



**PATIENT**

Riley Wright

**SPECIES**

Canine

**BREED**

Cocker Spaniel

**SEX**

Neutered Male

**AGE**

14 Years 8 Months

**WEIGHT**

28 lbs

**INTERPRETED BY**

Eric Lindquist, DMV,  
DABVP (CFM), Cert.  
IVUSS

**IMAGING PERFORMED BY**

Kathleen Byrnes

**HOSPITAL NAME**

Animal Hospital of  
Lake Brandt

**REFERRING VET**

Dr. Smith

**INVOICE**

72966

**DATE**

1/6/26

**PRESENTING CLINICAL SIGNS**

P has a history of DCM heart dz and hypertension managed by cardiologist. P presented for Double Cavity due to decreased HCT, elevated ALP, BUN, and Globulins, 2 Rads attached BP- systolic 160 x 2 140 x 3

**ULTRASONOGRAPHIC EXAMINATION OF THE HEART & ABDOMEN**

CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (M-Mode)	LA/AO (Heart Base; Swe)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	Up to 1.6	28-40	40-100	<0.6
PATIENT	--	--	NM	1.5	37	70	NM
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT (lbs)	LAD LA MAX 4 Chamber	LVIDd Avg; 2D and m-mode short axis (cm)	LVIDs Avg; 2D and m-mode short axis (cm)
NORMAL PARAMETER	50-100	0.7-1.7	0.7-1.6				
PATIENT	~60	1.68	1.34	28	3.3	2.4	--

**E-wave velocity = 0.52**

**Thorax**

A thoracic mass appeared to be occupying the right thorax, impinging upon and deviating the heart to the left. The mass appears to be extracardiac and resembles hepatic tissue. Diaphragmatic hernia of hepatic lobe is possible versus hepatization of the lung field, as no peripheral air appeared to be present around the mass, which would indicate non-pulmonary origin. The heart presented normal volumes and contractility. Trivial mitral and aortic insufficiency noted in this patient, not clinically significant. No evidence of primary cardiac disease.

**Urinary System**

The urinary bladder, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal.

The residual prostate measured 1.25 cm.

The kidneys revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex. Right kidney measured 6.1 cm. Left kidney measured 6.17 cm with slight pyelectasia.



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**Adrenal Glands**

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Both **adrenal glands** were visualized and recognized as having 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 measured 1.23 cm x 0.50 cm at the caudal pole and 0.45 cm at the cranial pole. Right measured 1.83 cm x 0.82 cm at the cranial pole and 0.49 cm at the caudal pole.

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**Spleen**

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

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**Liver**

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

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**Gastrointestinal**

There was some residual chyme and gas was noted in the **stomach**, yet not pathological. This is consistent with end post prandial presentation. Transit of chyme into the small intestine was normal. Curvilinear patterns were maintained throughout the GI tract. No evidence of pathology. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

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**Pancreas**

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The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

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**Other**

Slight free fluid noted in the caudal abdomen.

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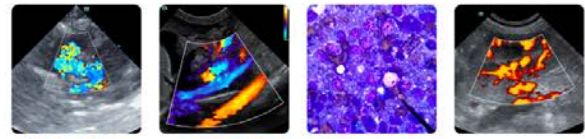
Transdiaphragmatic view revealed a 5.5 cm x 3.5 cm isoechoic mass in the thorax that was impinging upon the diaphragm.

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**ULTRASONOGRAPHIC FINDINGS**

- Thoracic mass – may represent herniation of hepatic tissue.
- Secondary trivial valvular disease with cardiac deviation.
- Unremarkable abdomen with slight free fluid of unknown origin.
- Age related renal and hepatic changes.



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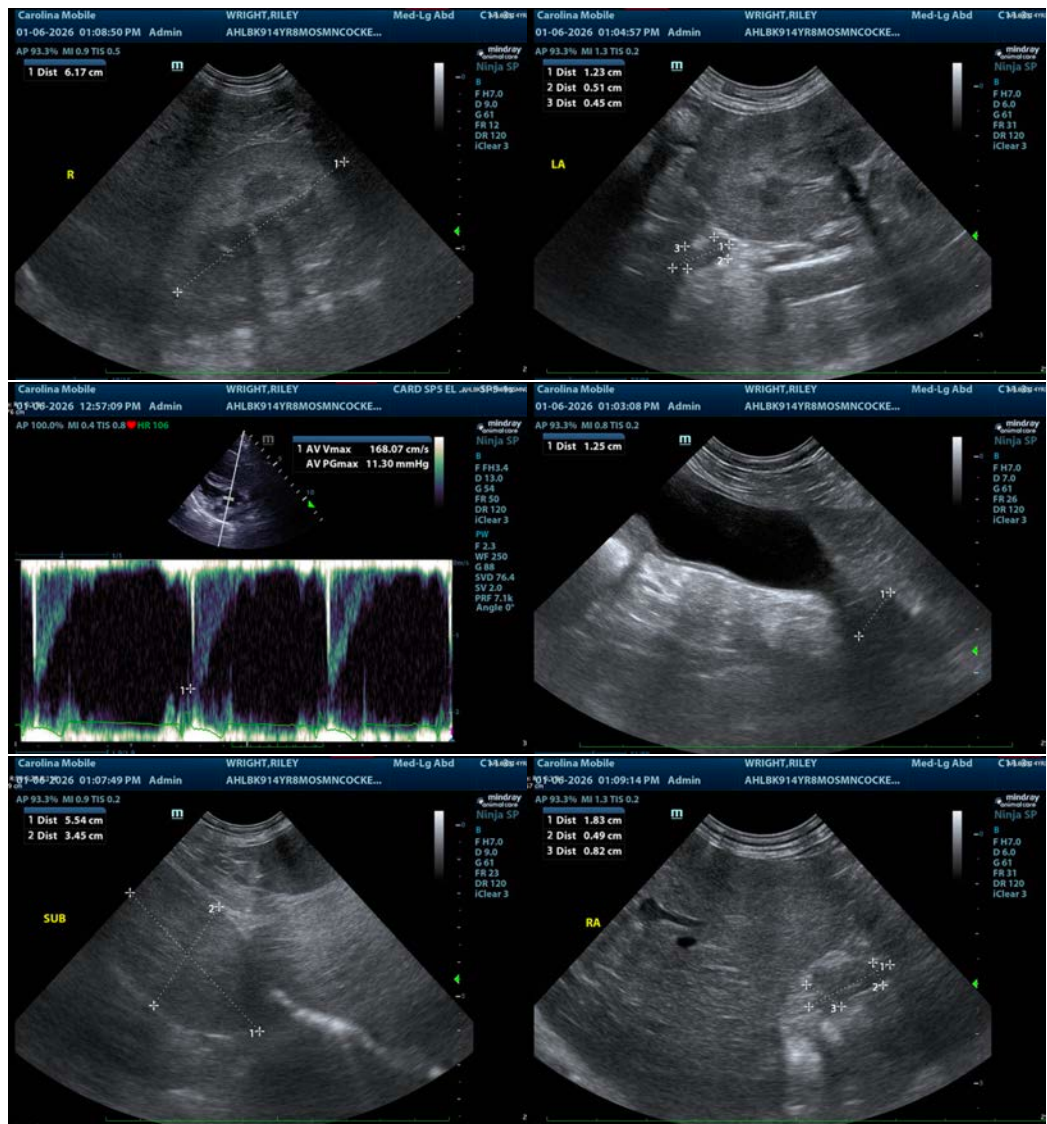
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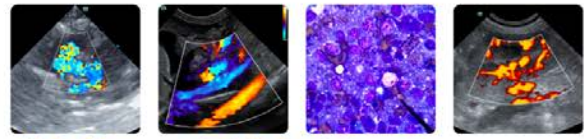
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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Ultrasound guided FNA of the mass from an intercostal approach recommended to assess if this is liver tissue versus pulmonary tissue. Strong suspicion of hepatic herniation. Chest CT would be ideal in this patient for further definition and potential surgical planning. There appears to be a continuous pattern of parenchyma and vasculature from the cranial liver through the diaphragm. However, this should be confirmed by CT.

Note that there is no structural or functional evidence of DCM at this time. There is the possibility that DCM-like disease may have been present in the past such as myocarditis or nutritional cardiomyopathy/taurine deficiency or other causes. There appears to be adequate contractility, no evidence of volume overload, and no thinning of the myocardium. No DCM criteria present at this time.





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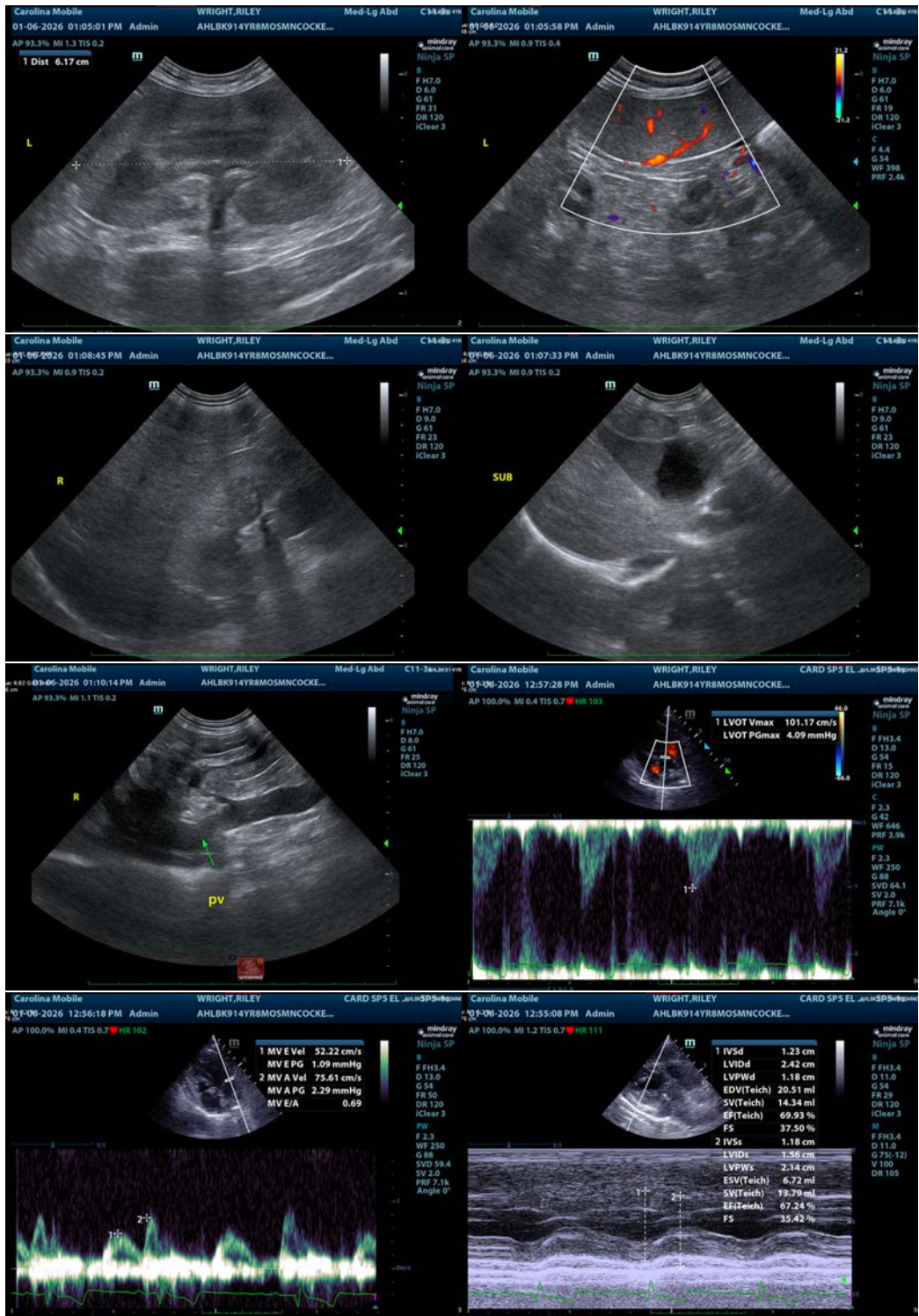
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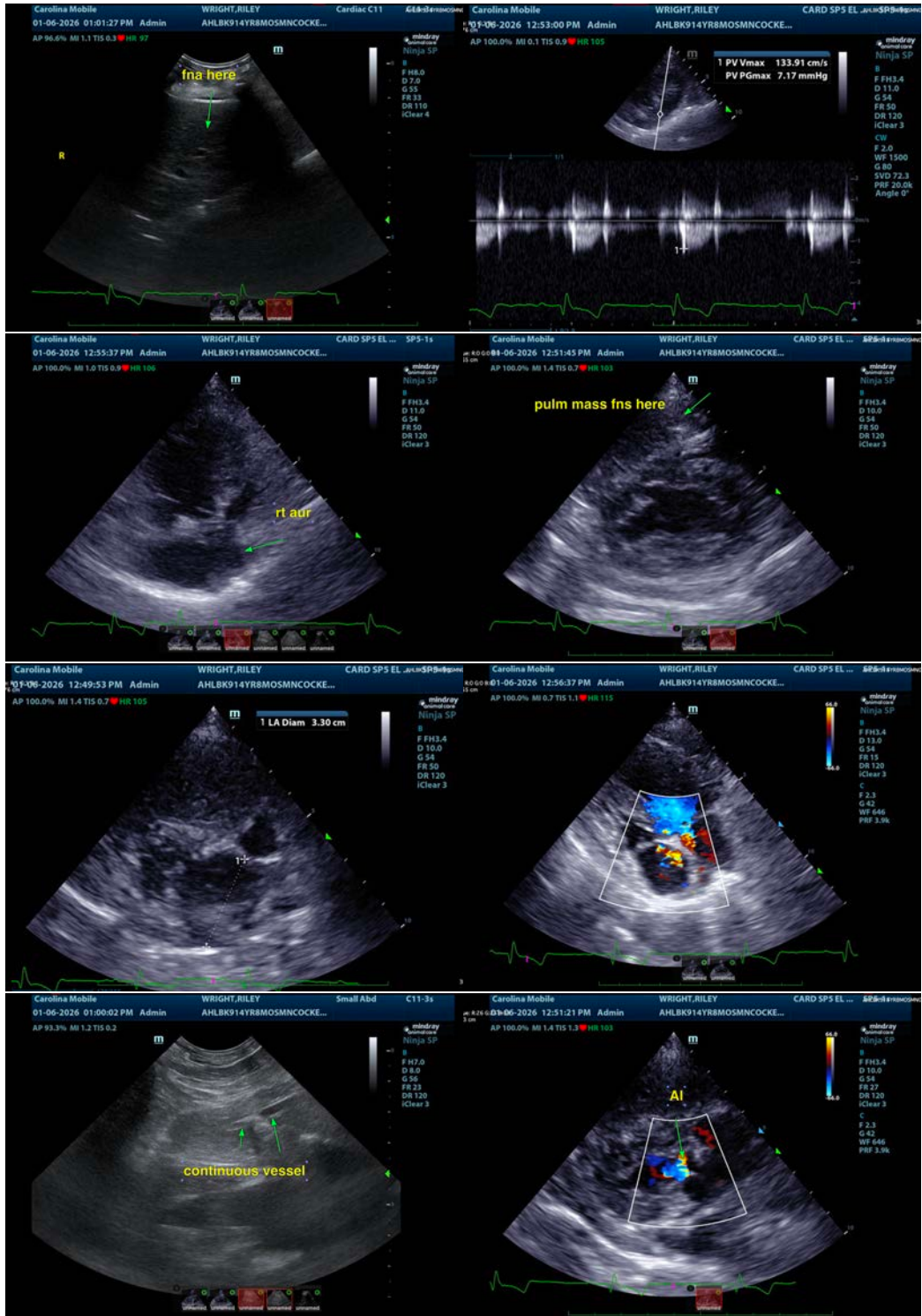
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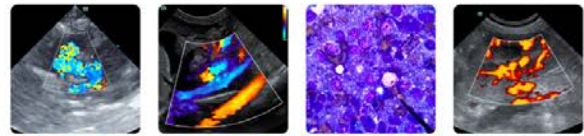
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Eric Lindquist**, DMV, DABVP(CFM), Cert. IVUSS,  
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