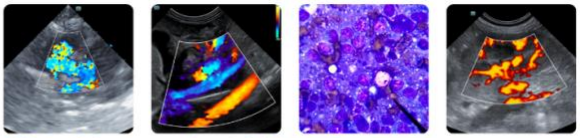

PATIENT

Pebbles Kessel

SPECIES

Canine

BREED

Maltese Mix

SEX

Spayed Female

AGE

14 Years 5 Months

WEIGHT

Not Provided

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

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PRESENTING CLINICAL SIGNS

- Grade 4/6 left parasternal systolic hm
- Meds: Gaba 50mg BID- TID, Carprofen 25 mg 1/2 BID

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	5.6	--	NM	1.4	54	85	0.2
CANINE CARDIAC PARAMETERS	**HR** (BPM)	**AV VMAX** (m/s)	**PV MAX** (m/s)	**BODY WEIGHT** (kg)	**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	183	1.5	1.0	NP	2.8	2.9	--

Cardiac Presentation

The echocardiogram in this patient demonstrated normal **left atrial** size based on 2 different LA measurement methods. The cranial and caudal **mitral** valve leaflets presented thickening consistent with endocardiosis. Doppler indicated measurable moderate eccentric MR. 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. 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 cardiac / pericardial tumors was visible.

Urinary System

A sessile based dorsal urinary bladder mass with nonhomogenous mildly hyperechoic parenchyma was present and measured 1.6 cm x 1.1 cm. Concurrent adjacent to focally thickened areas of dorsal and ventral urinary bladder wall with confirmed blood flow within the mass on doppler. Example of thickened urinary bladder wall measured 0.40 cm wall width. Anechoic urine was present in the lumen

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with mild non-dependent particulate urine sediment. The ureteral papillae were normal. The ureters were not visible which is normal. The urethra was normal in structure and tone to a depth of 3.0 cm.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary border demarcation was also present. The left kidney measured 3.6 cm in length. The right kidney measured 4.2 cm in length.

Adrenal Glands

The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.49 cm width in the caudal pole. The right adrenal gland measured 0.36 cm width in the caudal pole.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. 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. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease.

Liver & Gallbladder

The liver presented enlarged exhibiting nonhomogenous hyperechoic parenchyma and multifocal discrete hypoechoic parenchyma nodules. Normal vascular volume was maintained.

The gallbladder was non distended in size with mild nonorganized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained nonshadowing ingesta consistent with food echogenicity.

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 pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia. These changes are consistent with age-related pancreatic changes and considered incidental.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

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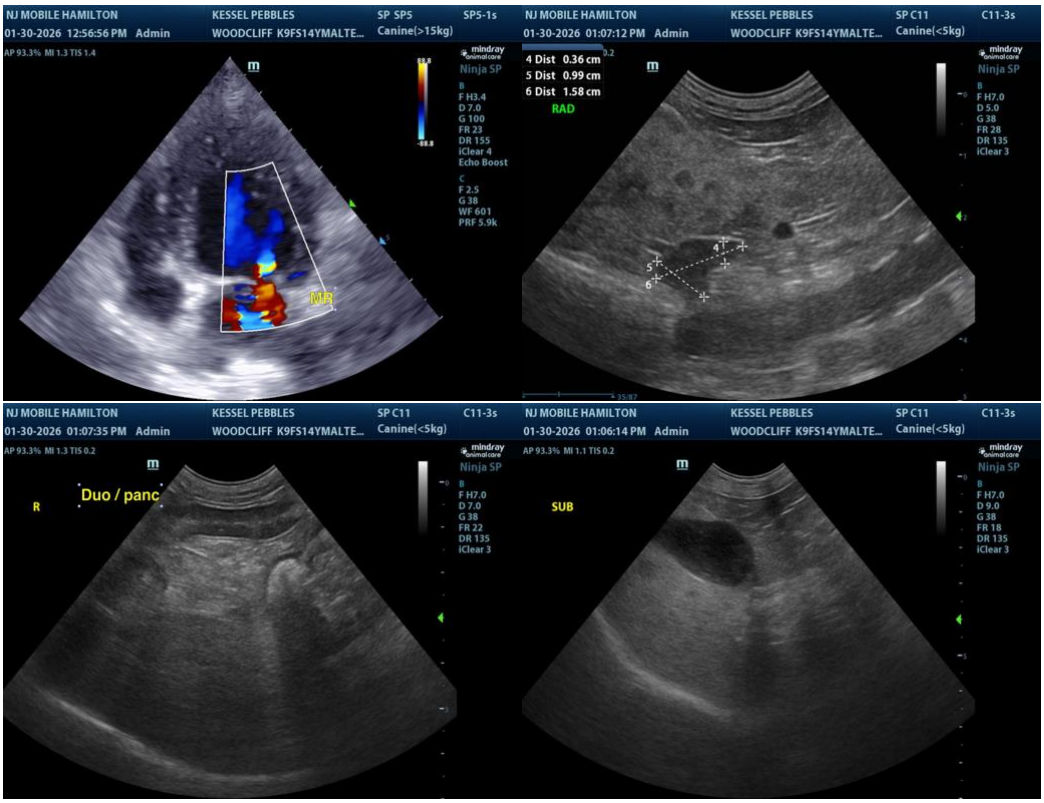
- Compensated mitral valve insufficiency (B1).
- Urinary bladder mass with concurrent adjacent to focally thickened urinary bladder wall- consistent with neoplasia i.e. transitional cell carcinoma.
- Bilateral age-related renal/adrenal changes.
- Enlarged hyperechoic liver with diffuse discrete hypoechoic nodules- vacuolar/cholestatic hepatopathy, inflammatory disease, hyperplasia, fibrosis, primary or metastatic hepatic neoplasia are all possible.
- Nonorganized gallbladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of the murmur is chronic degenerative valvular changes with secondary eccentric mitral valve insufficiency. The lack of left atrial enlargement implies that the risk of complication secondary to mitral valve insufficiency is low at this time and, without current clinical signs, indicates that medical therapy is not required. Prognosis is considered variable and sonographic monitoring is recommended. Recheck echo cardiogram is suggested in 6-12 months, sooner if clinical signs arise. No anesthetic contraindications.

Screening BRAF assay is recommended. No evidence of regional lymphatic metastasis. Assuming normal clotting status and using a 25-gauge needle, hepatic FNA cytology could be considered for further clarification. Hepatosupportive medications are warranted, assuming elevated liver enzymes or non-obstructive cholestasis.



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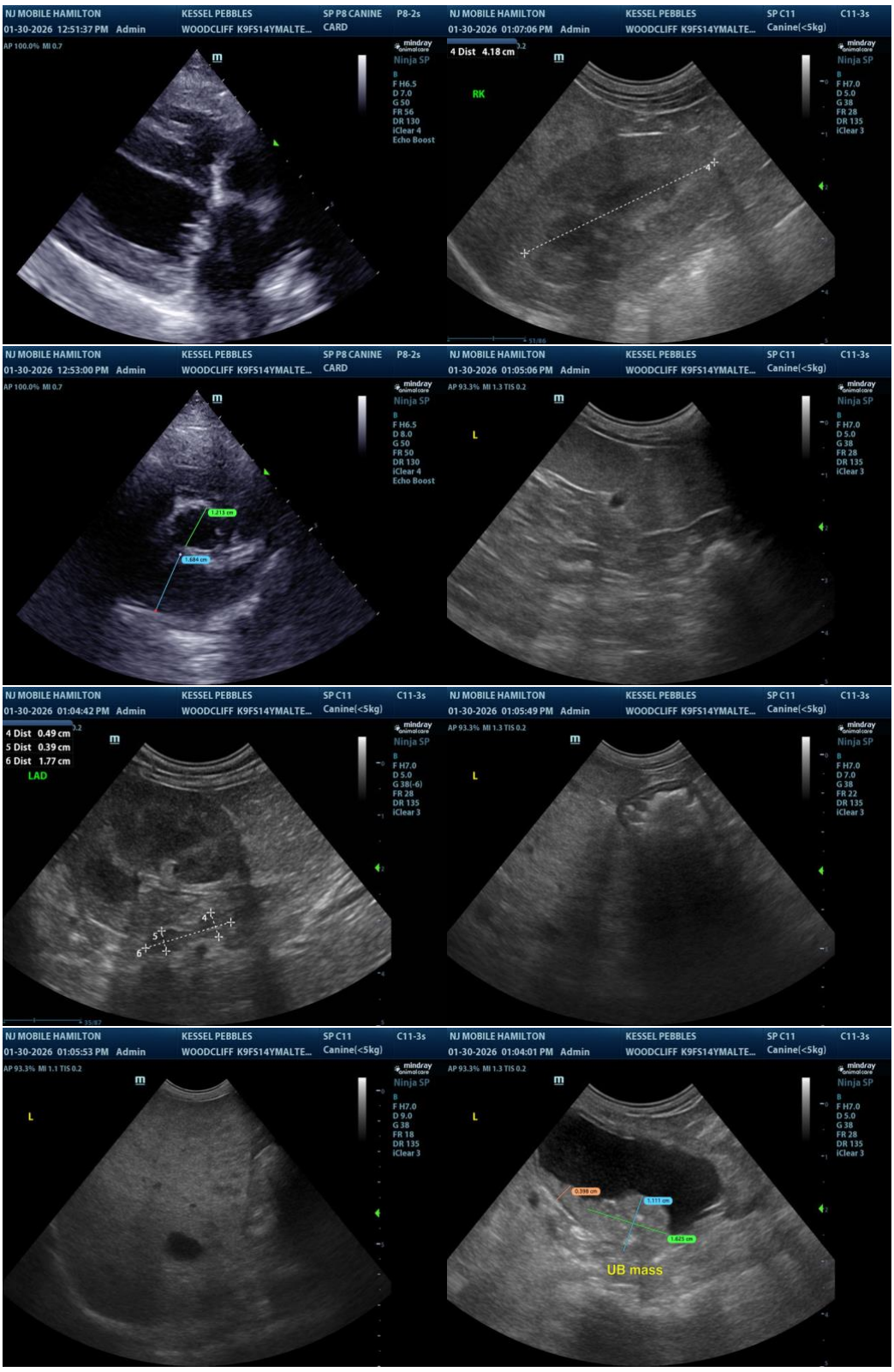

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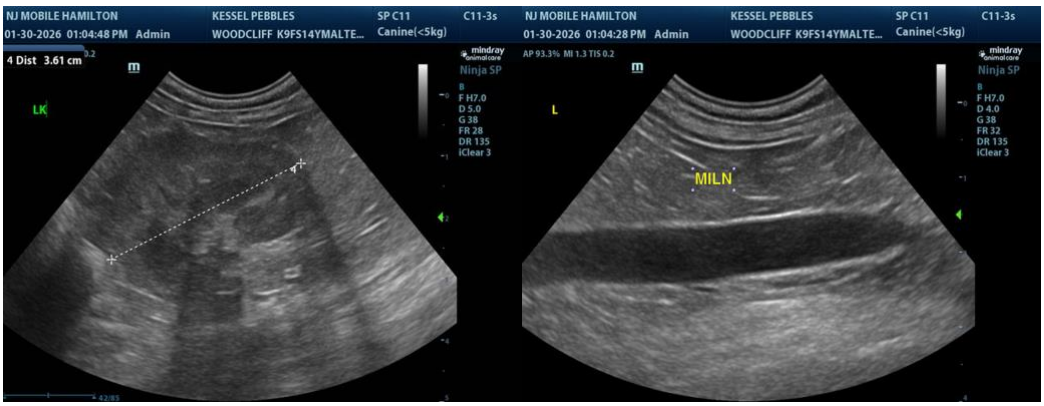

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@SonoPath.com