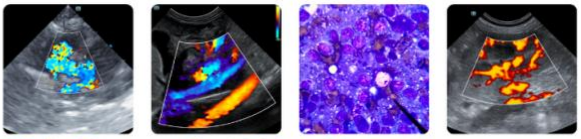


PATIENT

Ranger Beimdiek

SPECIES

Canine

BREED

Chihuahua Mix

SEX

Neutered Male

AGE

12 Years

WEIGHT

12.9 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Chrissy Krell DVM

HOSPITAL NAME

Isaacson Veterinary Hospital

REFERRING VET

Dr. Barb Lester DVM

INVOICE

14785

DATE

04/01/26

PRESENTING CLINICAL SIGNS

Decreased appetite, vomited/phlegm and it was blood tinged and a decent sized this am. He did eat some of the vomit/phlegm. Mom thinks its more from his throat, then actual vomit. No known triggers, not any certain time of day. Doesn't seem congested in am. Anorexic w/ dog food yesterday. Ate scrambled egg & ham just fine. Hacking for about 1.5 wks. They brought them in for anal glands and nails, so mom thought that took care of the issue but the next day he was back to not wanting to eat much. Polydipsia 1.5 wks. Sometimes drinking sets off hacking. Old back issue T11-T12, had MRI, stays controlled w/ gaba. CHF: Lasix, benazepril & Pimobendan long term. Last baseline BW in Feb. '25 w/ dental. Hx of collapsing trachea. Continued unintentional wgt loss. Drinking LOTS of water. Started on Cerenia and bland diet, patient did begin eating right away readily but has decreased some the last two days.

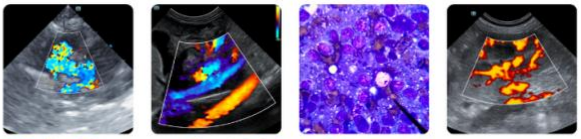
BCS: 7/9, FAS 1/5, today just QAR. MM tacky, thickened stifles bilaterally, increased abdominal effort to breathing while laying at rest, incomplete cataracts OU, menace & PLR still present OU, Grd IV/VI L sided heart murmur, abd soft & non-painful, little gassy, dental grade II CBC: regenerative anemia Hct 27.6 (37.3-61.7), mild leukocytosis 20.61 (5.05-16.76), mild neutrophilia 16.62 (2.95-11.64) CHEM17: mildly elevated BUN 34 (7-27), mild hyperglobulinemia 4.6 (2.5-4.5)SDMA: WNLTT4: WNL4dx = neg. XR Consult: suspect pancreatitis, gastroenteritis. historical boney change over caudal T vertebrae, Prostatomegaly, narrowing of the trachea and chondromalacia suspected, cardiomegaly, bilateral OA of stifles, left MPL UA: SG 1.012, pH 7, unremarkable

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	--	--	NM	1.3	50	83	0.2
CANINE CARDIAC PARAMETERS	**HR** (BPM)	**AV VMAX** (m/s)	**PV MAX** (m/s)	**BODY WEIGHT** (lbs)	**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	NM	1.2	NM	12.9	3.1	2.4	--

Cardiac Presentation

The echocardiogram in this patient demonstrated mild increased **left atrial** size based on LA 2D measurement with minor intra-atrial septal deviation. The cranial and caudal **mitral** valve leaflets presented thickening consistent with endocardiosis. Doppler revealed measurable moderate eccentric MR. The **left ventricle** presented thicknesses with linear contour and was not dilated nor restricted.



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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

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 was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Mild pyelectasia was present bilaterally. The left kidney measured 4.1 cm in length. The right kidney measured 4.4 cm in length.

Adrenal Glands

The bilateral adrenal glands were mildly enlarged in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.75 cm width in the caudal pole. The right adrenal gland measured 0.85 cm width in the caudal pole.

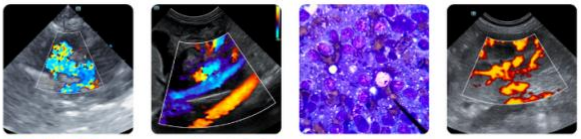
Spleen

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 presented subjective borderline to mildly enlarged in size. The liver parenchyma was mild / moderate nonuniform and hypoechoic to the spleen with a mild/ moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion.

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



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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained variably echogenic, nonshadowing ingesta without signs of obstruction or foreign material. No evidence of obstruction to pyloric outflow or mechanical pyloric outflow obstruction. The pylorus wall measured 0.30 cm wall width. Concurrent mild lumen gas was present.

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. The duodenum wall measured 0.40 cm wall width. The jejunum wall measured 0.35 cm wall width.

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

Pancreas

The pancreas was mildly prominent in size with normal contour and with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Chronic mitral valve disease (ACVIM stage B2).
- Prominent nonhomogenous pancreas- chronic pancreatitis probable with remodeling.
- Unremarkable gastrointestinal tract with gastric ingesta- consistent with food echogenicity.
- Borderline mild hepatomegaly- benign.
- Nonorganized gallbladder debris.
- Chronic renal changes with mild pyelectasia.
- Bilateral mild adrenomegaly. Sonographically normal residual prostate.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Adrenal work up is recommended if clinical signs are consistent with Cushing's syndrome. No overt evidence of abdominal neoplastic criteria. Correlation with most recent meal ingestion is recommended if documented NPO. Some degree of metabolic or non-obstructive gastric ileus or delayed gastric emptying with gastric food echogenicity may be possible. GI panel to include PLI, TLI, cobalamin and folate to correlate with the pancreas and assess for non-structural intestinal disease given reported unintentional weight loss is recommended.

The lack of significant LA enlargement, secondary to MR, indicates the current and future risk of complication is mildly elevated yet no evidence of congestive criteria. No evidence of clinical pulmonary hypertension. Continued Pimobendan at current dose is recommended without overt indication for diuretic therapy. ACE inhibitor is warranted if systemic BP is greater than 130. Recheck echo is recommended in six months, sooner if clinically indicated. Cardiac anesthetic risk, if required is considered mild. 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.

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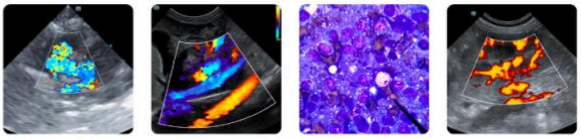

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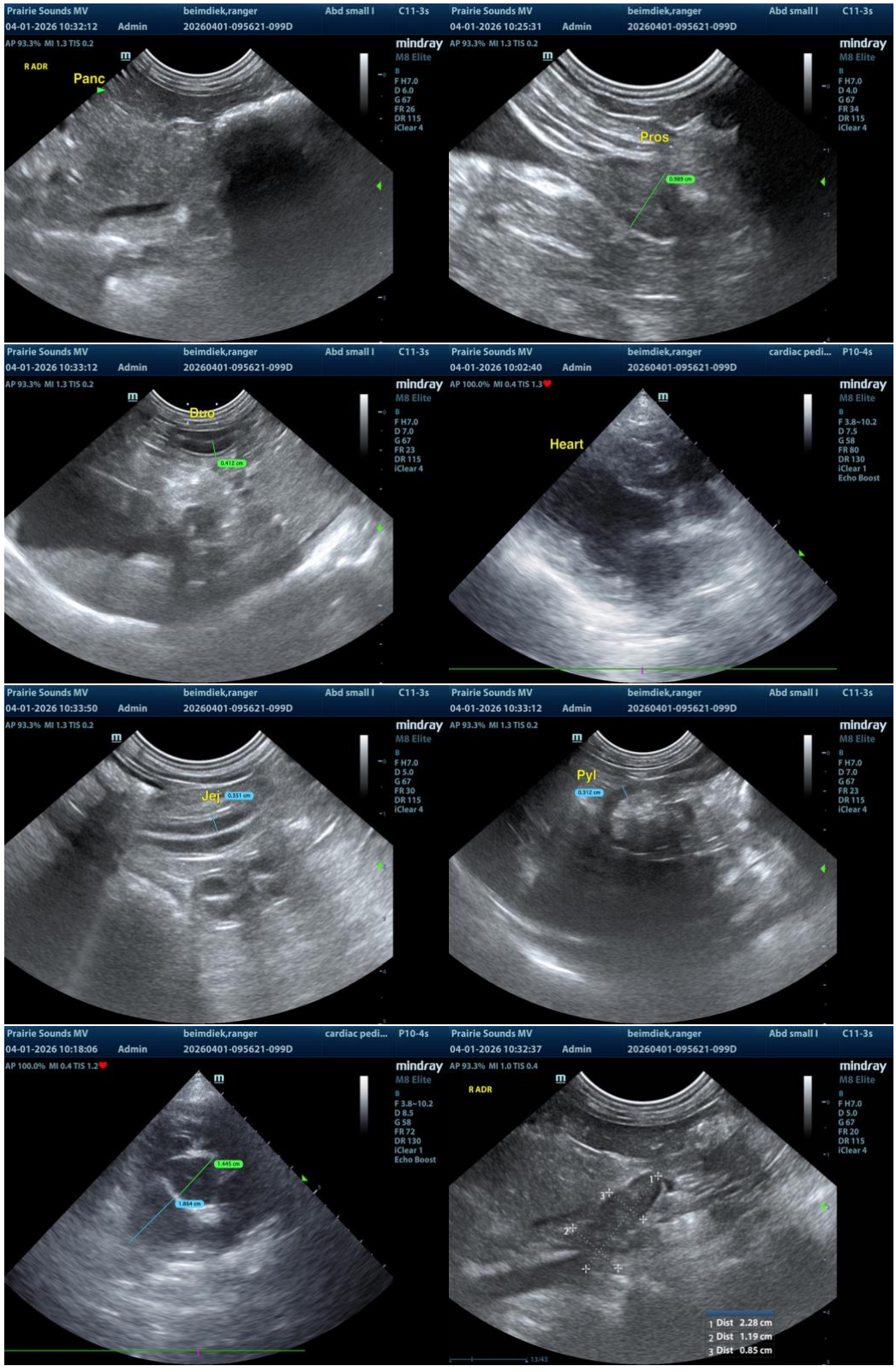

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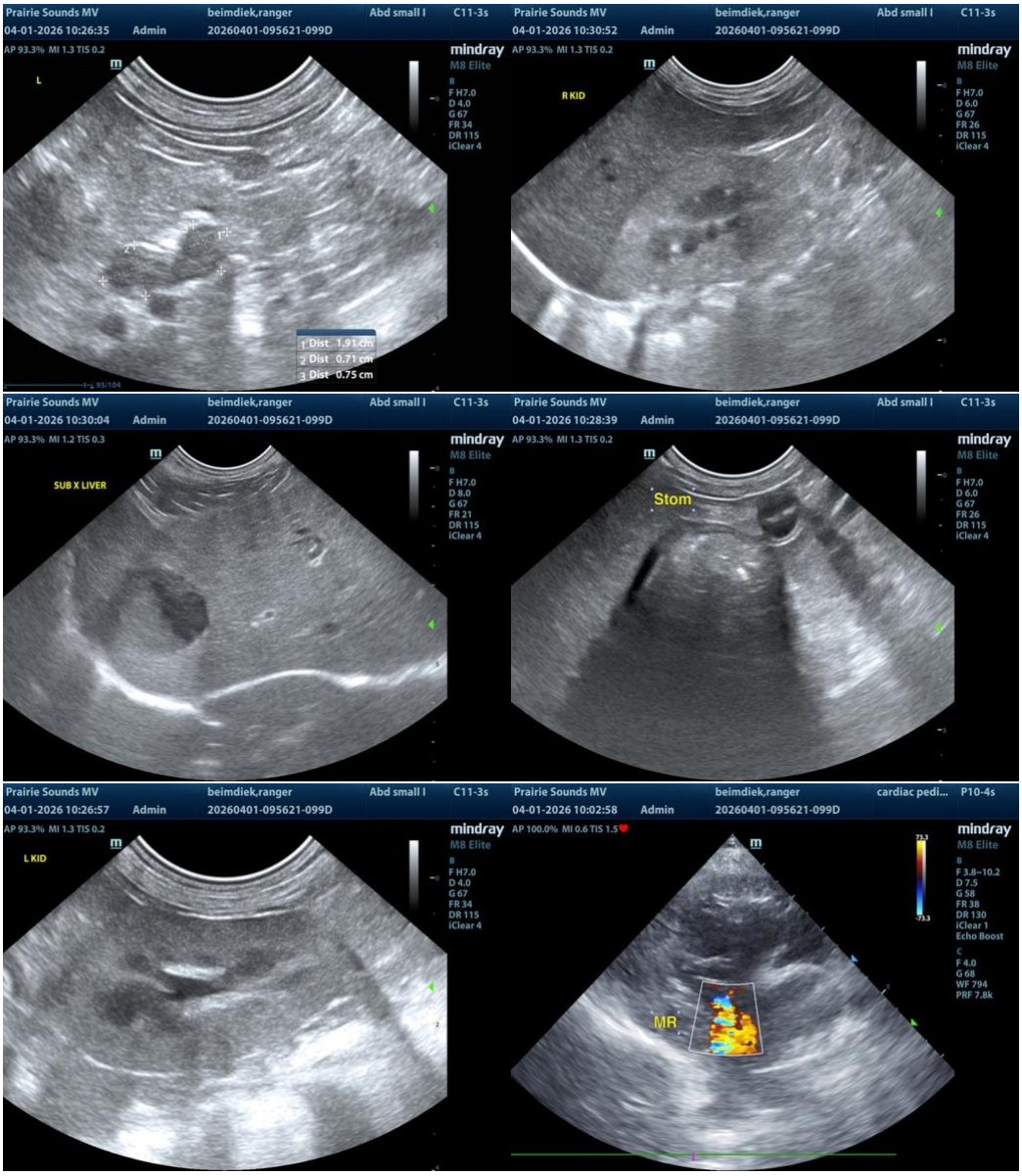

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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