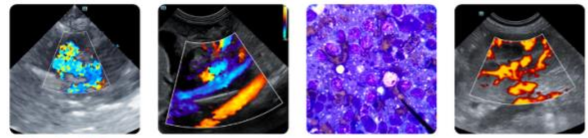


PATIENT

Archer Berry

SPECIES

Canine

BREED

Maltese

SEX

Neutered Male

AGE

13 Years 7 Months

WEIGHT

10.3 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Kerri Becker

HOSPITAL NAME

Wyckoff Veterinary Hospital

REFERRING VET

Dr. Eisenberg

INVOICE

15861

DATE

05/06/26

PRESENTING CLINICAL SIGNS

Recheck echo and abd scan- had some evidence of liver pathology.

Abnormal PE/Chem/CBC/UA Results: alt-207 alkp-1802

ULTRASONOGRAPHIC EXAMINATION OF THE HEART & ABDOMEN

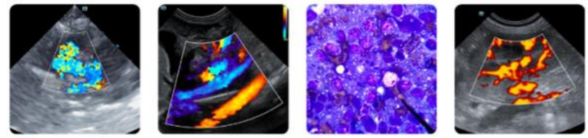
CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (M-Mode)	LA/AO (Heart Base; Swe)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	Up to 1.6	28-40	40-100	<0.6
PATIENT	5.0	--	1.7	2.0	41	73	0.1
CANINE CARDIAC PARAMETERS	**HR (BPM)**	**AV VMAX (m/s)**	**PV MAX (m/s)**	**BODY WEIGHT (lbs)**	**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	193	1.3	0.90	10.3	3.55	3.08	--

Cardiac Presentation

The **left atrial** size is increased by approximately 0.50 cm as well as increased **left ventricular** diameter compared to the prior sonogram. Prolapse of the anterior mitral valve leaflet was noted. Doppler indicated measurable insufficiency. 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. The **right atrium** and auricle revealed normal size, structure and content. No evidence of masses was noted or chamber overload. **Tricuspid** valvular assessment demonstrated adequate linear morphology. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. **Pulmonic** 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. No echographically detectable evidence of infiltrative disease was visible. The cranial **mediastinum and pericardial regions** were free of masses in the visible window.

Urinary System

The **urinary bladder**, trigone, and pelvic urethra to a depth of 3.0 cm 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.



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The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some moderate age-related loss of curvilinear patterns regarding the capsule and C/M junction. Minor microcystic changes were noted in the renal cortices. Medullary structure differed distinctly from that of the cortex. The left kidney measured 4.18 cm in length. The right kidney measured 4.4 cm in length.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as at the upper limits or normal in size, position and acceptable echogenicity for this age group and breed. Some heterogeneity was noted within the adrenal parenchyma without concerning capsular distortion. These changes are likely age related but should be monitored by sonogram should the patient be suspected of having adrenal disease. The left adrenal gland measured 1.69 cm x 0.61 cm width at the caudal pole and 0.52 cm width at the cranial pole. The right adrenal gland measured 1.92 cm x 0.95 cm width at the cranial pole and 0.74 cm width at the caudal pole.

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.

Liver

The **liver** revealed coarse architecture with moderate remodeling, similar to the prior sonogram. The gallbladder revealed coalesced debris yet not overtly pathological.

Gastrointestinal

The **gastric** wall was mildly thickened with mural thickening of the pyloric outflow measuring 1.2 cm with some loss of mural detail. This area should be monitored to assess for any inappetence or evidence of gastric ulcer/gastritis. The small intestine and colon were unremarkable.

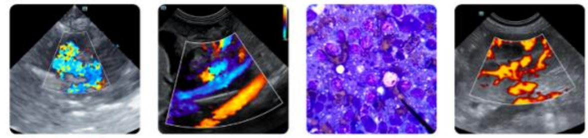
Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some moderate parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

ULTRASONOGRAPHIC FINDINGS

- Hepatic remodeling.
- Gastric wall thickening.
- Age-related renal/adrenal changes.
- Moderate pancreatic remodeling.
- Stage B2+ valvular disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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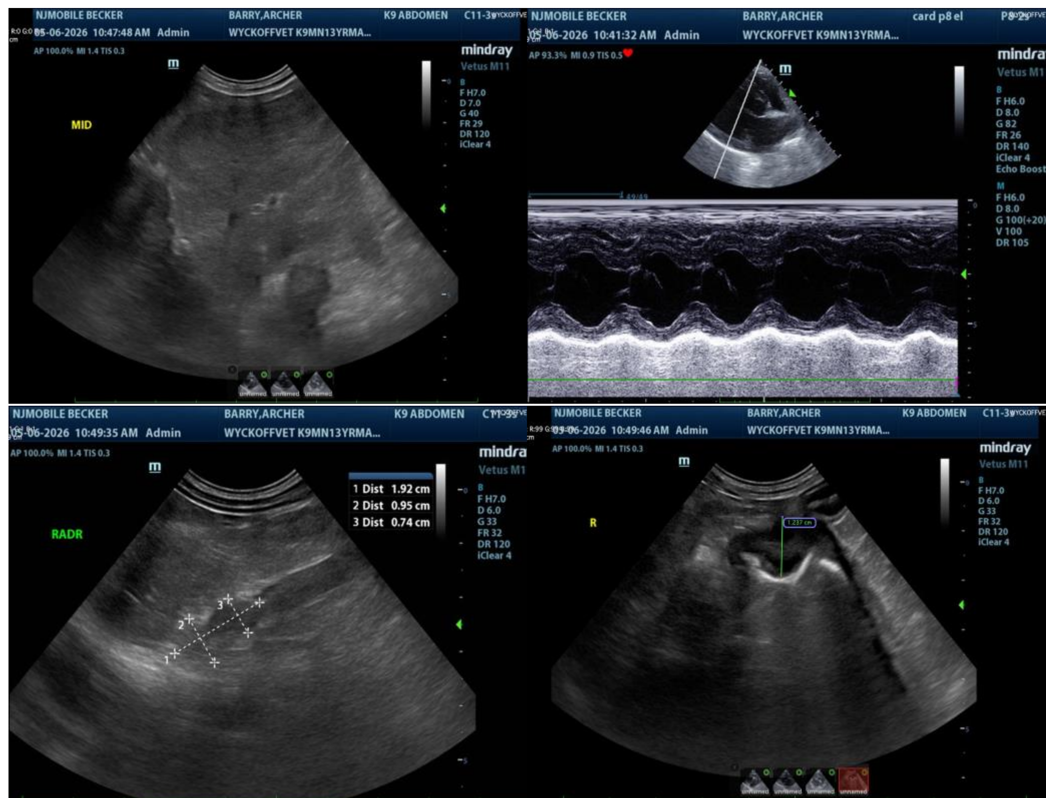
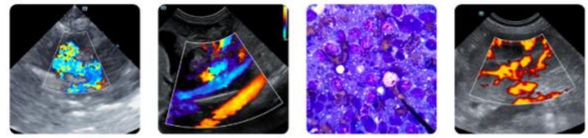
Recommend adjusting the current medications in addition to Pimobendan. An ACEi at 0.50 mg/kg SID progressing to BID and Spironolactone at 1-2 mg/kg SID. If any pulmonary edema is present, Lasix therapy would be indicated. The mitral valve apparatus is very fragile in this patient. Decompensation can occur at any time. If further rupture of chordae tendineae occurs, blood pressure measurements would be indicated. Bile acid profile would be ideal.

The heart is in a somewhat precarious state with volume overload and a heart that is working to compensate for the valvular insufficiency. Target respiratory rate is < 20 resp/minute after therapy. After initiating therapy, I recommend recheck on the clinical exam, BUN, Creatinine, USG, Chest radiographs & Blood pressure in 5-7 days. Recheck echo in 1 month. Earlier if clinical decompensation is occurring. I do not recommend anesthesia at this time until stabilization has occurred on the recommended medications. Repeat preanesthetic echo is ideal if anesthesia is eventually necessary.





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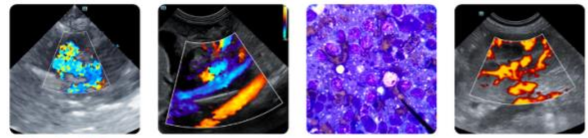
The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

CEO, Owner, Founder -- SonoPath.com

info@SonoPath.com



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