



**PATIENT**

Max Quanni

**SPECIES**

Canine

**BREED**

Lhasa

**SEX**

Neutered male

**AGE**

13 years

**WEIGHT**

-

**INTERPRETED BY**

Eric Lindquist, DMV,  
DABVP, Cert. IVUSS,  
CEO of SonoPath.com

**IMAGING PERFORMED BY**

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**HOSPITAL NAME**

Franklin Lakes AH

**REFERRING VET**

Dr. Ward

**INVOICE**

68290

**DATE**

11/4/25

**PRESENTING CLINICAL SIGNS**

Elevated ALP 1350, ALT 218 and suspected Cushing's disease. Grade III/VI systolic murmur, non-clinical.

**ULTRASONOGRAPHIC EXAMINATION OF THE HEART**

The echocardiogram in this patient demonstrated enlarged **left atrial** size based on 3 different LA measurement methods. Moderate filling of the left atrium was noted. Chamber volumes and echogenicity were normal. The cranial and caudal **mitral** valve leaflets presented vegetative thickening consistent with endocardiosis. Prolapse of the anterior mitral valve leaflet was noted. Doppler indicated measurable insufficiency. The **left ventricle** presented normal 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. The **right atrium** and auricle revealed normal size, structure and content. No evidence of masses was noted or chamber overload. **Tricuspid** insufficiency was noted and measured 3.0 m/sec. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. Moderate **pulmonic** insufficiency was noted and measured 2.5 m/sec. The pulmonary artery was dilated. 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. The hepatic veins were not dilated.

<b>CANINE CARDIAC PARAMETERS</b>	<b>MR VMAX</b> (m/s)	<b>TR VMAX</b> (m/s)	<b>LA/AO</b>	<b>LA/AO</b> (Heart Base)	<b>FS</b> (%)	<b>EF</b> (%)	<b>EPSS</b> (cm)
<b>NORMAL PARAMETER</b>	4.5-5.5	<2.7	1.3	<1.6	28-40	40-100	<0.6
<b>PATIENT</b>	6.3	3.0	1.6	1.5	45	77	0.1
<b>CANINE CARDIAC PARAMETERS</b>	<b>HR</b> (BPM)	<b>AV VMAX</b> (m/s)	<b>PV MAX</b> (m/s)	<b>BODY WEIGHT</b> (kg)	<b>LA</b> 2D short axis Base view (cm)	<b>LVIDd</b> Avg; 2D and m- mode short axis (cm)	<b>LVIDs</b> Avg; 2D and m- mode short axis (cm)
<b>NORMAL PARAMETER</b>	50-100	0.7-1.7	0.7-1.6	BELOW	BELOW	BELOW	BELOW
<b>PATIENT</b>	124	1.8	2.0		3.5	2.86	



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**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. Persistent bladder calculus was noted and measured 0.94 cm. Minor bladder polypoid changes were noted. This is consistent with low-grade cystitis.

The **kidneys** revealed bilateral enlargement with normal 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. Moderate mineralization was noted in the kidneys. Vascularity to the kidneys appeared to be adequate. The right kidney measured 4.61 cm with corticomedullary calculi. The left kidney measured 4.47 cm.

**Adrenal Glands**

The left **adrenal** was uniform and measured 2.4 x 0.65 cm at the cranial pole and 0.75 cm at the caudal pole. The right adrenal gland was prominent and measured 2.4 x 1.13 cm at the cranial pole and 0.55 cm at the caudal pole.

**Spleen**

A new development of the **spleen** revealed an expansive, focal nodule measuring 1.4 cm at the cranial pole and minor heterogenous changes noted elsewhere in the spleen. Differentials include emerging hemangiosarcoma, round cell neoplasia, hyperplasia possible. However, there is concern with capsular expansion.

**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. The hepatic veins were not overtly dilated.

**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.



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**Pancreas**

The **pancreas** revealed coarse architecture with mixed, heterogenous parenchymal changes with capsular expansion. The right pancreatic limb measured 2.7 cm.

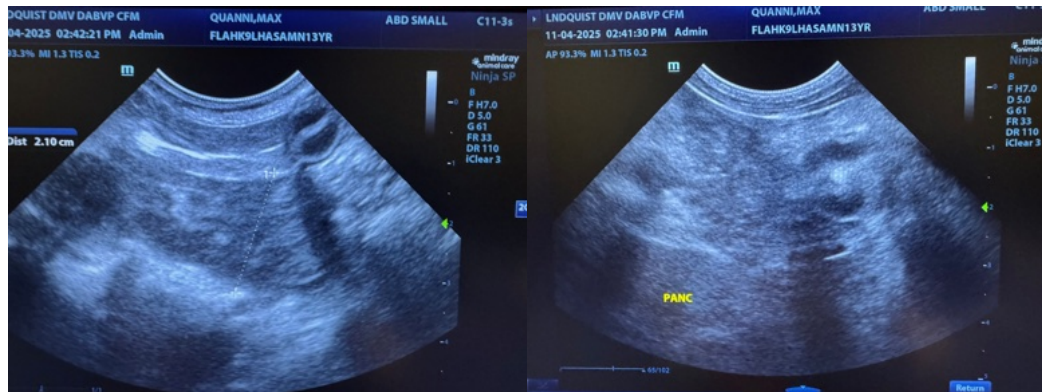
**ULTRASONOGRAPHIC FINDINGS**

- Pulmonic insufficiency.
- Early borderline pulmonary hypertension.
- Mitral insufficiency was noted.
- Mild left atrial enlargement.
- Moderate degenerative renal changes.
- Benign hepatopathy. This is consistent with chronic inflammatory hepatopathy like feeding the liver in a reactive hepatopathy fashion due to the portal system.
- Chronic pancreatic changes with likely low grade inflammation.
- Splenic nodule.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Stage B2 valvular disease. I recommend initiating Pimobendan at 0.3 mg/kg b.i.d., ace inhibitor therapy is indicated if hypertension is present.

I am most concerned with the splenic nodule in this patient. After management for cardiac disease with prescribed medication, I recommend three view chest radiographs followed by splenectomy, cystotomy and stone analysis. If the patient is PU/PD this may be secondary to the bladder calculus, possible UTI or emerging Cushing's.





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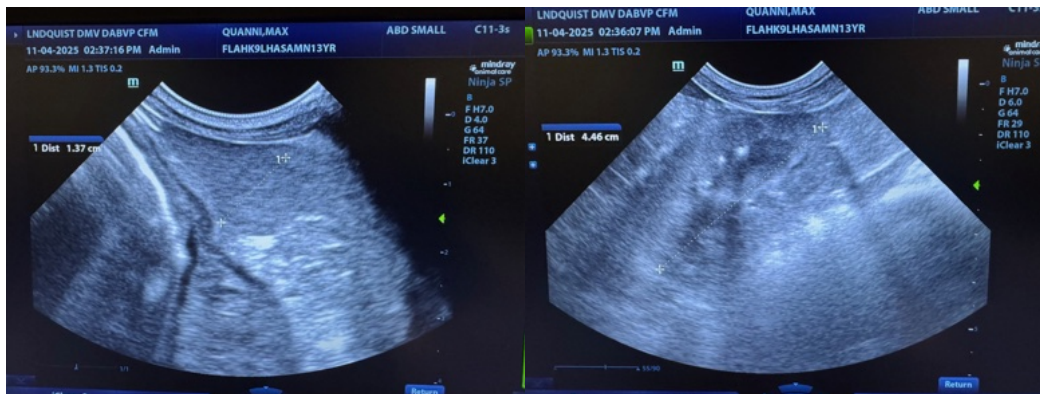
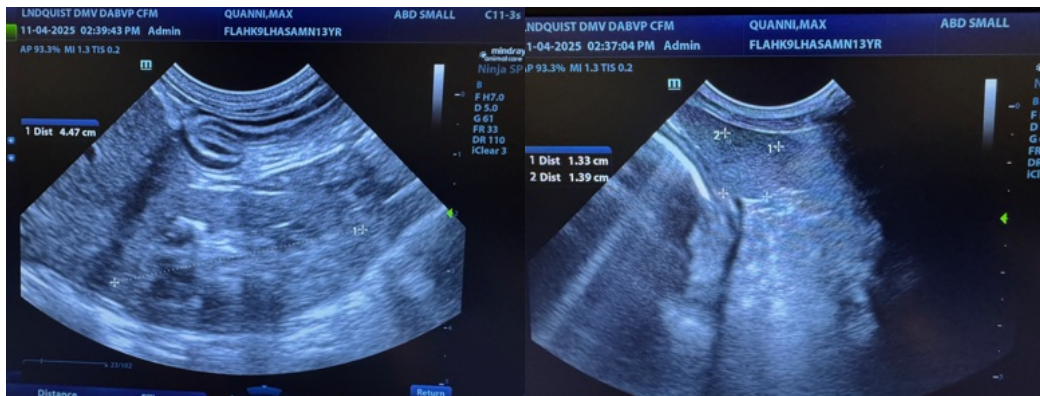
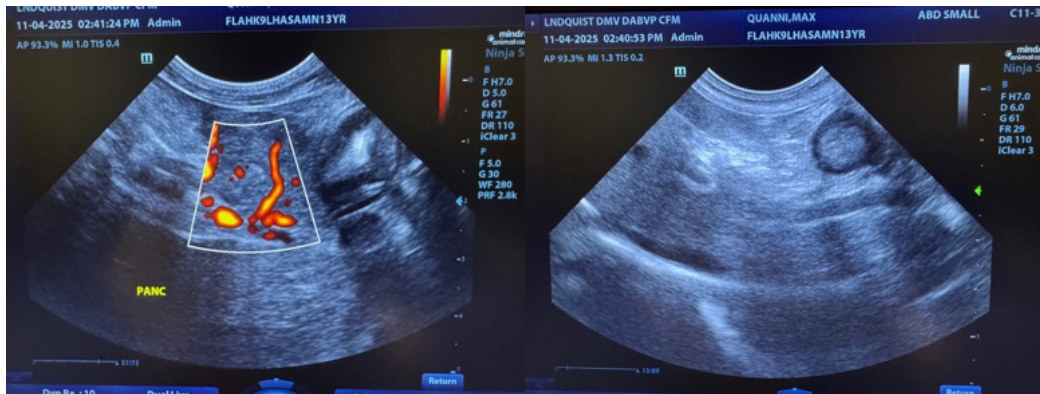
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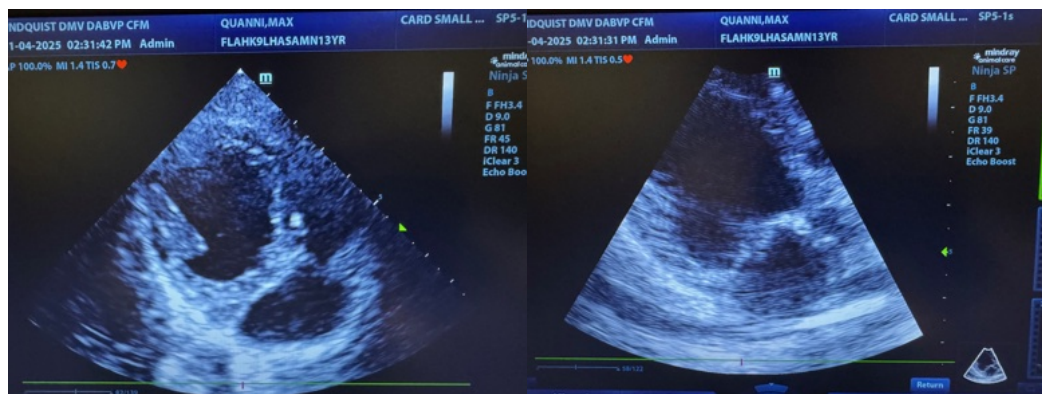
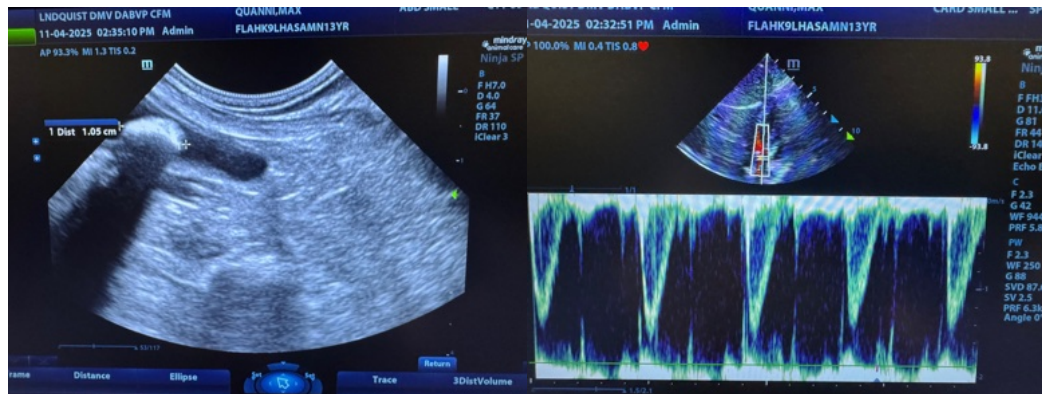
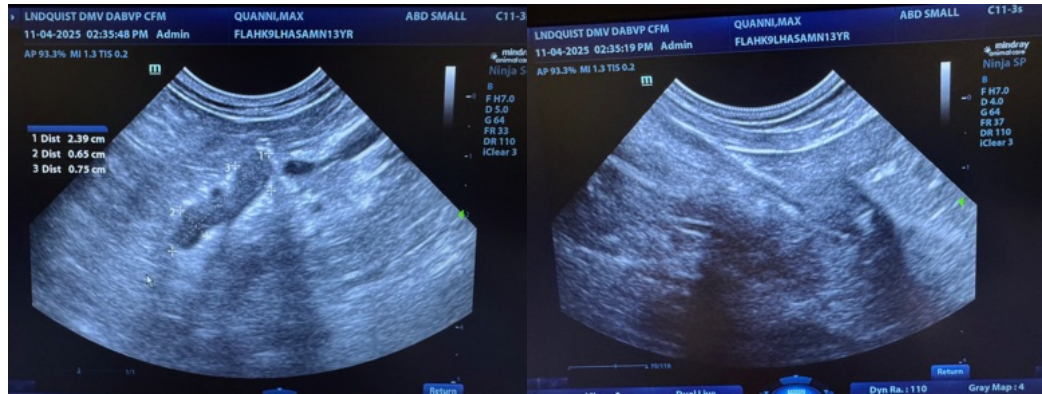
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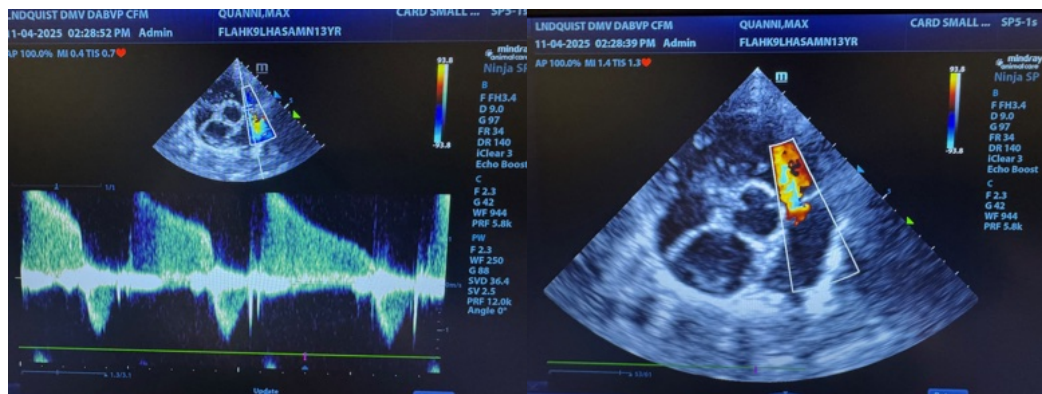
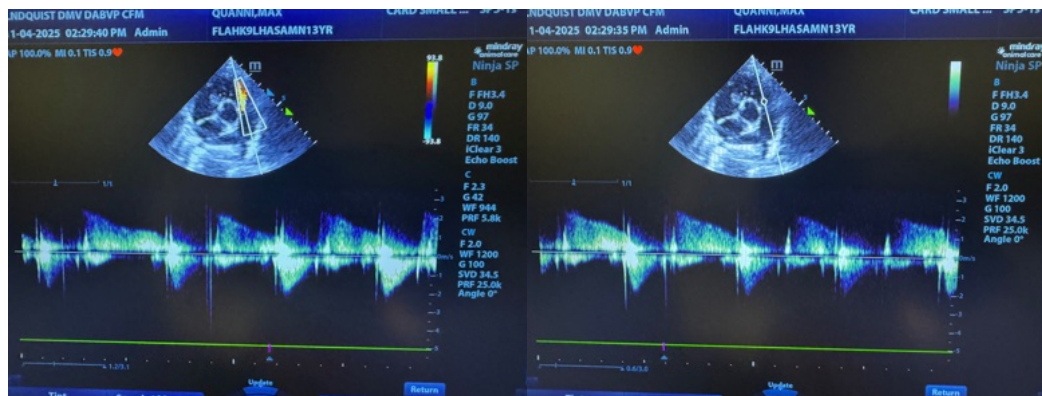
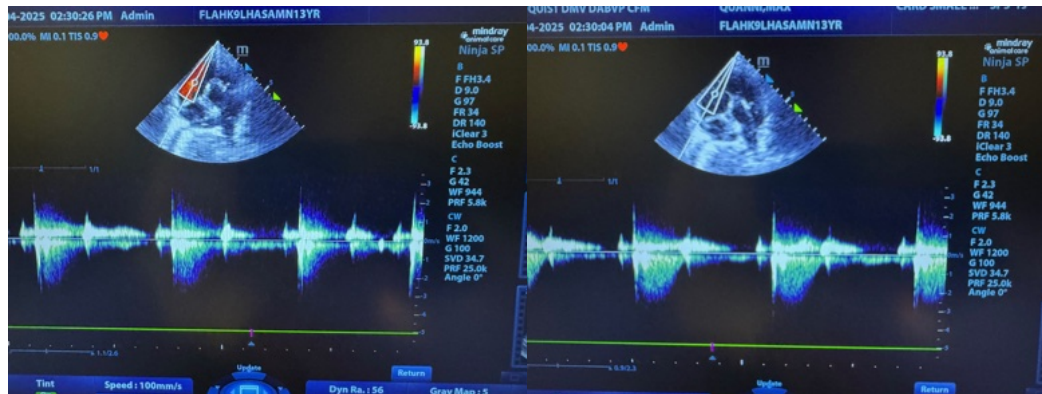
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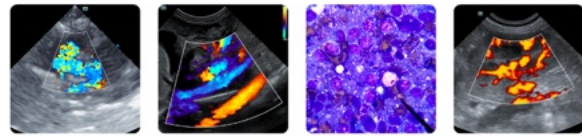
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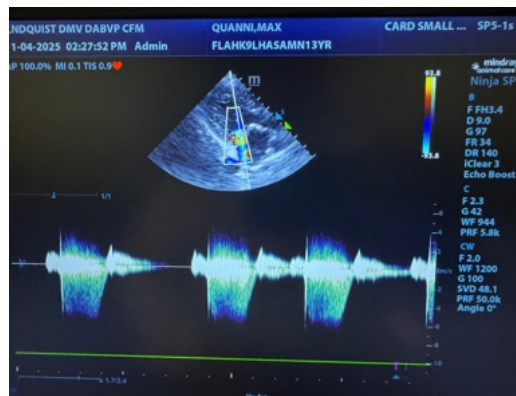
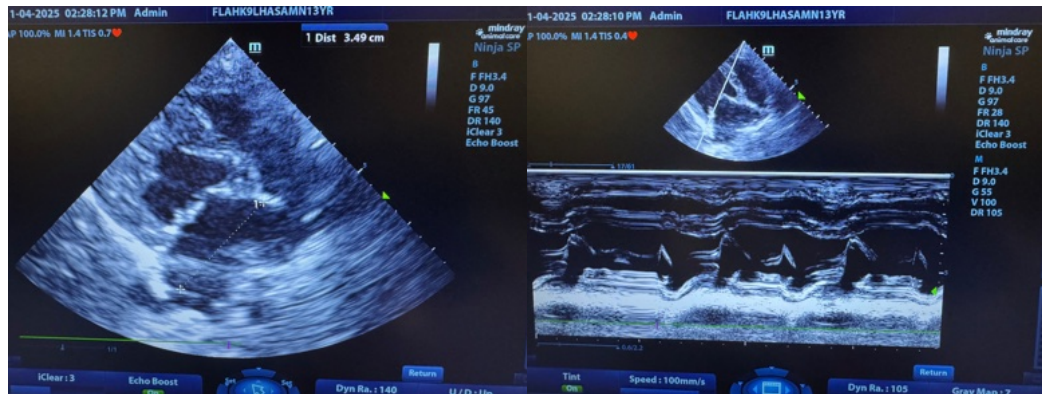
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, Cert. IVUSS, CEO of SonoPath.com

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