



PATIENT

Rocco DeGaetano

SPECIES

Canine

BREED

American Staffordshire
Terrier

SEX

Neutered Male

AGE

8 Years

WEIGHT

56 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jeremiah Gabriel

HOSPITAL NAME

Central Jersey Animal
Hospital

REFERRING VET

Dr. Jeremiah Gabriel

INVOICE

72311

DATE

12/3/25

PRESENTING CLINICAL SIGNS

Losing weight (lost more than 10 LBS in 2 weeks) panting (taking prednisone for allergy) grade 3 left apical murmur.

Abnormal PE/Chem/CBC/UA Results: cbc/chem pending

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	--	--	1.3	1.3	25	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	--	--	--	56	3.0	3.9	--

Cardiac Presentation

The echocardiogram in this patient demonstrated normal left atrial size based on 3 separate methods of LA evaluation. The cranial and caudal mitral valve leaflets presented normal linear structure, extension in systole, and union in diastole with normal kinesis. The left ventricle presented thicknesses with linear contour and was not dilated nor restricted. The myocardium presented normal echogenicity without subjective evidence of significant fibrotic or ischemic disease. Contractility of the ventricular walls was adequate and in normal range for this patient evidenced by the fractional shortening measurement and subjective evaluation of the different regions of the myocardium. The left ventricular outflow tract demonstrated normal laminar flow and subjective structural integrity. Flattening of the left ventricular septum noted. The right atrium and right ventricle were enlarged. Tricuspid insufficiency noted. Periodic tachyarrhythmia present. No visible pericardial or free pleura fluid was noted. The cranial mediastinum and pericardial and extra-cardiac regions were free of masses in the visible window.

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 pelvic urethra was imaged 2.0 cm beyond the cystourethral junction.

The kidneys revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present.



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The capsules were acceptably uniform without significant irregularities. Right kidney measured 7.2 cm. Left kidney measured 7.2 cm.

Adrenal Glands

The **adrenal glands** were not visualized.

Spleen

The **spleen** was largely smooth with subtle heterogeneous parenchymal changes while maintaining normal echogenic relationship to the liver and kidney. These changes are consistent with normal age-related alteration. The capsule was smooth without noticeable impingement from within the spleen or from pathology in the adjacent abdomen. The splenic vasculature demonstrated normal volume without signs of congestion or significant contraction. No evidence of active acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

Liver

The **liver** was uniformly swollen with minor, excessive gallbladder debris and over distension with dependent and suspended bile without evidence of overt mucocele formation. However, excessive sludge was present. The liver presented coarse architecture with mildly increased portal markings and subtle, mixed echogenic changes. This is consistent with vacuolar hepatopathy and some level of remodeling and history of inflammatory component. There was no overt suspicion of neoplasia. Hepatic veins were dilated, suggestive of emerging right-sided failure.

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.

Pancreas

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.

ULTRASONOGRAPHIC FINDINGS

- Volume overload of the right heart with tricuspid insufficiency. Exact cause is unclear.
- Passive congestion liver.
- Mild nodular hyperplasia splenic pattern.
- Partially full stomach.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommend further imaging of the right heart, as sound beam attenuation was an issue, as well as further doppler assessment of the pulmonic valve and pulmonary artery. Bubble study may be appropriate. Presumptive diagnosis is tricuspid insufficiency and emerging right-sided failure. However, this is to be further defined. The exact cause of weight loss is unclear. Note: The Prednisone may be suppressing a more significant presentation.



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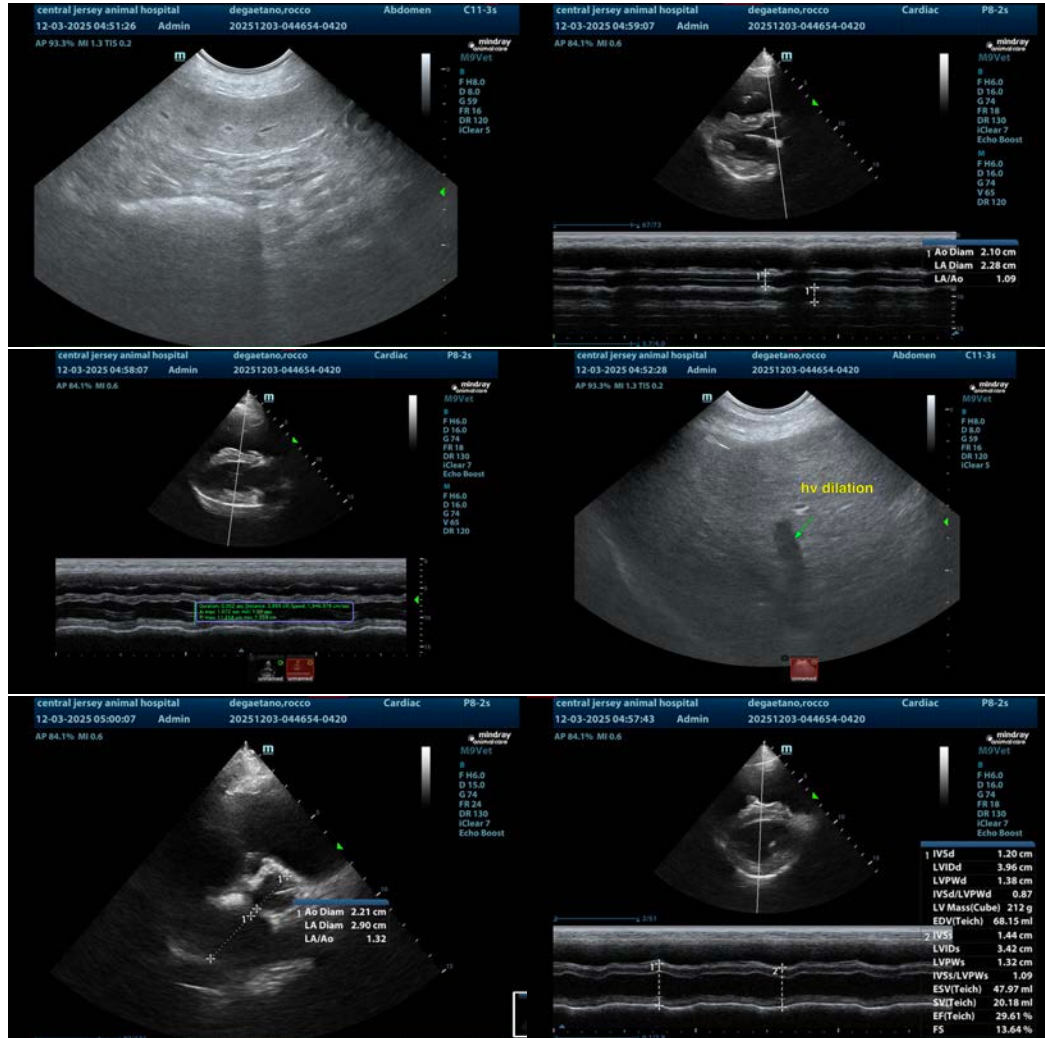
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No evidence of significant abdominal disease. Maldigestion panel, three view chest radiographs and full CNS examination is recommended to examine for occult disease that could be responsible for the weight loss. Evaluation for competitive eating environments should also be considered. Further imaging of the adrenal glands would also be indicated.





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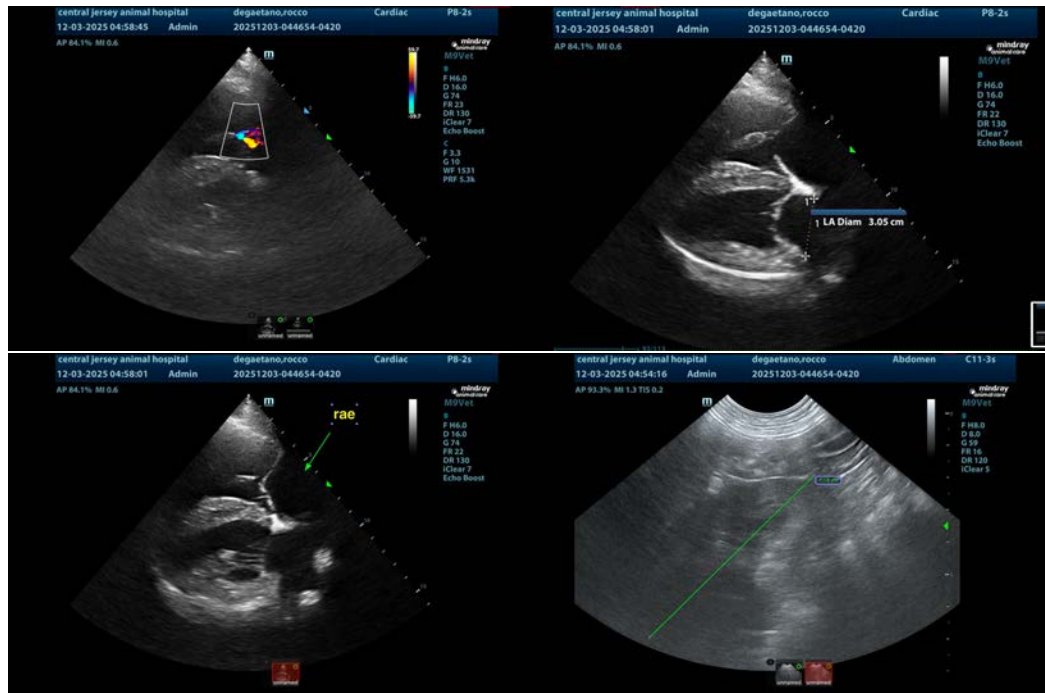
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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