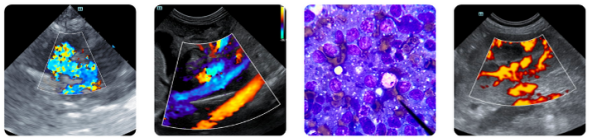


PATIENT

Giselle Leister

SPECIES

Canine

BREED

Shih Tzu

SEX

Female Spayed

AGE

11 yrs 2 mos

WEIGHT

7.4 kgs

INTERPRETED BY

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

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Country Companion AH

REFERRING VET

Amanda Wanner, DVM

INVOICE

12825

DATE

11/17/25

PRESENTING CLINICAL SIGNS

History: Double cavity. AUS for LES elevation and changes on CXR for possible heart base mass vs other (see report), hepatomegaly on rads. Recheck Echo following DMVD Stage B2 and early pulmonary hypertension, chronic grade 4/6 HM, cardiomegaly and pleural effusion on radiographs. Prev echo preformed on 9/4/25 with Sonopath interpretation. Also noted on CXR was a outpouching of the right cranial lung may represent right auricular aneurysmal dilation vs. a heart base/cranial mediastinal mass. Hx of seizures- now focal instead of grand-mal, occurring with a frequency of 1-2 seizures/day. Time of echo: Grade 3/6 parasternal HM with muffled heart sounds. No arrythmia, PQSS. Increased BVS, panting. Mild increased RE. Excitable.

Meds: Keppra 500 mg TID, Started Lasix, Pimobendan 0.3mg/kg PO q12h Blood Pressure: 102/85, 110/88. Left hindlimb.

Abnormal PE/Chem/CBC/UA Results: Echo (9/4/25) Chronic DVD, mod MR & mild TR. Mod LA enlargement. Early PHT, likely due to reported cough. Scant pericardial effusion & Fat deposition susp. Advanced imag w/ local Cardio or thoracic CT scan should be considered. Rt AV groove is hyperechoic, typically due to fat deposition. CXR (DACVR), 11/25 CON: Cardiomegaly (bilat) may represent chronic valvular dz +/- cor pulmonale secondary to chronic PHT. Outpouching of the rt cr lung may represent rt auricular aneurysmal dilation vs. a heart base/cranial mediastinal mass. Small vol pleural effusion unknown etiology (secondary to inflamm, infectious (exudative), chylous, neoplastic, or hemorrhage). Multilobar patchy alveolar patterns may represent atelectasis from the pleural effusion vs. pulm edema - CHF. Nonspecific hepatomegaly

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

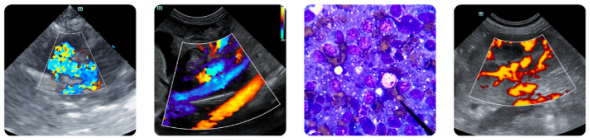
The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 4.2 cm in length. The right kidney measured 4.4 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.59 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.63 cm width at the caudal pole.



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Spleen

The spleen was normal to subjective mild subnormal in size suggestive pf mild splenic volume contracting. 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

The liver presented mildly enlarged in size with symmetrical mildly rounded hepatic capsule contour and maintained homogeneous parenchymal exhibiting mild coarse echotexture. The parenchyma exhibited conserved uniform parenchyma with normal echogenicity isoechoic to the spleen and falciform fat. Prominent hepatic vasculature most notable at the hepatic vein/caudal vena cava junction. Subjective concurrent, mildly prominent cranial abdomen caudal vena cava measuring 0.88 cm in diameter. No evidence of thrombosis. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. No evidence of gallbladder wall edema. The cystic and common bile ducts were normal.

Gastrointestinal

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 evidence of ascites, significant omental lymphadenopathy or masses.

ULTRASONOGRAPHIC FINDINGS

- Congested liver – currently compensated without concurrent evidence of ascites
- Normal to mild volume contracted spleen
- Age-related renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of significant visceral pathology such as masses or neoplastic criteria. The congested liver is consistent with passive congestion with considerations including pericardial effusion and secondary cardiac tamponade given patient history. Right-side heart disease, i.e. right-sided heart failure, pulmonary hypertension, non-obvious thoracic or vascular pathology. Correlation with echocardiogram is indicated. Specific therapy recommendations for the abdomen with as needed

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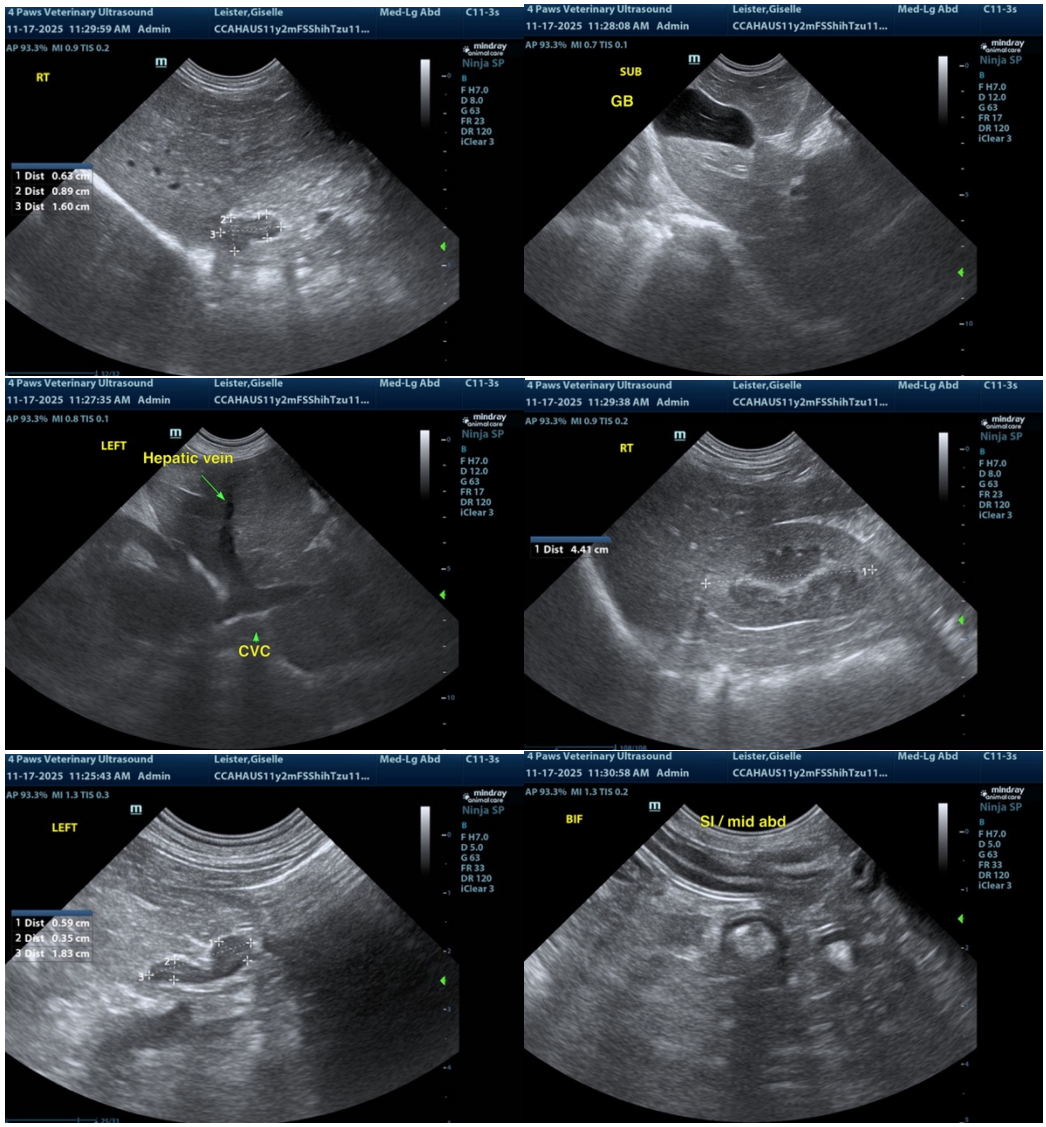
sonographic monitoring for evidence of progressive congested liver or development of ascites.



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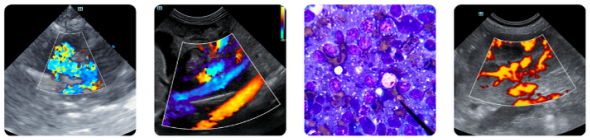

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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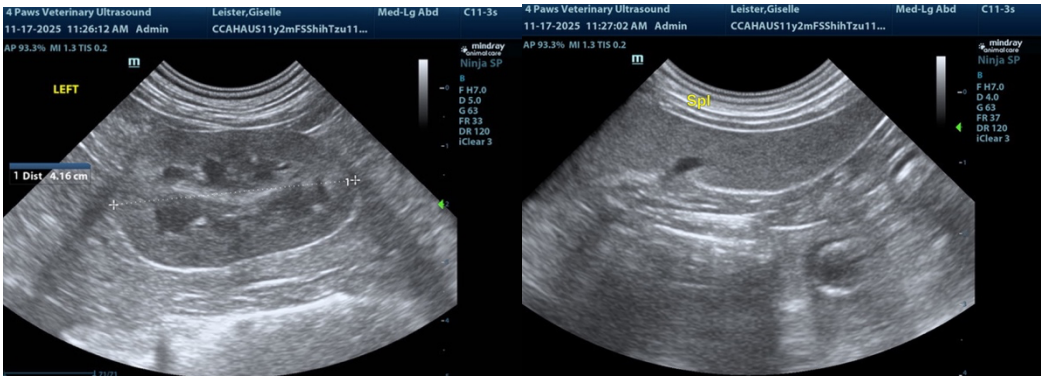

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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