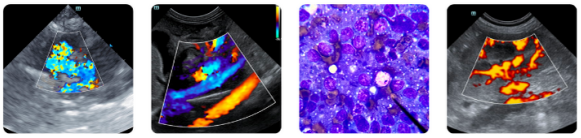


PATIENT

Lucy Cericola

SPECIES

Canine

BREED

Silkypoo

SEX

FS

AGE

14 years 7 months

WEIGHT

6.2 lbs

INTERPRETED BY

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

Bergen County VC

REFERRING VET

Dr. Halloran

INVOICE

11753

DATE

4/20/2026

PRESENTING CLINICAL SIGNS

ADR, Decreased appetite, Patient has a new grade 4/ heart murmur, and ~ 2 weeks shes been lethargic w/ a reduced appetite. Some back pain noted on exam. Meds: Meloxicam, Gabapentin. Did not respond to GI support.

Abnormal PE/Chem/CBC/UA Results: Mild Monocytosis, mild basophilia, Chem WNL, Normal CPL, * Rads show mild pleural effusion, unremarkable abd.

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

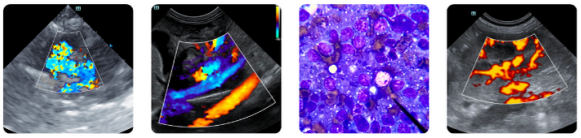
CANINE CARDIAC PARAMETERS	BW	HR BPM	LAD 4 ch Long	RAD 4 ch Long	La/Ao Heart Base	LVIDd	LVIDs
NORMAL PARAMETER		50-100			<1.6		
PATIENT	2.82 kg	200	1.58	1.29	1.12	1.73	1.01
CANINE CARDIAC PARAMETERS	**FS**	**EPSS**	**PV V MAX (m/s)**	**AV V Max (m/sec)**	**MR Vmax**	**TR Vmax**	**RPA distensibility (normal >30%)**
NORMAL PARAMETER	28-40	<0.6	0.7-1.6	0.7-1.7	4.5-5.5	< 2.7	
PATIENT	42	0.2	0.6	1.0	5.3	3.6	29

Cardiac Presentation

The left atrium is normal to small in dimension. The left ventricle is normal to small in dimension with normal systolic function. The right atrium and ventricle are normal in dimension with normal systolic function. The anterior and posterior mitral valve leaflets are thickened and redundant consistent with myxomatous changes, and there is mild prolapse. There is no significant mitral regurgitation identified. The tricuspid valve leaflets are appropriately thin with adequate apposition and intact chordae, with mild tricuspid regurgitation and evidence of mild pulmonary hypertension. The left ventricular outflow tract demonstrates normal laminar flow, and the visible aorta is unremarkable. The right ventricular outflow tract assessment reveals normal laminar flow with appropriate main pulmonary artery diameter and right pulmonary artery distensibility. There is no pulmonic and no aortic valve insufficiency identified. There is no visible pericardial, and mild pleural fluid documented. No evidence of hepatic venous congestion is noted. There are numerous B-lines noted within the pulmonary parenchyma. The cardiac chambers, pericardial, and visible extra-cardiac regions are free of masses, spontaneous echo contrast, or thrombi.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System



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The urinary bladder is minimally distended with anechoic urine. It's inadequately distended for complete evaluation of the bladder wall thickness and layering. The trigone appears patent with no evidence of proximal urethral obstruction.

The kidneys are normal in size. The cortices are hyperechoic with a loss of corticomedullary distinction. Normal cortex to medulla ratio. There is no pyelectasis or pelvic dilation present. The capsules are minimally irregular bilaterally. Left kidney measures 2.86 cm, and the right kidney measures 3.4 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. Left adrenal measures 0.49 cm x 1.55 cm. The right adrenal measures 0.43 cm x 1.25 cm.

Spleen

The spleen is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented. The spleen measures 0.93 cm at the hilus.

Liver

The liver is subjectively mildly enlarged with a diffusely heterogenous or mottled parenchyma. The vasculature is within normal limits with no evidence of congestion.

The gallbladder is minimally distended with anechoic bile and a mild amount of suspended echogenic debris and dependent sediment. There is no intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach and intestines are free of stasis and peristaltic activity, with no significant dilation noted. There is normal wall thickness and acceptable curvilinear mural detail. The pyloric-duodenal junction and ileocecocolic junction are patent, and the colon contains normal shadowing feces. There is no evidence of shadowing obstructive material or overt infiltrative disease noted. No associated abnormal lymphatic activity is documented.

Pancreas

The base and limbs of the pancreas are 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 lymphadenopathy and no free fluid noted in these images.

ULTRASONOGRAPHIC FINDINGS

- The kidneys are relatively normal in size and structure, and cortex:medulla ratio (cortex 1/3 of medulla) is essentially maintained. There is age-related loss of the normal smooth capsular

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contour and C/M junction definition. The cortices are largely uniform in texture with mild hyperechogenicity expected for this patient's age. There is no evidence of pelvic dilation present.

- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory, immune-mediated, metabolic, or endocrine disease. Infiltrative neoplasia or acute hepatitis cannot be ruled out.
- The gallbladder contains echogenic, suspended and dependent unorganized debris. This is not yet to the level of an organized mucocele, however early/developing mucocele cannot be ruled out. This dependent sediment is often an incidental finding or may be associated with concurrent endocrine disease such as hyperadrenocorticism or diabetes mellitus.
- These findings identify significant pulmonary hypertension (PH) in the absence of any clinically relevant left sided disease, making the PH more likely related to primary respiratory disease or other etiology (non-type 2 PH). Pulmonary hypertension in dogs is most commonly secondary to primary respiratory disease (chronic bronchitis, pulmonary fibrosis, or other forms of pulmonary interstitial disease). Pulmonary hypertension can also develop in dogs with severe heartworm disease or secondary to pulmonary thromboembolism (PTE). Less commonly, pulmonary hypertension is identified in dogs as an idiopathic condition. Pulmonary hypertension commonly causes syncope, and a patient's signs may be attributable to this condition.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection.

Fine needle aspirates of the liver 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.

Thoracocentesis with pleural fluid analysis and cytology is recommended at this time.

Repeated thoracic radiographs may be beneficial to further evaluate the pulmonary parenchyma. Ultimately, a CT scan with angiography may be required for further diagnostics.

No cardiac therapy is indicated at this time. Treatment for the PH/presumed respiratory disease is warranted, as clinical signs are present. The use of sildenafil (2 mg/kg TID) or tadalafil (2mg/kg SID) is appropriate. The merits of an airway scope/wash should be discussed with the owner, especially prior to any steroid use. A repeat echo is indicated in another 6 months, or sooner if progression is suspected, clinical signs develop/worsen, or cardiac therapy is being contemplated.

Anesthesia considerations:
While there is no CHF present, there is likely an increased anesthetic risk which must be considered prior to any anesthetic procedure. If anesthesia is necessary, then alpha-2 agonists, ketamine, and Telazol should be avoided. Fluid therapy during anesthesia does not necessarily need to be adjusted. A shorter anesthetic duration will reduce the risk of complications. Pre-oxygenation is mandatory. Premedication with an opioid (e.g., butorphanol, hydromorphone, oxymorphone) with or without a benzodiazepine is generally the safest protocol. An induction agent such as Propofol, alfaxalone, or

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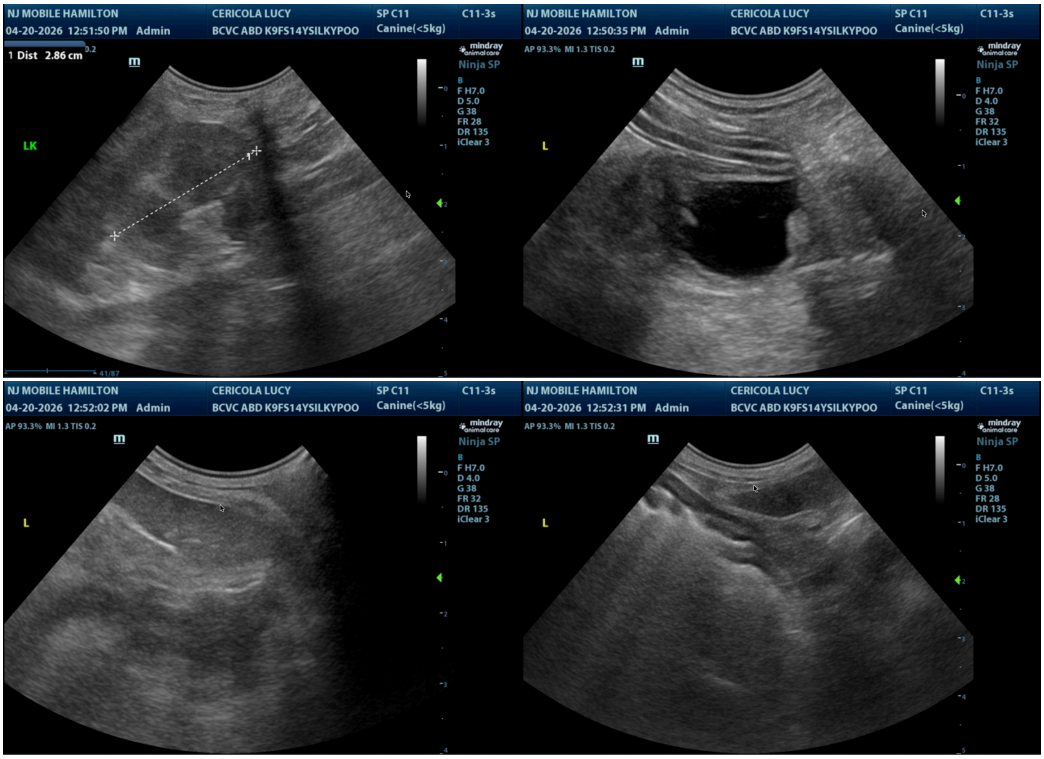
diazepam/etomidate can be used to effect. Maintenance of anesthesia with isoflurane or sevoflurane is reasonable.

Diet:
No special considerations are necessary. Any high-quality food from Hills, Royal Canin, Science Diet, Eukanuba, Iams, or Purina is reasonable.

Activity:
Moderate physical activity (meandering walks, exploring the backyard, playing with toys inside, getting excited when family gets home, etc.) is encouraged, but periods of strenuous aerobic activity (jogging, strenuous outdoor ball play, prolonged play at the dog park, etc.) should be avoided, especially during periods of high heat (> 80 F) and humidity. Dogs with heart disease tend to tolerate cool and cold temperatures much better than high temperatures. Avoid sudden increases in activity (e.g. 2 block walks during the week but 2 mile walks followed by 30 minutes at the dog park on the weekends) as this may be difficult for the cardiovascular system to deal with.



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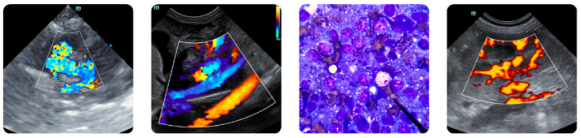

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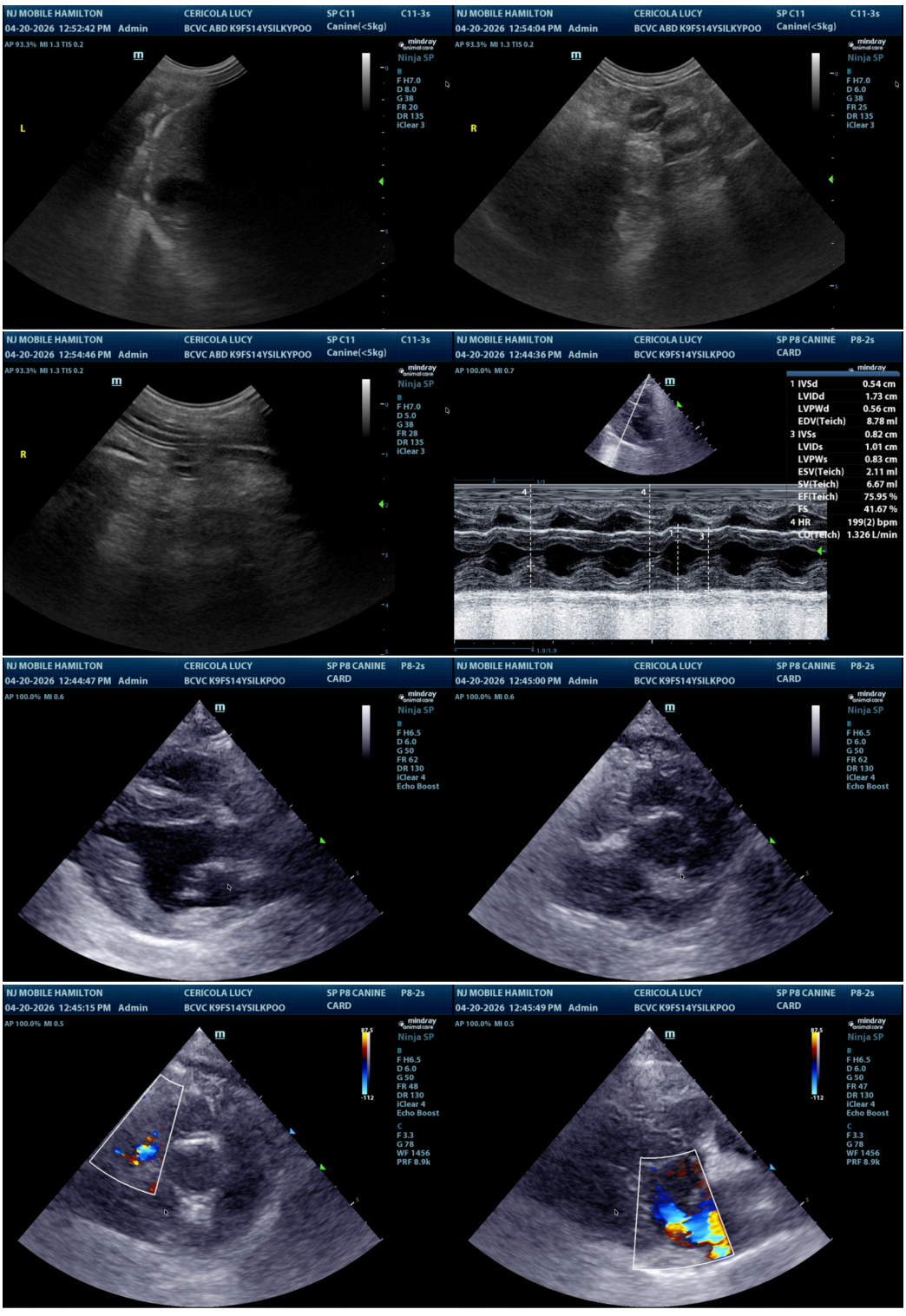
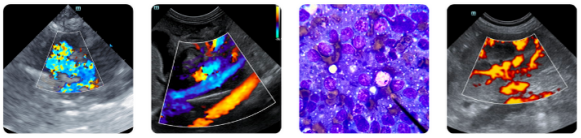


The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not



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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)

info@SonoPath.com