



**PATIENT**

Autumn Haddon

**SPECIES**

Canine

**BREED**

Pit Bull Terrier

**SEX**

Spayed female

**AGE**

8 years

**WEIGHT**

70 lbs

**INTERPRETED BY**

Bradley Harris, DVM,  
 DACVECC, DACVIM  
 (cardiology)

**IMAGING PERFORMED BY**

Rebecca Hamilton

**HOSPITAL NAME**

Newton VH

**REFERRING VET**

Dr. Chan

**INVOICE**

70968

**DATE**

1/27/26

**PRESENTING CLINICAL SIGNS**

- hematemesis, suspect GI ulcer
- hypothermia
- pepcid, pantoprazole, sucralfate, Cerenia
- ALB 2.4

**ULTRASONOGRAPHIC EXAMINATION OF THE HEART**

The left atrium is normal in dimension. The left ventricle is normal 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 appropriately thin with adequate apposition, intact chordae, and there is no significant prolapse. There is no significant mitral regurgitation identified. The tricuspid valve leaflets are appropriately thin with adequate apposition, intact chordae, 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 pulmonic and no aortic valve insufficiency identified. There is no visible pericardial, pleural, or free peritoneal fluid documented. No evidence of hepatic venous congestion is noted. The cardiac chambers, pericardial and visible extra-cardiac regions were free of masses, spontaneous echo contrast, or thrombi.

CANINE CARDIAC PARAMETERS	Body Weight kg	HR BPM	LAD 4 ch Long	RAD 4 ch Long	La/Ao Heart Base	LVIDd	LVIDs
NORMAL PARAMETER		50-100			<1.6		
PATIENT	31.82 kg	100	4.85	2.68	1.13	3.75	2.62
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	30	0.5	0.7	1.0	NM	NM	



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**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

***Urinary System***

The urinary 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, and anechoic urine is present. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size and structure. The cortices are hyperechoic with a decreasing corticomedullary definition. Mild, scattered, small renal cortical cystic changes bilaterally with a normal cortex to medulla ratio and mildly irregular capsular contour. No significant pyelectasia or pelvic dilation is noted. The left kidney measured 7.18 cm and the right kidney measured 7.03 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 measured 0.54 x 1.91 cm. The right adrenal gland measured 0.71 x 3.07 cm.

***Spleen***

The spleen is slightly prominent with a mildly heterogenous or mottled reticular parenchymal pattern. The splenic vasculature is normal with no evidence of spontaneous echocontrast, congestion or thrombosis. The splenic capsule is smooth without significant irregularity. The spleen measured 1.85 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 with contains 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 GI is minimally distended with echogenic luminal contents. There is no evidence of pyloric outflow obstruction or other gastrointestinal mechanical obstruction. The gastrointestinal walls measure within normal limits for thickness with maintenance of normal wall layering. There is no overt mucosal lesion within the stomach or small intestine. However, this does not exclude the possibility of a small gastrointestinal ulcer that is not ultrasonographically identifiable. The colon contains normal shadowing feces.



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**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.

There is no free fluid in the abdomen.

**ULTRASONOGRAPHIC FINDINGS**

These findings are consistent with an essentially normal echocardiogram. Any murmur will be considered functional in origin. No cardiac cause of the morbidity is identified.

There is increased renal cortical echogenicity and thickening with a mildly irregular capsular contour. Multifocal cystic cortical changes are noted. This is secondary cystic formation consistent with chronic age related degeneration and remodeling. There is no evidence of abscessation or suspicion of neoplasia.

The mildly enlarged spleen with a coarse/mottled reticular pattern is most consistent with a reactive spleen, or possible splenitis. Round cell neoplasia is considered less likely, but cannot be definitively excluded.

Upper gastrointestinal ulcerative lesion is considered a possible etiology of the acute hematemesis. Alternatively, an acute gastritis or gastroenteritis can also be considered as well as occult pancreatic inflammation or pancreatitis.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Given these findings, no cardiac therapy is recommended. There are no cardiac contraindications to fluid therapy or corticosteroid therapy, as indicated for further assessment and treatment. No specific cardiac recheck is recommended unless a murmur or clinical signs of heart disease develop.

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 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.

A gastrointestinal panel (TLI, PLI, B12, folate) via Texas A&M gastrointestinal laboratory is indicated to further evaluate for potential chronic enteropathy. Ultimately, gastrointestinal biopsies may be required for a definitive diagnosis.

Consider a spec CPL to further evaluate the pancreas for occult inflammation or pancreatitis. Continued supportive care as clinically indicated pending additional diagnostics is recommended at this time.



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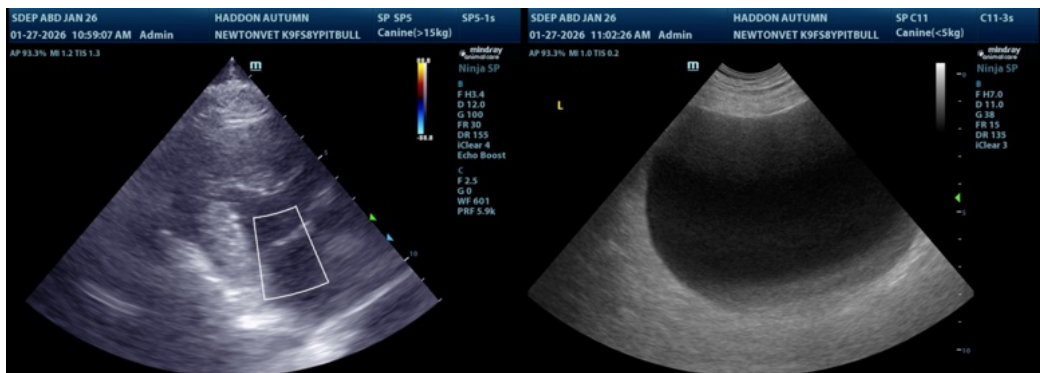
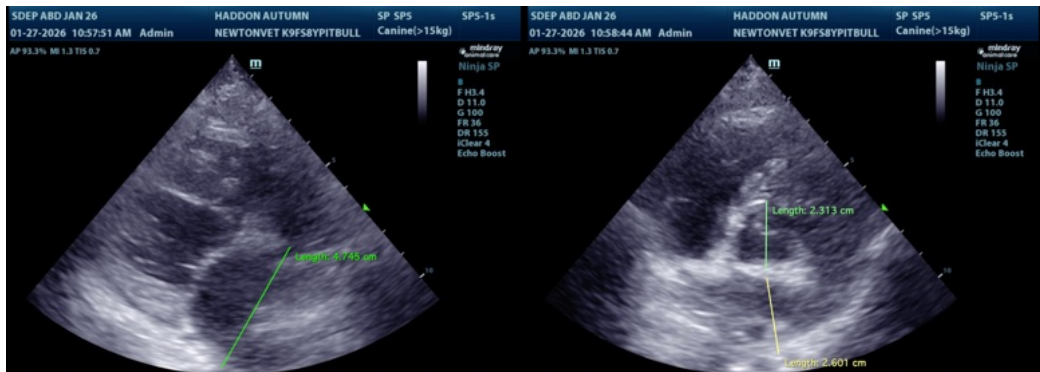
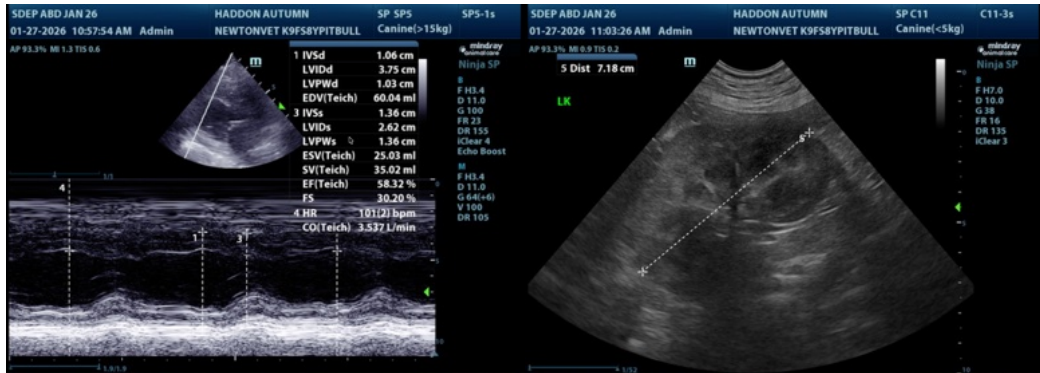
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Anesthesia considerations:  
 No special considerations are necessary.

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

Activity:  
 No special considerations are necessary.





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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)

[info@SonoPath.com](mailto:info@SonoPath.com)