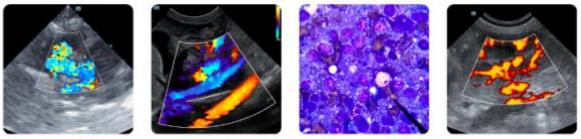

PATIENT

Harper Selby

SPECIES

Canine

BREED

Boston Terrier

SEX

Neutered Male

AGE

6 Years 9 Months

WEIGHT

11.9 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Renee Trionfetti VMD

HOSPITAL NAME

Cypress Veterinary Clinic

REFERRING VET

Dr. Laura Johnson VMD

INVOICE

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03/05/26

PRESENTING CLINICAL SIGNS

- AUS to further evaluate elevated LES and recent reported seizure (vs syncope). First seizure-like episode lasting less than one minute. Second episode was shorter in duration. Both episodes occurred after jumping down from chair. During episodes: rolled to side/back, unable to get up initially, non-responsive to stimuli. Rapid recovery (within 30 seconds), returned to normal behavior immediately. No loss of bowel or bladder control during episodes. No previous history of seizures. E/D normally, no CSVD. Occasionally loose stools at the end of bowel movements. BW shows mild ALT, AST LES, normal ALP, mild elevated glucose, mild hypoproteinemia (mild low globs and low normal alb), mild low cholesterol.
- Weight gain of 5 lbs in about 1 week
- Sedation for ultrasound: Butorphanol 0.35 mg/kg IV.

Abnormal PE/Chem/CBC/UA Results: Time of ultrasound: Grade 1/6 left apical HM with distant heart sounds, unable to appreciate heart sounds on the right. Tachycardic, tachypneic with increased RE, short shallow resp, difficult to appreciate lung sounds. Jugular vein distention with pulsations. Abdominal distention, palpable fluid wave. - CBC: Hct 50.1 %, Monocytes 1.311 H, Platelets 424 H - Chem: Gluc 141 H, TP4.4 L, Alb 2.7 low norm, Glob 1.7 L, A:G Ratio 1.6 H (0.7 - 1.5), ALT 245 H (18 - 121), AST 61H (16 - 55), ALP 30-n, Chol101 L, normal BUN, Cr, SDMA

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 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 change were noted.

The area of the residual prostate appeared normal and free of pathology.

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 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. The left kidney measured 4.8 cm in length. The right kidney measured 5.0 cm in length.

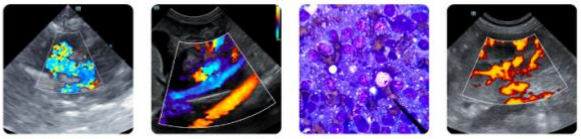
Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.48 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 0.53 cm width at the caudal pole.

Spleen

The spleen presented normal in size with hyperechoic splenic parenchyma adjacent to splenic vasculature. Mildly expansive lateral homogenous splenic nodule was present measuring 0.70 cm in diameter.



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Liver & Gallbladder

The liver presented mild enlarged in size with symmetrical yet mild swollen contour. The parenchyma exhibited conserved uniform parenchyma with normal echogenicity isoechoic to the spleen and falciform fat. The hepatic vasculature was mildly congested in appearance, most notable at the level of the hepatic vein / caudal vena cava junction, without evidence of overt thrombosis.

The gallbladder was non-distended in size. The gallbladder wall was mild thickened in appearance consisting of an echogenic double rim corresponding to the inner and outer portions of the wall. This is consistent with gallbladder wall edema. Possible causes may include acute inflammation, edema and anaphylaxis.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained echogenic, mild nonshadowing ingesta without signs of 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 visualized significant or swollen mesenteric lymphadenopathy was present. A moderate volume of peritoneal effusion was present. Mild primarily homogenous omental hyperechogenicity.

Heart

Brief subjective echocardiogram revealed overall normal cardiac structure and function without evidence of left or right heart chamber enlargement and subjective adequate LV contractility. Moderate volume of pericardial effusion was present with secondary cardiac tamponade. Overtly normal visible right auricle with concurrent pleural effusion.

ULTRASONOGRAPHIC FINDINGS

- Subjectively normal cardiac structure/function.
- Moderate volume pericardial effusion with secondary cardiac tamponade.
- Congested liver with mild gallbladder debris.
- Mildly expansive homogenous splenic nodule.
- Pleural/peritoneal effusion.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pleural and peritoneal effusion in addition to hepatic congestion is secondary to pericardial effusion and concurrent cardiac tamponade. Infectious, inflammatory, hematologic or neoplastic

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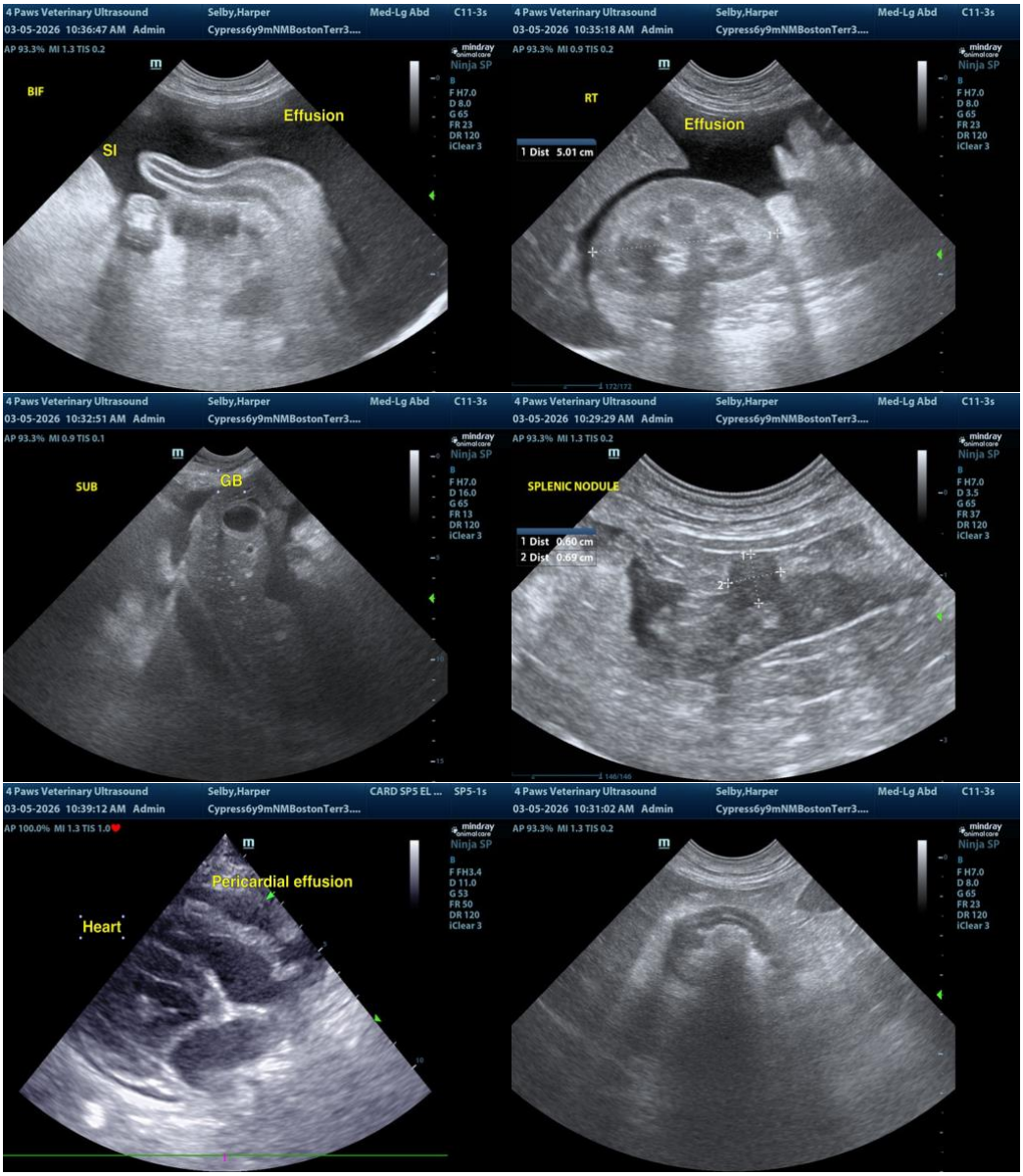
etiology is possible. A definitive cardiac tumor as a potential cause of pericardial bleed was not obvious yet may be sonographically undetectable in early stages and not definitively excluded.

The mildly expansive splenic nodule may indicate hyperplasia, hematopoiesis, inflammation or emerging neoplasia. Correlation with peritoneal or pleural effusion analysis and consideration for referral for pericardiocentesis with pericardial effusion analysis +/- advanced imaging for further assessment and potential definitive diagnosis would be ideal. Extremely guarded prognosis.



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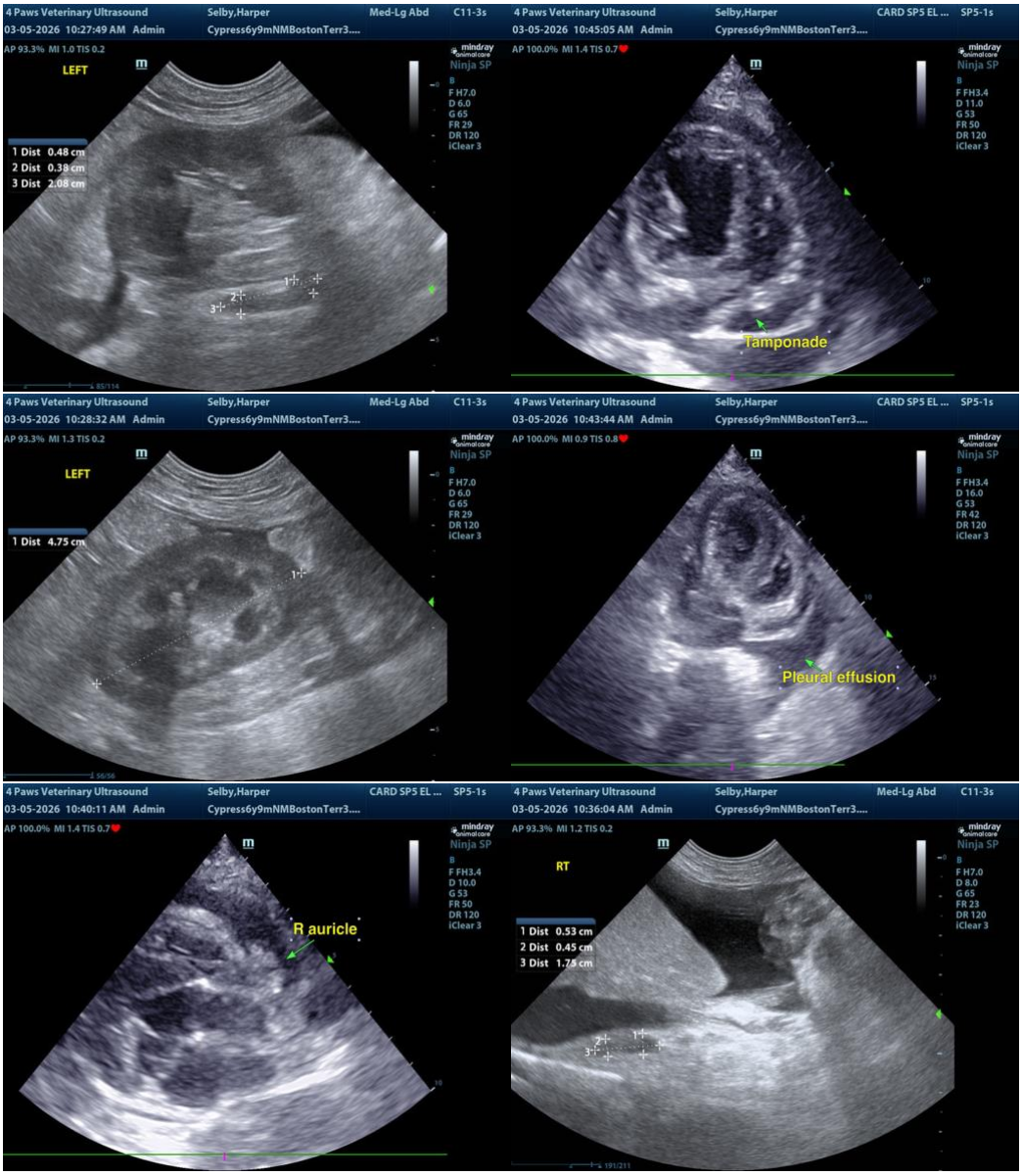

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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