4.6 (H), Amylase 1567 (H), rest WNL. EPOC: pCO2 17.5 (L), HCO3 12.8 (L), pH 7.471 (H), Hct <10 4DX: All negative Imagyst blood smear cytology: Erythron: Marked anemia with subjectively mild polychromasia; moderate acanthocytosis Leukon: Occasional intermediate sized lymphocytes Thrombon: Moderate thrombocytosis with numerous platelet clumps Bone Marrow Biopsy performed, results pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with anechoic urine. A small amount of echogenic luminal material is present, typical of mucus. The ureteral papillae, trigone and pelvic urethra (visible to 1.0 cm) are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted.

The prostate is not distinctly visualized, likely due to its intrapelvic location.

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 5.0 cm. Right kidney measures 5.2 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 measures 5.9 mm at the caudal pole. Right measures 6.4 mm at the caudal pole.

Spleen

The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. 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 diffusely hyperechoic and subjectively enlarged, with sharp borders and a homogenous echotexture. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.



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The gallbladder is moderately distended with anechoic contents and a small amount of freely-moveable echogenic sludge. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

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Gastrointestinal

The stomach is moderately distended with ingesta and several small objects casting an anechoic shadow, typical of pills or dense ingesta. The gastric wall is 2.6 mm with normal deviations due to rugal folds, and exhibits appropriate wall layering. The pylorus is of normal appearance.

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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 (1.1 mm) with intact wall layering. The ileocecal junction is not seen.

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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.

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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.

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PRIMARY FINDINGS

- Diffusely hyperechoic liver, typical of a benign / reactive hepatopathy
- Dense shadowing foci in the stomach - most typical of pills or dense food, but given the history, the possibility of a metallic object (such as zinc-based coin) should be excluded

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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There is no pathology noted within the abdomen to definitively explain the patient's severe anemia. The pending bone marrow aspirate should provide further insight. The appearance of the liver, and lack of liver enzyme elevations is consistent with a reactive hepatopathy. Additional suggestions include:

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- Full vector-borne disease panel
- Three view chest radiographs (including the stomach, to rule out the possibility of metallic foreign material)
- 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.
- Treatment with clopidogrel at 2mg/kg PO once daily is recommended until Hct is >25%, unless the patient is 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.

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- 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.

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