



PATIENT

Pepper Fetter

SPECIES

Canine

BREED

Pomeranian

SEX

Spayed female

AGE

14 years

WEIGHT

13.2 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Hollway

HOSPITAL NAME

Valley Green VH

REFERRING VET

Dr. Hollway

INVOICE

73690

DATE

3/23/26

PRESENTING CLINICAL SIGNS

- HX of grade 3/6 HM -- worse today at 4/6
- HX of Splenic nodule (measured 1.4 x 1.6 cm)
- HX of Minor mitral insufficiency, no left atrial enlargement. Stage B1 valvular disease.
- NO new concerns per O. Eating Farmers Dog. No C/S/V/D. E/D/U/D all WNL. Last full meal yesterday morning. Gabapentin and trazodone administered last night and again this am around 6:30am
- BP - avg 125mmHg
- pre-sedation ECG = NSF --> AV Block noted once sedated and atropine administered
- 3/13/26:
- CBC: RBC NSF, WBC NSF
- -PLT increased, which can occur w/ stress but may also occur w/ inflammation, rebound, neoplasia. The AUS scheduled will screen for many pathologic r/os.
- Chem -BG NSF, KES NSF, e-lytes NSF, proteins NSF, LES NSF
- T4 WNL
- 4dx negx4
- PT/PTT is similar to last measured where PTT is slightly faster than the reference range, meaning Patient is not at an apparent status of impaired clotting. While blood loss via sampling on AUS is still possible, pathologic blood loss is considered less likely.
- 11/2025: US-guided FNA of Pepper's splenic mass (currently measuring ~1.3x1.6cm)
- Pathology Report INTERPRETATION: Reactive/hyperplastic splenic lymphoid tissue.
- BAR. Soft nonpainful abdomen; mass effect not palpable. AUS 10/2025: Splenic nodule (measured 1.4 x 1.6 cm). Worsening HM -- now a 4/6HM (prev = 3/6); loudest on the left (Per Recent Echo 10/2025: Minor mitral insufficiency, no left atrial enlargement. Stage B1 valvular disease.) Lungs auscultate clear bilaterally; trachea clear. New large lipoma-like mass left lateral thorax -- not prev noted, recommend FNA. Nuclear sclerosis. Slight tacky mm; grade 2 dental disease with numerous missing teeth from previous COHAT. Currently only Simparica Trio SIM + PVPs for veterinary visits.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** and visible pelvic urethra were unremarkable for the level of repletion presented. The urine, however, did present some mildly echogenic debris consistent with mucous, exfoliated cells from renal or bladder origin, and/or blood clots as these echogenic changes can all present similarly. This is often related to urinary tract infection but may represent simple evidence of exfoliated debris or sterile inflammation. Cystocentesis, urinalysis, +/- culture would be recommended to rule out and define any UTI.

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 this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 3.5 cm. The right kidney measured 3.87 cm.



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Adrenal Glands

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. The left adrenal gland measured 0.5 cm. The right adrenal gland measured 0.61 cm at the cranial pole and 0.5 cm at the caudal pole.

Spleen

The **spleen** revealed an expansive nodule that measured 1.68 cm. The nodule was non-cavitated. The remainder of the spleen revealed minor, heterogenous parenchymal changes.

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.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. 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 EXAMINATION OF THE HEART

The echocardiogram in this patient demonstrated mild **left atrial** enlargement. This is best represented in the LA max position. The **mitral** valve insufficiency was noted. 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



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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. The **right atrium** and auricle revealed normal size, structure and content. No evidence of masses was noted. Minor **tricuspid** valvular insufficiency was noted. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. **Pulmonary outflow** tract assessment revealed normal valve structure, laminar flow, and diameter (approx.1:1 pa/ao ratio). 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.

CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO	LA/AO (Heart Base)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	<1.6	28-40	40-100	<0.6
PATIENT	-	-	1.0	1.9	30	-	NM
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT	LA 2D short axis Base view (cm)	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	BELOW	BELOW	BELOW	BELOW
PATIENT	70	-	0.9	13.2 lbs	2.8	2.25	

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ULTRASONOGRAPHIC FINDINGS

Hyperplastic spleen. Mild potential for underlying neoplasia.
Geriatric abdomen.
Mitral valve insufficiency.
Mild left atrial enlargement.
Early stage B2 valvular disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I cannot rule out a preneoplastic state. Proactive splenectomy would not be inappropriate.
Pimobendan is indicated at 0.3 mg/kg. There was no evidence of metastatic disease in the heart.
The heart has minor volume overload and is working to compensate for the valvular insufficiency. Target respiratory rate is < 20 resp/minute after therapy. After initiating or adjusting therapy, I recommend recheck on the clinical exam, BUN, Creatinine, USG, Chest radiographs & Blood pressure in



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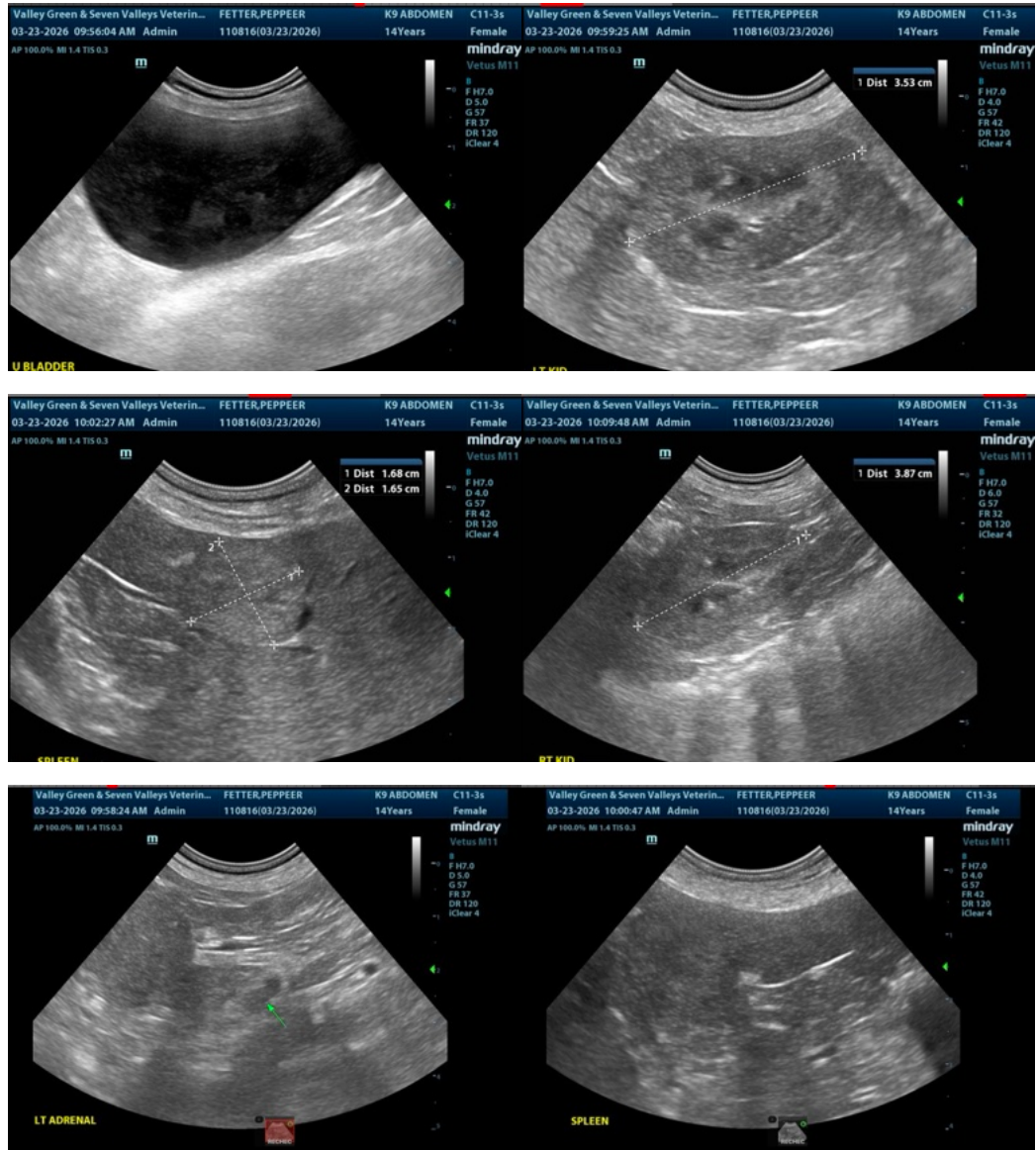
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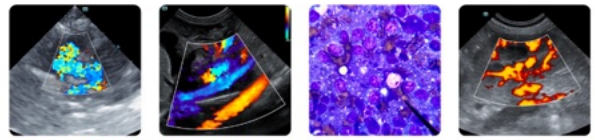
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5-7 days. Recheck echo in 3-6 months, earlier if clinical decompensation is occurring. Minor anesthetic risk for a brief procedure at this time. Repeat preanesthetic echo is ideal if anesthesia is eventually necessary. A suggested anesthetic combination would involve Torbutrol premed, propofol induction, Isoflurane maintenance or equivalent protocol.





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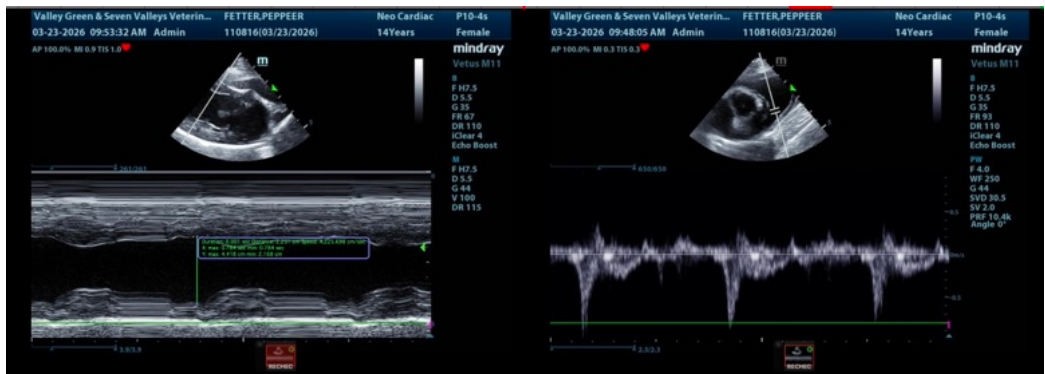
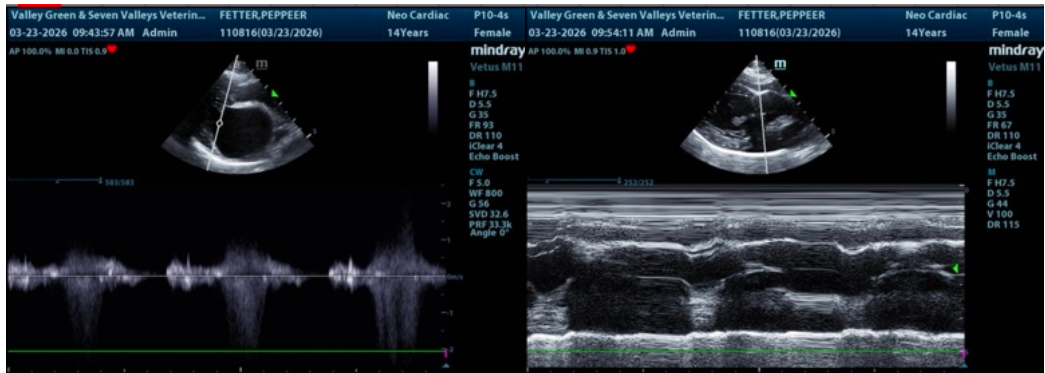
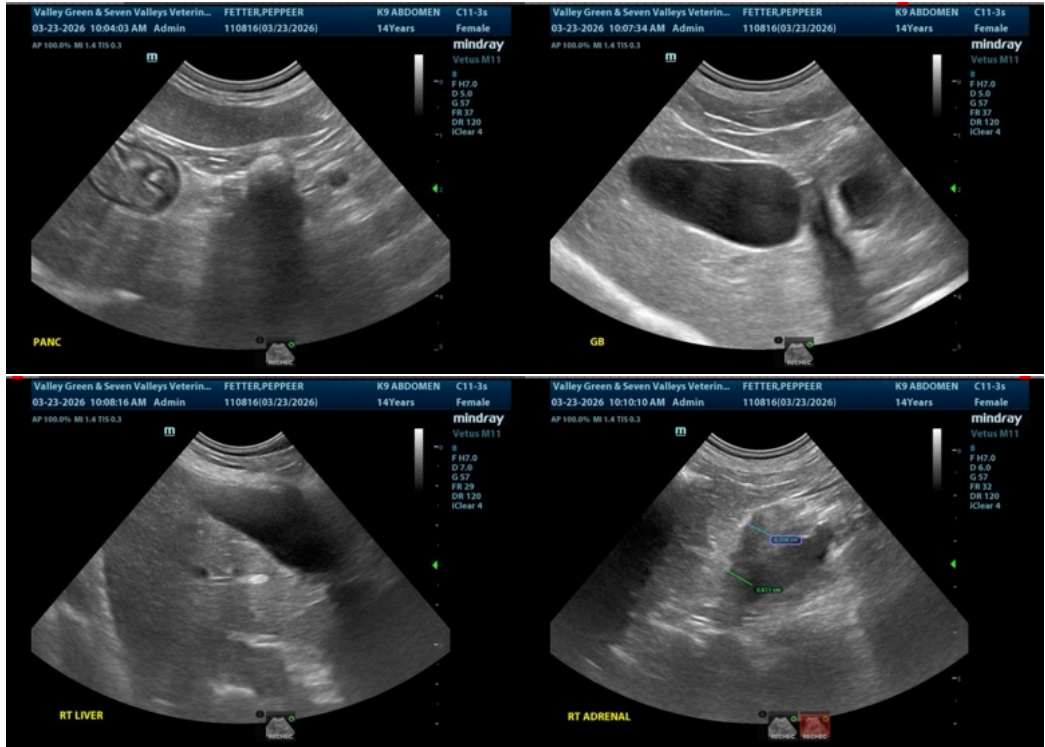
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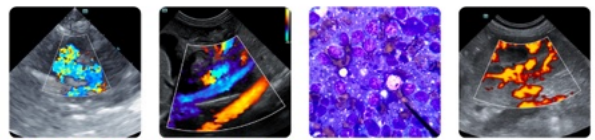
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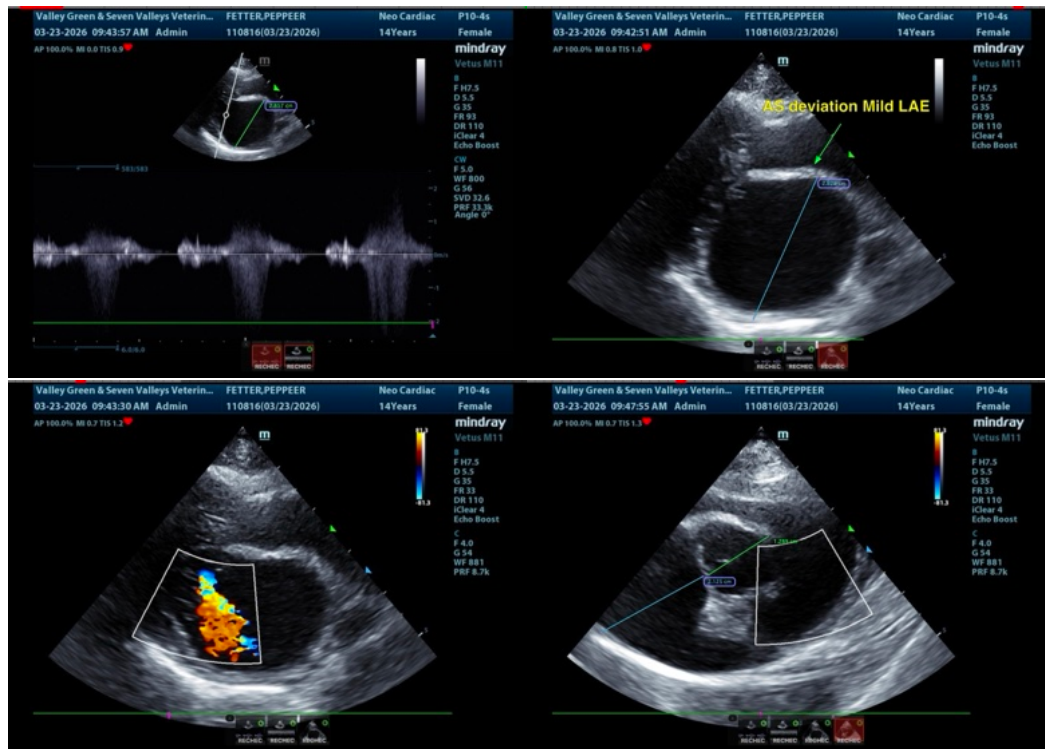
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, CEO of SonoPath.com

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