



**PATIENT**

Bailey Bubbico

**PRESENTING CLINICAL SIGNS**

Cardiomegaly HM 4/6. Baseline meds needed?

Abnormal PE/Chem/CBC/UA Results: WBC-17.84 Neut-14.17

**SPECIES**

Canine

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN AND HEART**

**BREED**

Schnoodle

**SEX**

MN

**AGE**

13yr

**WEIGHT**

28.6lb

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	5.1	<2.0	--	1.3	37	68	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	--	1.3	1.0	--	3.0	3.4	--

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Kerri Becker

**HOSPITAL NAME**

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**Cardiac Presentation**

The echocardiogram in this patient demonstrated normal left atrial size based on 2 different LA measurement methods. Chamber volumes and echogenicity were normal. The cranial and caudal mitral valve leaflets presented thickening consistent with endocardiosis. Doppler indicated measurable moderate to significant eccentric insufficiency. 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 mild thickening with mild TR present on Doppler. 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**



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

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Normal size and margination were 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 4.8 cm in length. The right kidney measured 5.2 cm in length.

**BREED**

Schnoodle

The area of the aortic trifurcation was free of pathology.

**Adrenal Glands**

**SEX**

MN

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 0.68 cm width in the caudal pole. The right adrenal gland measured 0.65 cm width in the caudal pole.

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**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.

**WEIGHT**

28.6lb

**Liver/Gallbladder**

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The liver presented subjectively mildly increased in size. The parenchyma of the liver was subjectively increased in echogenicity compared to the spleen and renal cortices. Multifocal variably sized non-homogenous to hypoechoic intraparenchymal nodules were present, an example measured 1.6 cm in diameter. The echotexture of the liver parenchyma was uniform with a mild coarse echotexture. The capsule of the liver was symmetrical in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. Normal vascular volume was present. The gallbladder was non-distended in size with moderate non-dependent variably congealed yet non-organized debris occupying the majority of the gallbladder lumen. Minor gallbladder wall edema was present with no evidence of pericholecystic effusion. The common bile duct was not visualized without overt evidence of dilation or post hepatic obstructive criteria.

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**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.

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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 mechanical/metabolic ileus, obstruction or foreign material.

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

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**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 was present.

Suspect ventral intra-abdominal lipoma present measuring ~ 7 cm in diameter.

A non-homogenous cystic to cavitated appearing right perithoracic subcutaneous mass measuring ~ 10 cm in diameter was present.

**ULTRASONOGRAPHIC FINDINGS**

**Primary**

- Compensated mitral valve insufficiency (B1)
- Mild TR-no evidence of clinical pulmonary hypertension
- Non-homogenous hyperechoic liver with multifocal hypoechoic intra-parenchymal nodules - vacuolar hepatopathy, inflammatory /immune mediated disease i.e. Cholangiohepatitis, hyperplasia, hematopoiesis, fibrosis, cholestasis, primary or metastatic hepatic neoplasia all potentials
- Cholecystitis with early to immature gallbladder mucocele
- Age-related renal changes
- Non-homogenous cystic / cavitated right perithoracic subcutaneous mass
- Indistinct intra-abdominal lipoma

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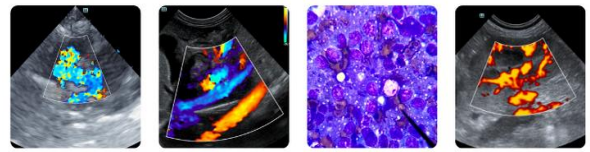
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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The cause of the murmur is subjective mild chronic degenerative valvular changes with secondary MR. No evidence of additional issues such as DCM criteria, LV systolic dysfunction or clinical pulmonary hypertension. The lack of left atrial enlargement implies that the risk of complication secondary to mitral valve insufficiency is relatively low at this time and, without current clinical signs, indicates that medical therapy is not required at this stage. Prognosis at this stage is variable and serial sonographic monitoring is recommended with a recheck echocardiogram in 6 months, sooner if clinical signs suggestive of heart disease develop. No overt anesthetic contraindications if anesthesia is required. Suggested anesthetic protocol may include opioid or Benzodiazepine pre-med, induction with Propofol or Alfaxalone, and appropriate gas anesthesia with avoidance of alpha 2 agonists.

Assuming normal clotting status and using a 25g needle, a hepatic parenchyma and subcutaneous mass FNA for screening cytology is warranted for further assessment. Correlation with hepatic enzyme parameters for evidence of inflammation and consideration for hospitalization with hepatic support if evidence of clinical hepatopathy is warranted.



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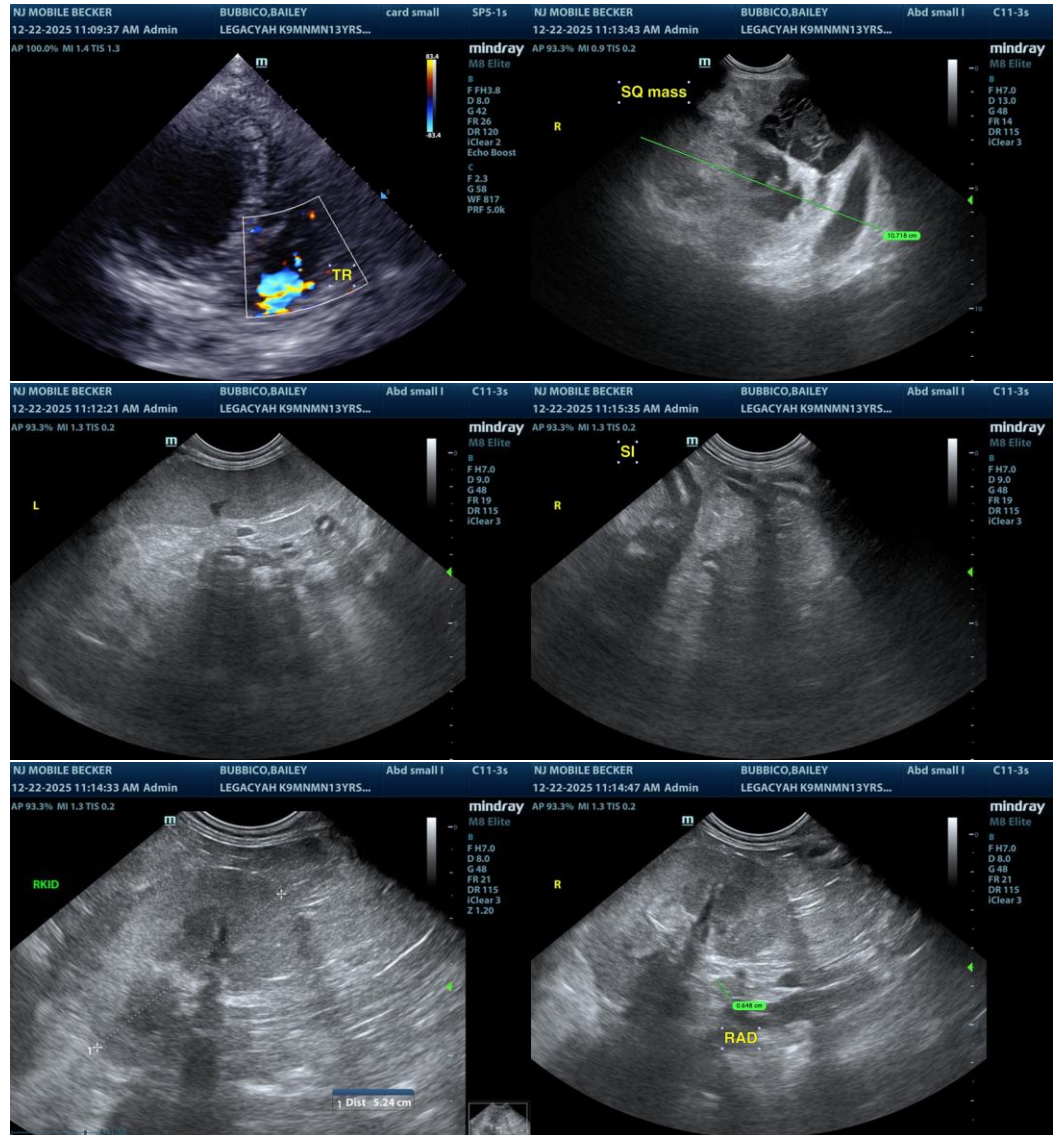
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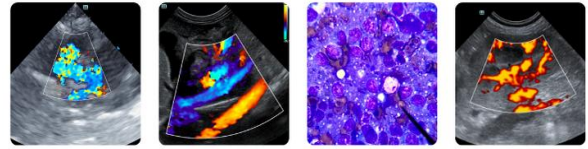
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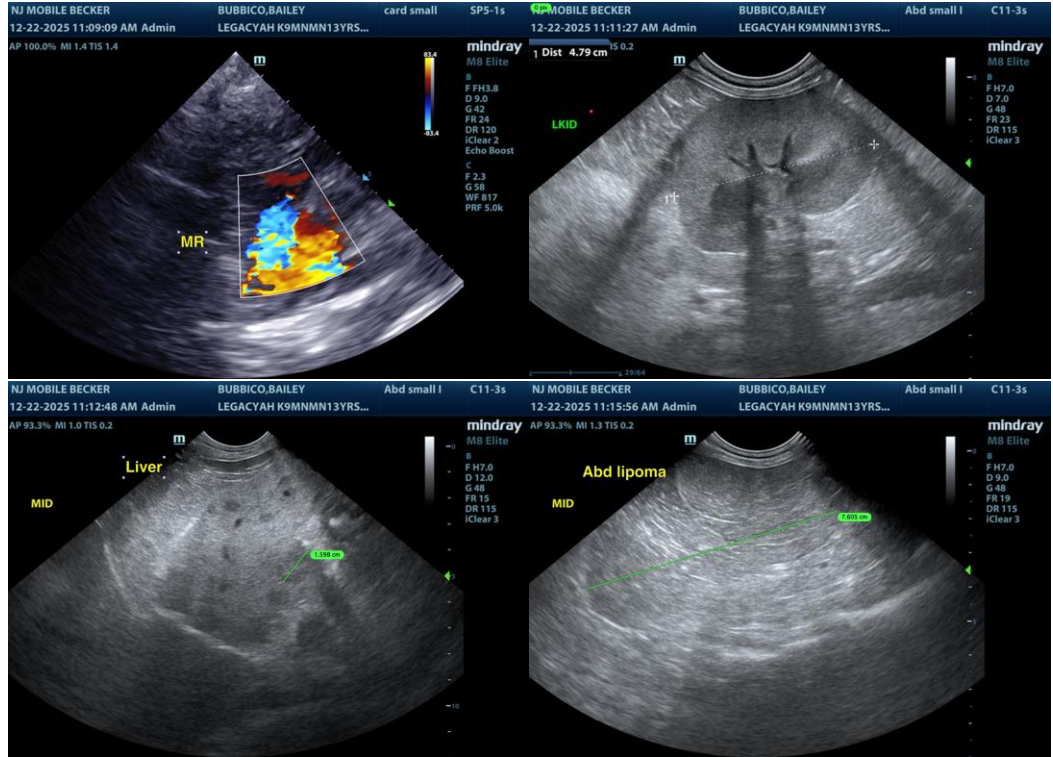
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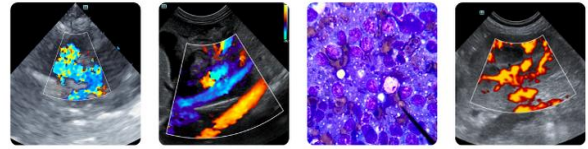
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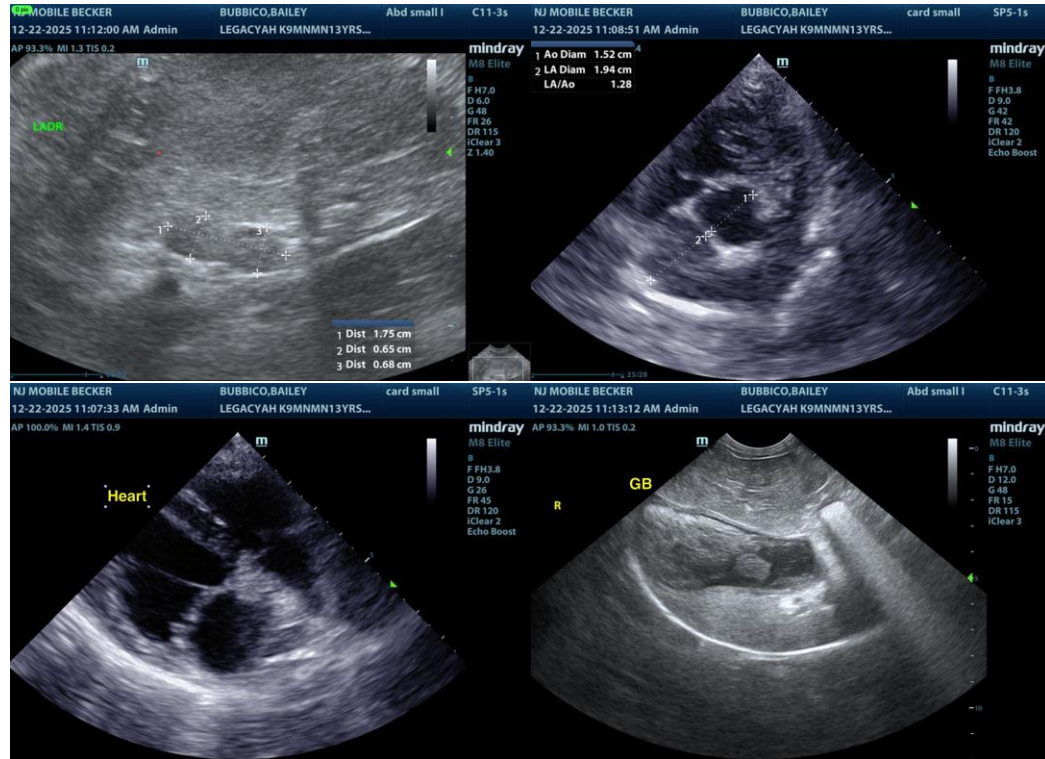
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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