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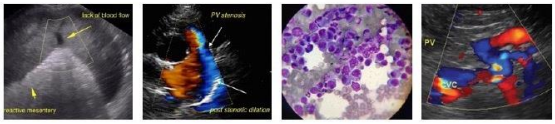


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT
Oakley Marche

SPECIES
Canine

BREED
American Bully

SEX
FS

AGE
5yr

WEIGHT
28.3lb

INTERPRETED BY
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY
Kelly Rescny

HOSPITAL NAME
Snelgrove VS

REFERRING VET
Dr. Ioannou

INVOICE
12659ag

DATE
01/11/2023

PRESENTING CLINICAL SIGNS

hadnt eaten for 2 days prior to last week - normally eats derm complete, had been on and off eating for 1-2 weeks before then had some rice and she ate first night, then didnt want to eat the kibble and rice and o tried rice only she didnt want any offered peanut butter didnt want it off of apoquel since not feeling well having diarrhea - 1 week , unsure if soft stool or diarrhea blood tinged poop no vomiting - since cerenia but also no vomiting before, gagging a week ago but no vomit (cerenia inj given on 01-05-2023) slight yeasty smell for skin lethargic at home doesnt want to do much - o not taking on walks approx 5-7% dehydrated decrease lung sounds on cranial and caudoventral regions, no crackles no wheezes noted, normal rhythm no murmur but very quiet, tachypneoa with M1 increased abdominal effort M1 grunting on deep palpation but soft no distention, no palpable FB noted fecal staining yellow brown on hind end, liquid soft diarrhea on rectal thermometer, no blood noted Thoracocentesis- Approx 80 ml from right side chest and 120 ml left side chest drained, sanguinous /chylous slightly thick and white particle matter removed - possible blood tinged chyle vs other:? -trauma vs rupture vs idiopathic vs immune mediated, neoplastic etc

Current Medications Aventi GI, Apoquel

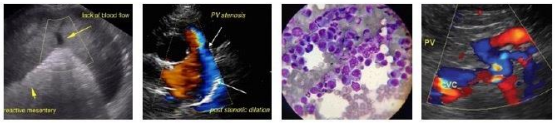
Abnormal PE/Chem/CBC/UA Results: CBC - WNL mild lymphopenia and eosinopenia - stress leukogram Chemistry- low normal urea, low normal TP, albumin and globulins - in light of dehydration status HR/RR/BP: HR 140, RR 52, BP not done Please see attached rads

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN AND HEART

CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (Boon method)	LA/AO (Heart Base; Swe)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	<1.3	28-40	40-100	<0.6
PATIENT				1.0	35.4	66.9	0.2
CANINE CARDIAC PARAMETERS	**HR** (BPM)	**AV VMAX** (m/s)	**PV MAX** (m/s)	**BODY WEIGHT** (kg)	**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				
PATIENT	NM		1.0		2.6	2.6	

Cardiac Presentation

The echocardiogram in this patient demonstrated normal to possible mild volume contracted left atrial size based on 2 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. No overt MR on Doppler. 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. Normal measured LVOT velocity. The right



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atrium and auricle revealed normal size, structure and content. No evidence of masses was noted. Tricuspid valvular assessment demonstrated adequate linear morphology and kinesis. No overt TR on Doppler. 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). Normal measured RVOT velocity. No visible pericardial effusion or overt cardiac tumors. Moderate volume pleural effusion exhibiting mild to moderate fluid echogenic changes suggestive of fluid cellularity was present. A definitive pericardial or thoracic mass/lesion was not obvious. No overt pathology in the area of the cranial mediastinum although cannot be definitely excluded.

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. Possible bilateral cortical microinfarctions were present. The left kidney measured 6.2 cm in length. The right kidney measured 6.9 cm in length.

The area of the aortic trifurcation was free of pathology.

The area of the iliac trifurcation was free of pathology including no evidence of medial, iliac or sublumbar lymphadenopathy.

The area of the uterine remnant appeared normal and free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.48 cm width at the caudal pole and 2.0 cm length. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.58 cm width at the caudal pole and 3.0 cm length.

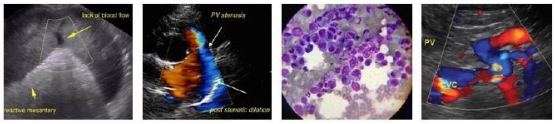
Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/Gallbladder

The liver was mildly enlarged with symmetrical capsule contour and normal uniform parenchyma echogenicity. Subjective discrete to borderline prominent hepatic vasculature most notable at the level of the hepatic vein/caudal vena cava junction was present. Concurrent mildly prominent caudal vena cava at the level of the liver and diaphragm was present measuring 1.2 cm in diameter. No evidence of thrombosis. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal



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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

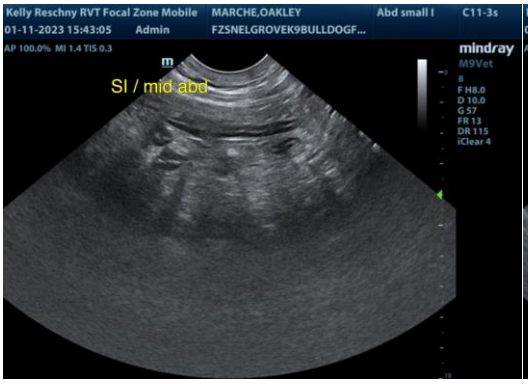
No omental masses, overt lymphadenopathy or peritoneal effusion/ascites was present.

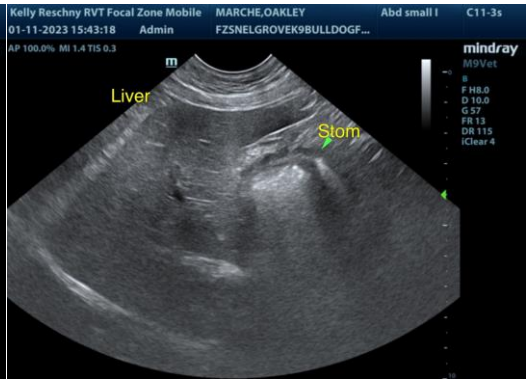
ULTRASONOGRAPHIC FINDINGS

- Overtly normal cardiac structure and function
- Moderate volume echogenic pleural effusion-noncardiogenic
- Non-specific benign mild hepatomegaly, possible emerging compensated hepatic congestion
- Sonographically unremarkable GI tract

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of structural or functional cardiomyopathy was present in this study including no evidence of clinical issues such as DCM criteria, LV systolic dysfunction, significant valvular insufficiencies or stenotic disease. No overt evidence of significant abdominal visceral pathology i.e., neoplastic criteria as a definitive cause or contributing factor to the pleural effusion. The described effusion appearance is not overtly suggestive of effusion secondary to decreased hydrostatic pressure secondary to hypoalbuminemia. Continued monitoring of albumin level is recommended. Pathology assessment of the pleural effusion to include cytospin cytology +/- C/S if evidence of inflammatory cells is warranted. As needed GI support and empirical therapy for gastroenterocolitis would be appropriate. Thoracic CT is likely ideal, if possible, given this presentation. A guarded prognosis is indicated.





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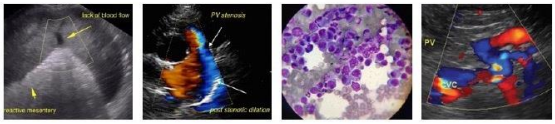

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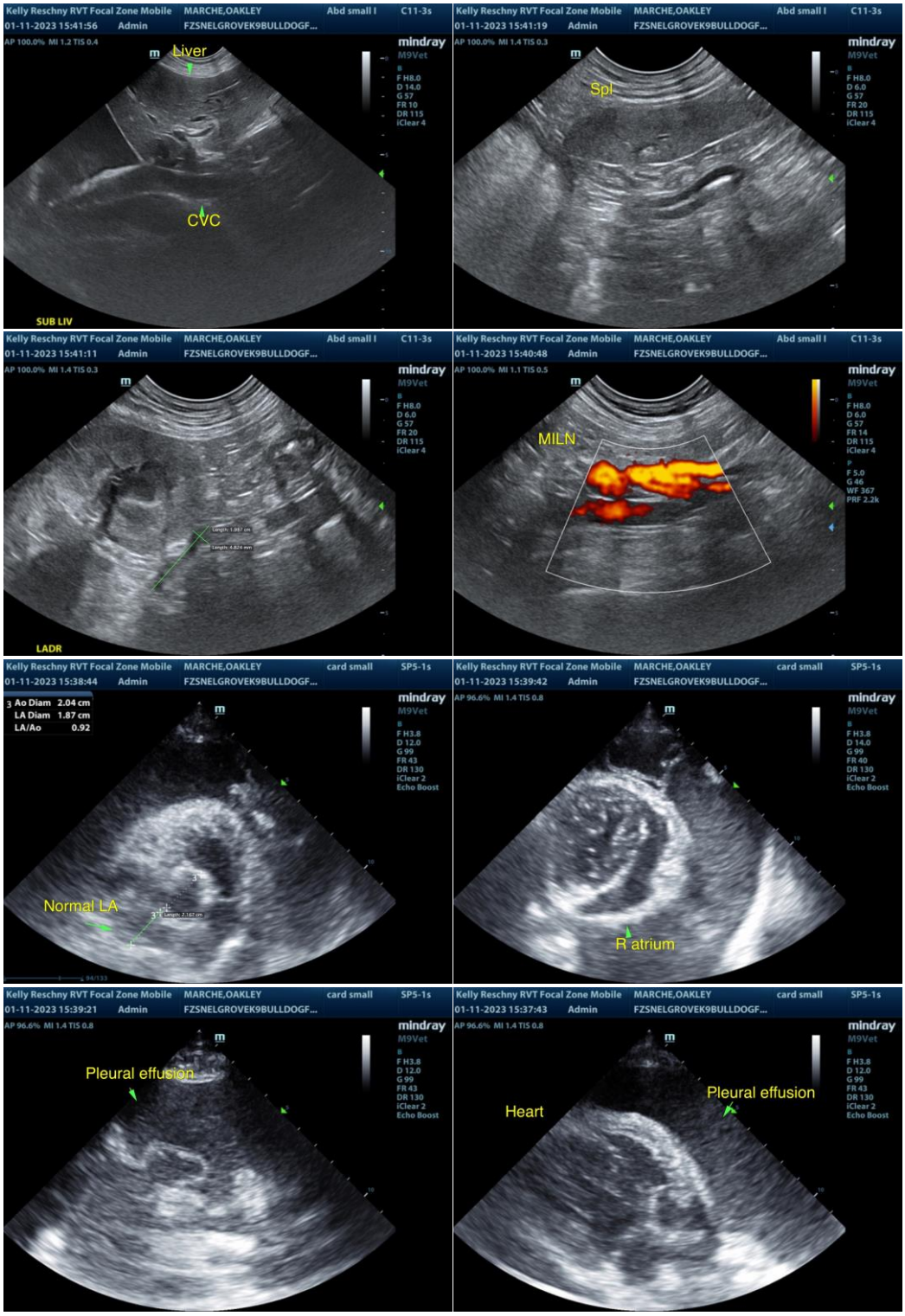

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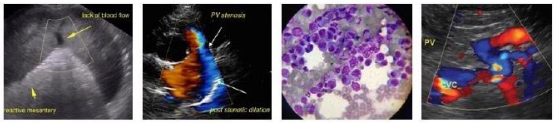

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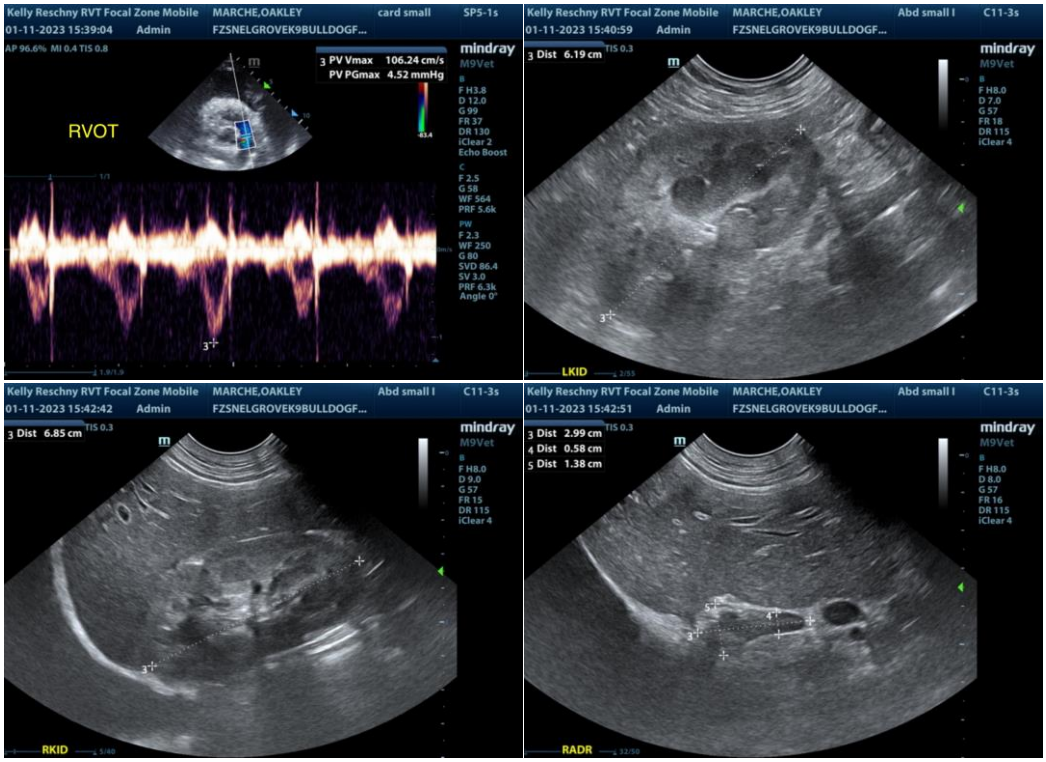

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

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