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FOSTERING THE ART OF VETERINARY MEDICINE™

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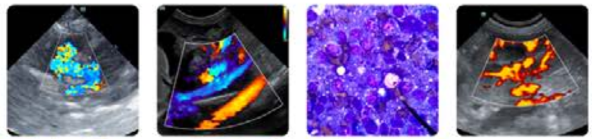


Clinical Sonography & Telecytology

Educational Teleconsultation Services™

PATIENT

Jax Brinkman

SPECIES

Canine

BREED

Maltese

SEX

Neutered Male

AGE

13.5 Years

WEIGHT

4.88 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Kim Ferritti

INVOICE

75190

DATE

5/16/26

PRESENTING CLINICAL SIGNS

P has loss of coordination. appears to be stumbling and off balance (can position appropriately once gets going). does not appear painful even upon examination (but balance visually off). crossed hind legs and weakness in hind end (swaying). falling over at times when really off balance. O states that p has a history of low rbc accompanied by anemia (low iron). in which primary was concerned once coordination began to be affected and prescribe iron injections (seems to collapse after receiving injections per o). p was also prescribed long term steroid (o unsure of what exactly was prescribed for). P has increased thirst. P received first iron injection and seemed a little better, second iron injection he seemed worse. P lethargic. P noted with weight loss. Concern for anemia, cachectic, history of azotemia, abdominal mass, other

Abnormal PE/Chem/CBC/UA Results: PE: comfortable, soft on abdominal palpation; BCS 4/9; age related changes; muscle atrophy, ataxia hind end; ataxic, CP deficits rads: suspected abdominal mass, looks splenic, pushing stomach craniodorsal; AFAST shows mixed echogenicity mass mid abdomen but no free fluid tru rapid 4dx: negative X4 cbc: wbc 19.68 H, neu 16.92 H, mono 1.83 H, eos 0.02 L, hct 26.2% L, hgb 8.9 L, rbc 4.10 L epoc: TCO2 15.9 L, Na 154 H, lactate 4.47 H, pH 7.490 H chem: phosphorus 5.8 H, TP 10.3 H, globulin 7.4 H, glucose 136 H, ALT 339 H, lipase 237 H

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine, and no luminal sediment is present. 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 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 measures 4.0 cm. Right measures 3.9 cm.

Adrenal Glands

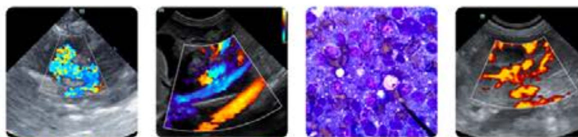
The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. Left measures 5.8 mm at the cranial pole and 6.5 mm at the caudal pole. Right measures 5.6 mm at the cranial pole and 6.7 mm at the caudal pole.

Spleen

There are two masses seen within the spleen, which disrupt the splenic capsule. One heterogeneous mass in the head of the spleen measures 5.2 cm x 4.1 cm, sitting adjacent to the liver. The 2nd heterogeneous mass within the tail of the spleen measures 2.7 cm x 2.2 cm. The surrounding omentum is hyperechoic. 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 difficult to visualize due to the cranial displacement of the liver by the splenic mass. In some views it appears to have a mildly thickened wall, and the contents appear to include striating bile. It is possible, however, that this appearance is an artifact due to the difficulty visualizing the gallbladder in the intracostal region.

Gastrointestinal

The stomach is mildly distended with gas. 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.

The visible portions of the colon are of normal thickness (1.1 mm) with intact wall layering. The ileocecal junction is not seen.

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 free fluid noted within the abdomen. There is hyperechoic, inflamed omental fat noted in the region of the spleen and gallbladder. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Multiple heterogeneous splenic masses, one of which is displacing the liver cranially
- Possible gallbladder mucocele

SECONDARY FINDINGS

- Diffusely hyperechoic liver, consistent with reactive hepatopathy
- Bilateral chronic renal changes, as expected for patient age

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The splenic masses may represent both benign (hemangioma, hematoma) and malignant (hemangiosarcoma, other malignancy) etiologies. It is unclear whether these could explain the patient's ongoing ataxia. Bile acid testing is recommended to rule out hepatic encephalopathy as a possible cause if not already performed. It is also possible that there is a primary neurologic lesion responsible for the patient's clinical signs - a CT of the head and spine could be considered to further investigate this possibility prior to any surgical procedure.

The gallbladder is difficult to visualize, due to the cranial displacement of the liver, but it is surrounded by inflamed fat, and there is the faint appearance of congealed contents in the lumen. Ideally, if chest radiographs are clear, and the neurologic symptoms are considered stable, then splenectomy, along with visual inspection of the gallbladder, and liver biopsy, would be recommended.

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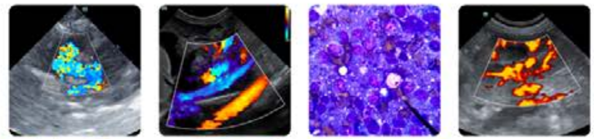

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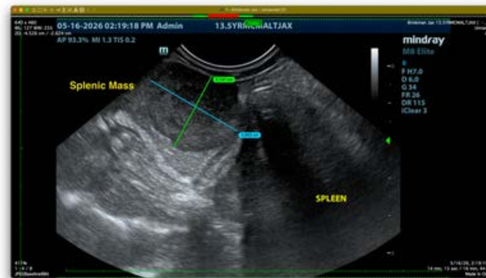

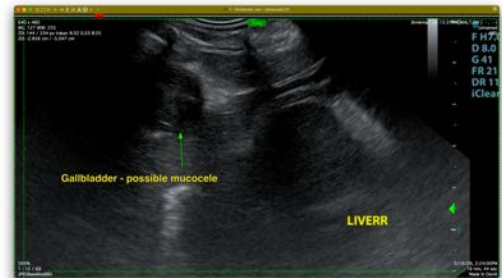

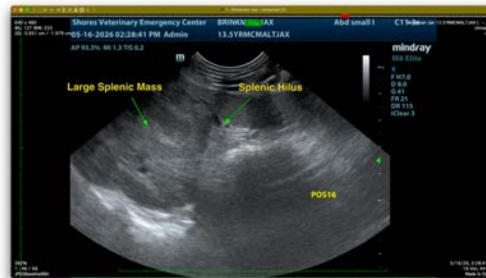

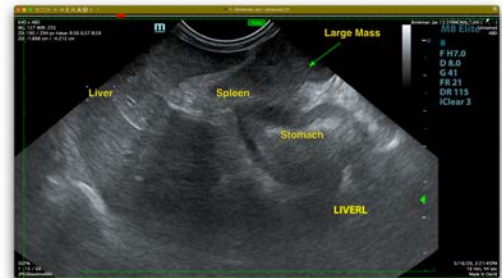

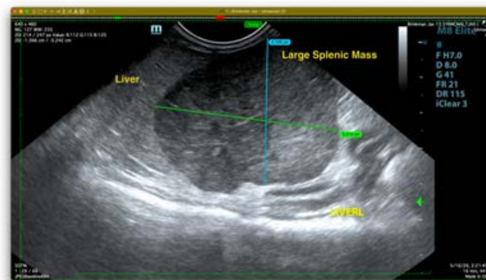

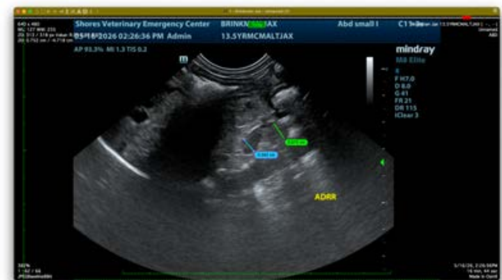

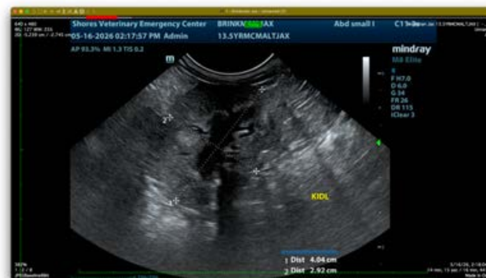

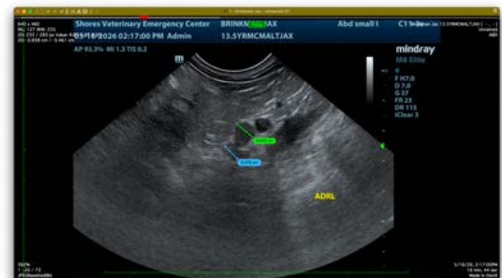

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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