



**PATIENT**

Dodger Blue Kurtz

**SPECIES**

Canine

**BREED**

Beagle

**SEX**

Neutered Male

**AGE**

12 Years

**WEIGHT**

23.3 pounds

**INTERPRETED BY**

Bradley Harris, DVM,  
DACVECC, DACVIM

**PRESENTING CLINICAL SIGNS**

Presented for V, lethargy and slow to eat. Persistent heterogenous soft tissue opacity noted in stomach (rads attached). Grade II-III heart murmur.

Current Medications: Gaba 50mg am and 100mg pm; Metacam; Thyroid tabs 0.2mg bid; Dasuquin; Azithromycin q3d

**ULTRASONOGRAPHIC EXAMINATION OF THE HEART & ABDOMEN**

<b>CANINE CARDIAC PARAMETERS</b>	<b>BW</b>	<b>HR BPM</b>	<b>LAD 4 ch Long</b>	<b>RAD 4 ch Long</b>	<b>La/Ao Heart Base</b>	<b>LVIDd</b>	<b>LVIDs</b>
<b>NORMAL PARAMETER</b>		50-100			<1.6		
<b>PATIENT</b>	10.59	160	3.26	2.33	1.04	2.91	2.13
<b>CANINE CARDIAC PARAMETERS</b>	<b>FS</b>	<b>EPSS</b>	<b>PV V MAX (m/s)</b>	<b>AV V Max (m/sec)</b>	<b>MR Vmax</b>	<b>TR Vmax</b>	<b>RPA distensibility (normal &gt;30%)</b>
<b>NORMAL PARAMETER</b>	28-40	<0.6	0.7-1.6	0.7-1.7	4.5-5.5	< 2.7	
<b>PATIENT</b>	27	0.3	0.7	1.0	5.1	NM	31

**IMAGING PERFORMED BY**

Shari Reffi CVT

**HOSPITAL NAME**

Bergen County  
Veterinary Center

**REFERRING VET**

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**Cardiac Presentation**

The left atrium is normal in dimension. The left ventricle is normal in dimension, with normal systolic function. The right atrium and ventricle are subjectively normal in dimension and systolic function. The mitral valve is thickened and redundant consistent with myxomatous changes, and there is no significant prolapse. There is evidence of mild mitral regurgitation. The tricuspid valve leaflets are subjectively normal with no significant tricuspid regurgitation and no evidence of pulmonary hypertension. The left ventricular outflow tract demonstrated normal laminar flow and the visible aorta is unremarkable. The right ventricular outflow tract assessment revealed normal laminar flow, and appropriate diameter and distensibility. There is no evidence of semilunar valve insufficiency. There is no visible pericardial, pleural, or free peritoneal fluid noted. The cardiac chambers, pericardial and visible extra-cardiac regions were free of masses, spontaneous echo contrast, or thrombi.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**



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The urinary bladder is adequately distended with anechoic urine. The bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. There are no uroliths or sediment noted. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size and structure, with appropriate corticomedullary definition and cortex to medulla ratio. The cortices are uniform in texture with normal echogenic relationship to liver and spleen. The medullary structure differed distinctly from the cortex and no evidence of pyelectasis is present. The capsules are uniform without significant irregularities noted. The left kidney measures 4.46 cm. The right kidney measures 4.69 cm.

**Adrenal Glands**

Both adrenal glands are visualized and have normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measures 0.48 cm x 1.87 cm. The right adrenal gland measures 0.56 cm x 1.91 cm.

**Spleen**

The spleen is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is smooth. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. There are several hypoechoic to minimally cavitated nodules within the splenic body that do not distort the smooth splenic capsule. The spleen measures 1.27 cm at the hilus.

**Liver**

The liver is subjectively normal liver size, contour, and structure. Parenchymal echogenicity is naturally coarse and hypoechoic to the spleen. Vasculature is within normal limits with no evidence of congestion. The gallbladder has thin walls which contain anechoic bile. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. No hepatic lymphadenopathy is documented. There is no overt structural evidence of inflammatory, infiltrative or regenerative pathology evident.

**Gastrointestinal**

The stomach is moderately distended with echogenic material. There is a large volume of shadowing material within the gastric fundus. This also extends partially into the pylorus and the pylorus contains echogenic fluid. There is no overt pyloric outflow obstruction, however, there is concern for gastric foreign body causing the clinical signs given the degree of distention with shadowing foreign material. The remaining small intestine is unremarkable with no significant dilation, normal wall thickness and maintenance of normal wall layering. The ICJ is patent and the colon contains normal shadowing feces.

**Pancreas**

The visible pancreas is isoechoic to surrounding omental fat. The pancreatic duct and capsular contour are normal. There is no overt evidence of active inflammatory or neoplastic disease.

**Free Abdomen**

There is no significant lymphadenopathy or free fluid.



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**ULTRASONOGRAPHIC FINDINGS**

- These findings are consistent with degenerative/myxomatous mitral valve disease with minimal to mild hemodynamic effects consistent with ACVIM Stage B1 disease. It is unlikely that any current morbidity is of cardiac origin.
- There are multiple hypoechoic splenic masses within the parenchyma that do not distort the splenic capsule. These may represent benign changes such as extramedullary hematopoiesis or lymphoid hyperplasia, however, infiltrative neoplastic disease cannot be definitively excluded.
- The shadowing material within the gastric fundus extending into the pylorus is concerning for gastric foreign material. This is considered likely the underlying cause of the clinical signs that have been noted as well as the radiographic changes provided.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Given these findings, no cardiac therapy is recommended. There are no cardiac contraindications to anesthesia, fluid therapy, vasopressor therapy, or corticosteroids as indicated for further assessment and treatment. If not already performed, baseline thoracic radiographs and blood pressure are recommended. A recheck echocardiogram is recommended in 6 months.

**Anesthesia considerations:**

If anesthesia is necessary, alpha-2 agonists, ketamine, high dose acepromazine, and Telazol should be avoided. Fluid therapy during anesthesia should be considered at a conservative rate (e.g., 5 ml/kg/hour) if possible.

**Diet:**

A high-quality food from Hills, Royal Canin, Science Diet, Eukanuba, Iams, or Purina that is highly palatable with adequate protein and calories for maintaining optimal body condition is reasonable.

**Activity:**

No special considerations are necessary.

Fine needle aspirates of the spleen with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis. Consider gastric exploratory laparotomy with potential gastrotomy given the persistence of clinical signs and material within the gastric fundus. Alternatively, an endoscopy for potential removal of gastric foreign material could be considered, however, if the consistency of the material is unknown, this could prove challenging.



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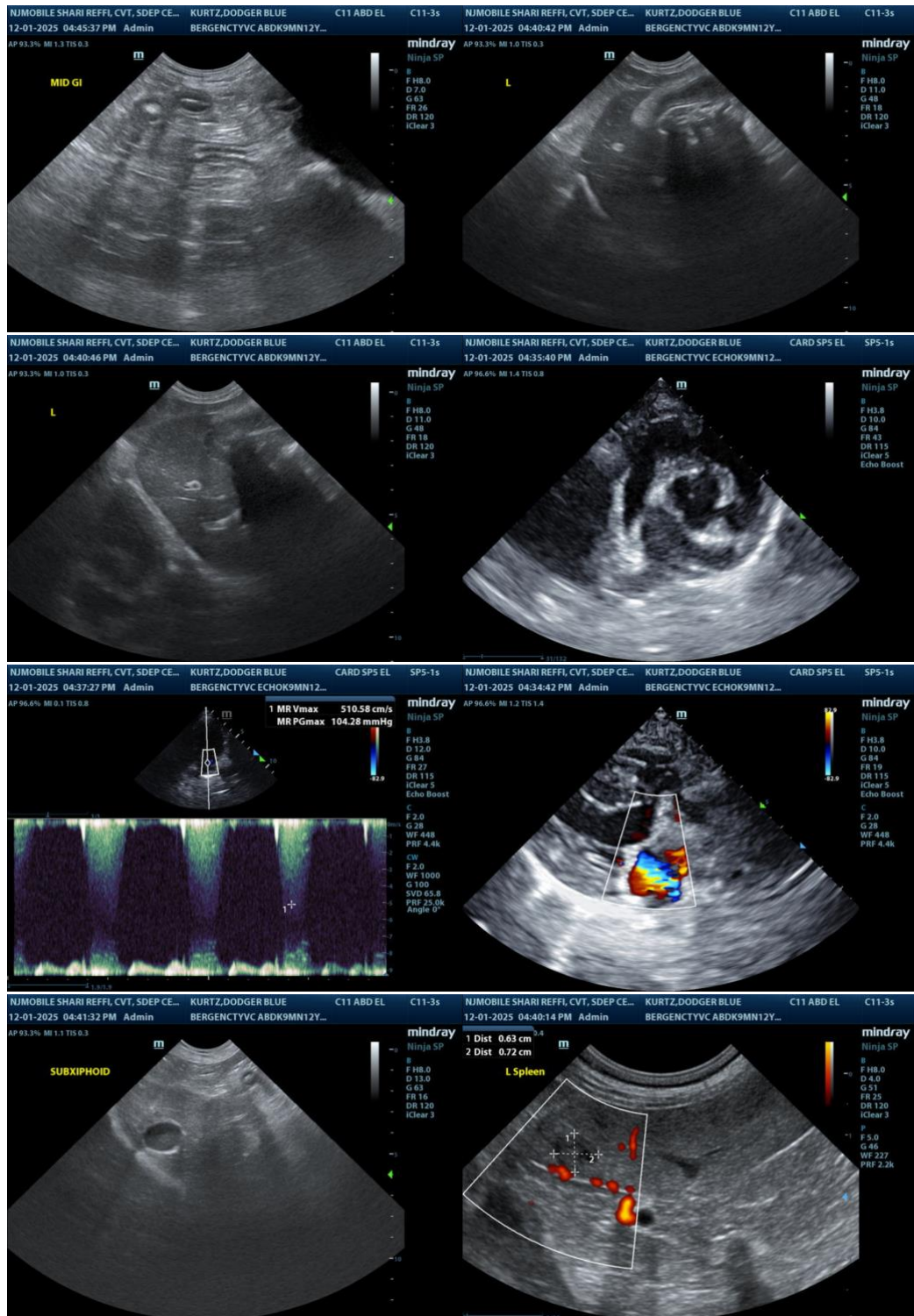
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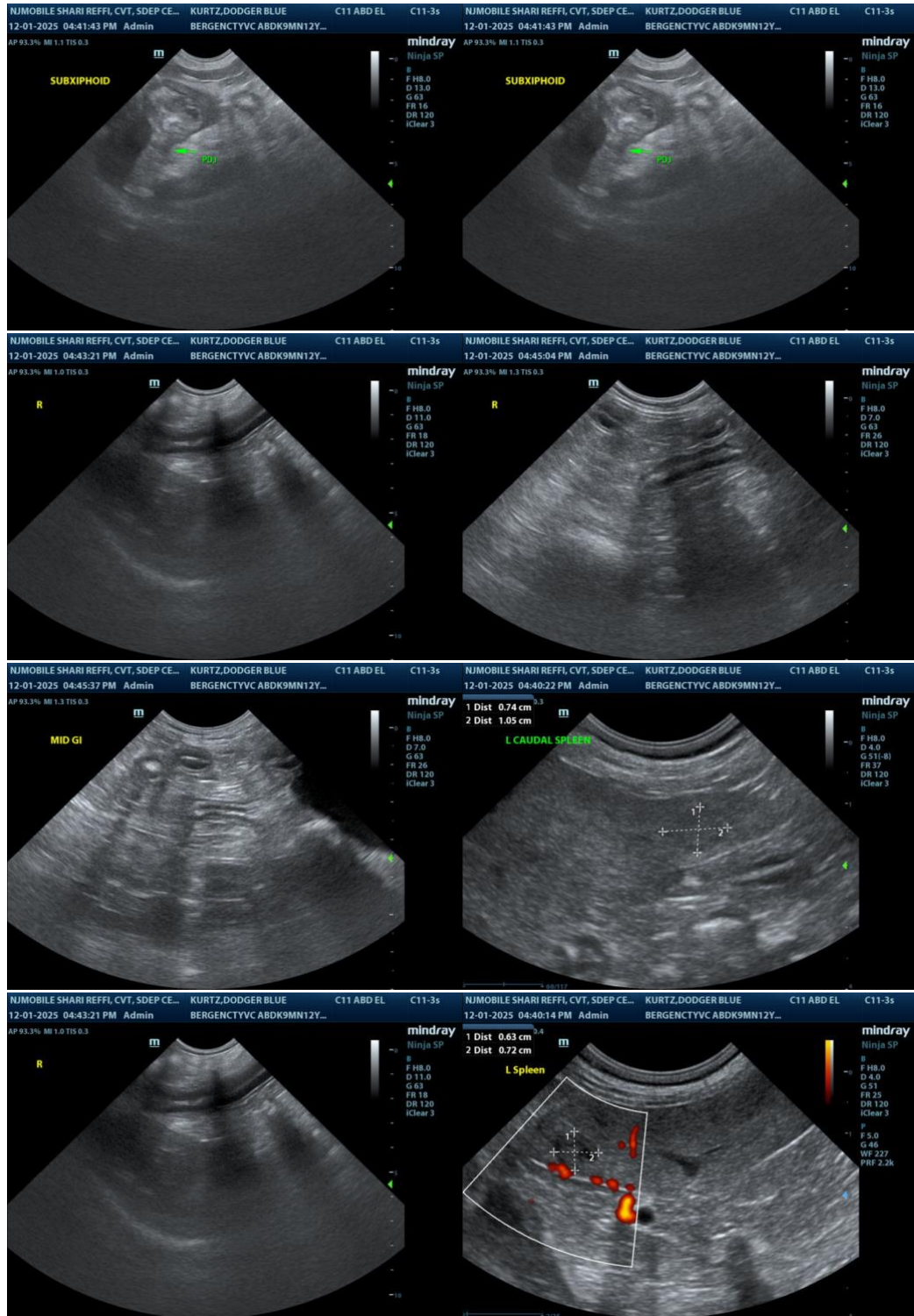
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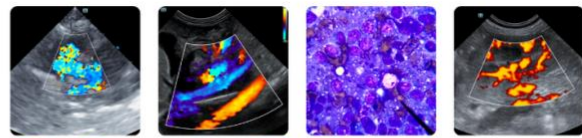
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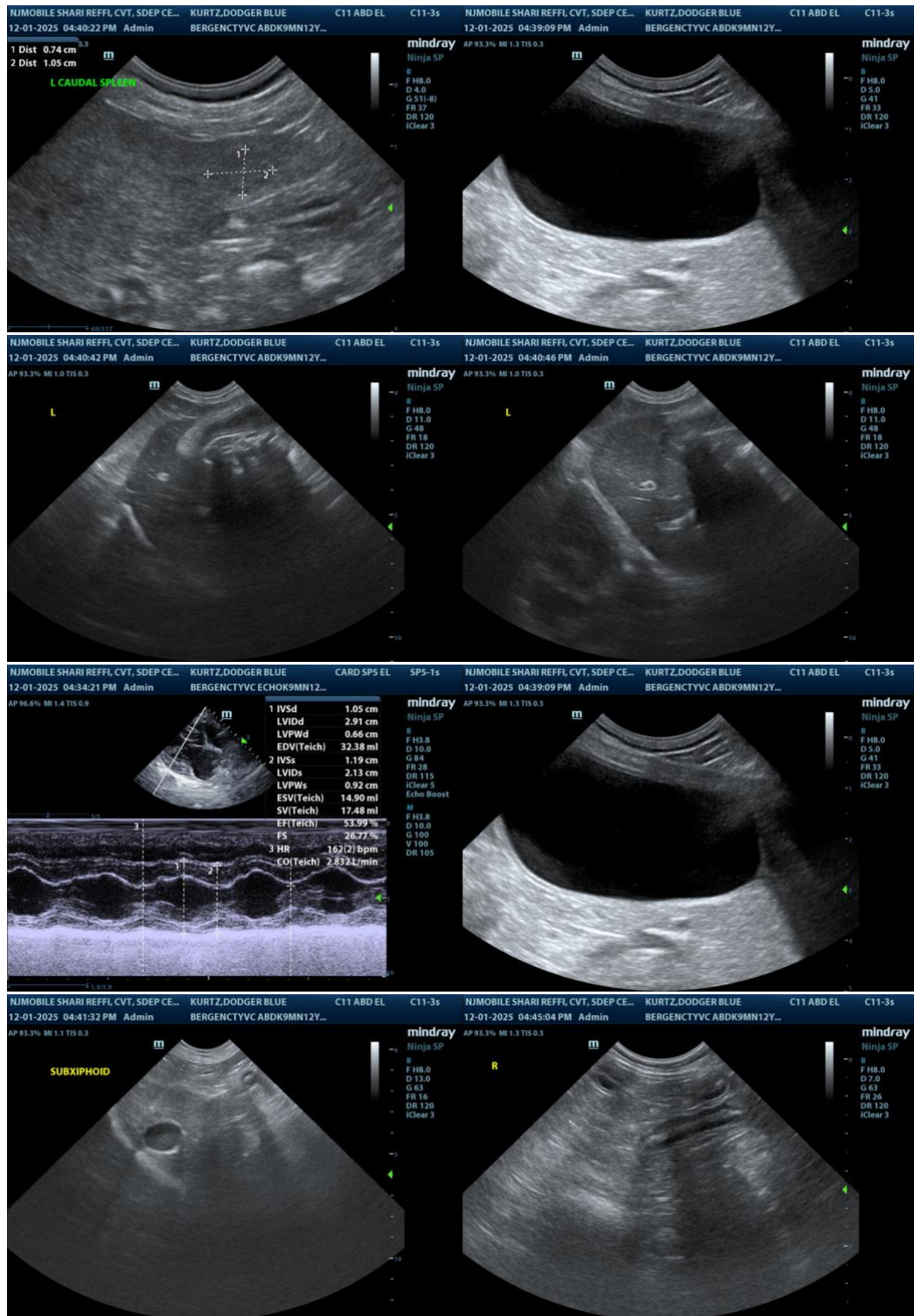
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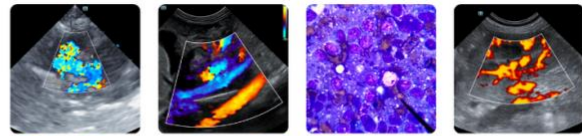
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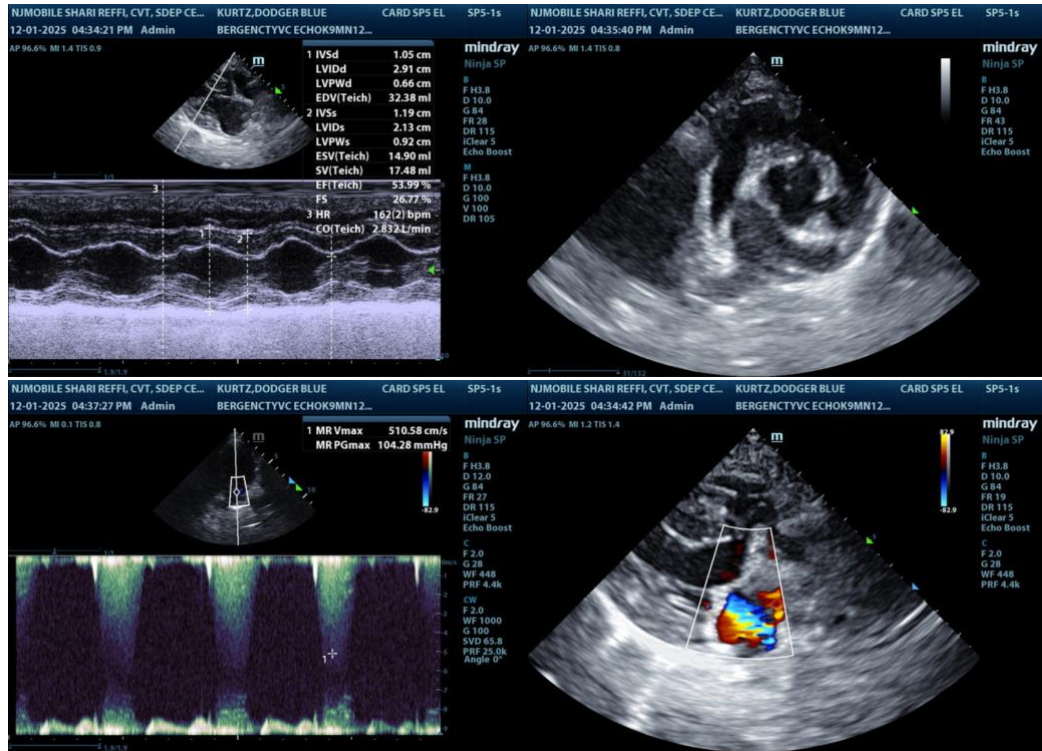
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Bradley Harris, DVM, DACVECC, DACVIM (Cardiology)

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