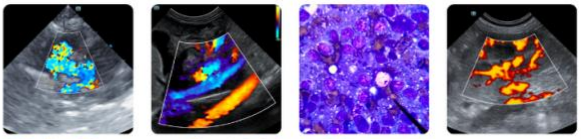

PATIENT

Brady Fager

SPECIES

Canine

BREED

Boxer Mix

SEX

Neutered Male

AGE

11 Years

WEIGHT

58.5

INTERPRETED BY

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

IMAGING PERFORMED BY

Brandon

HOSPITAL NAME

Dillsburg Veterinary Center

REFERRING VET

Dr. Amber

INVOICE

15019

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04/10/26

PRESENTING CLINICAL SIGNS

Brady has been being treated for gagging/nausea that started in August of 2025. He does not regurgitate but does bring up white phlegm foam daily. He has a chronic cough that sounds like upper airway and is nonproductive. Despite trying several medications (Hydrocodone/Homatropine, Ondansetron, Maropitant, Prednisone, Theophylline, Famotidine and Zyrtec) gag and cough continue. He is hypothyroid and is on Thyrosin. Concern for hiatal hernia. Radiographs have been performed and when looking at the hyoid apparatus area appears mor inflamed now that in August when symptoms started. The area is less crisp and has increased opacity just at/below the hyoid on x-rays. Palpation does not elicit discomfort or a cough. LN's palpate WNL. No murmur noted. Lungs sound clear overall. Was seen at specialist and had an esophageal wash and culture performed. Culture showed no growth.

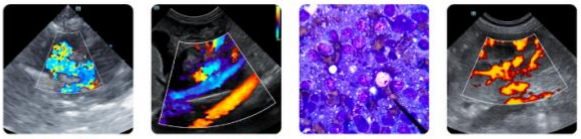
Abnormal PE/Chem/CBC/UA Results: AST 69, ALT 575, ALKP 987, GGTP 20, PSL 155

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	1.2	40	74	0.1
CANINE CARDIAC PARAMETERS	**HR** (BPM)	**AV VMAX** (m/s)	**PV MAX** (m/s)	**BODY WEIGHT**	**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	--	--	58.5	3.2	3.3	--

Cardiac Presentation

The echocardiogram in this patient demonstrated normal **left atrial** dimension based on 2 separate methods of LA evaluation. The cranial and caudal **mitral** valve leaflets presented normal linear structure, extension in systole, and union in diastole with normal kinesis. 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. **Tricuspid** valvular assessment demonstrated adequate linear morphology and kinesis. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. **Pulmonary outflow** tract assessment revealed normal valve structure, laminar flow, and



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diameter (approx.1:1 pa/ao ratio). No visible **pericardial** or free pleura fluid was noted. The cranial **mediastinum and pericardial and extra-cardiac regions** were free of masses in the visible window.

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of – 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.

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 6.6 cm in length. The right kidney measured 7.0 cm in length.

Adrenal Glands

The left adrenal gland was overtly normal. The left adrenal gland measured 0.54 cm width at the caudal pole.

The right adrenal gland was not visualized.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. An indistinctly visualized discrete hyperechoic nodule was present measuring 0.35 cm in diameter. 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 or neoplastic changes were not noted. The echogenic nodule tends to trend benign and is most consistent with benign hyperplasia or myelolipoma.

Liver & Gallbladder

The liver presented subjective mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The stomach was nondistended with mild lumen gas and mild retained echogenic fluid.

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.

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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 overt lymphadenopathy or peritoneal effusion was present. No obvious esophageal abnormalities noted on brief cervicothoracic ultrasound.

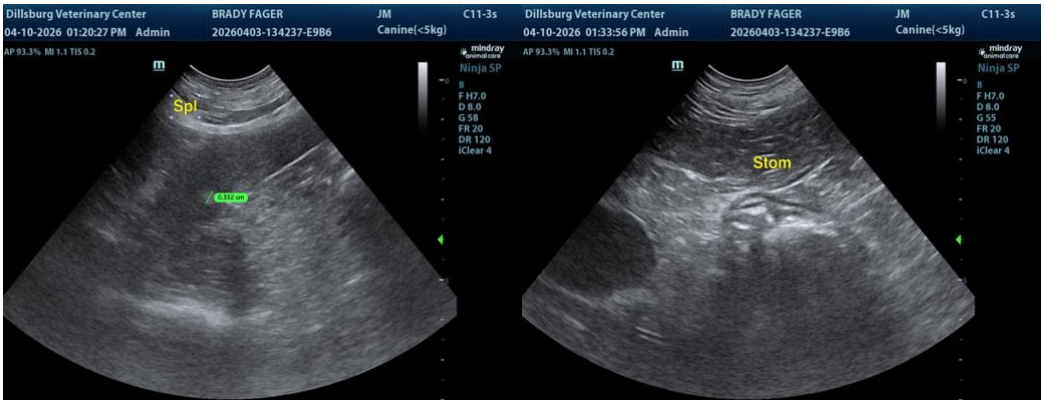
ULTRASONOGRAPHIC FINDINGS

- Normal cardiac structure/function.
- Structurally unremarkable gastrointestinal tract with mild retained gastric fluid/gas/
- Hepatopathy.
- Normal gallbladder.
- Small benign splenic nodule- consistent with myelolipoma.
- Age-related renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of structural or functional cardiomyopathy as a contributing factor to the patient's clinical signs. No obvious evidence of hiatal hernia, although sliding hernia is not definitively excluded. Mild to chronic pancreatitis may present sonographically normal. The hepatopathy, although nonspecific, is suggestive of benign criteria.

Hepatic FNA cytology may be considered for initial clarification, whereas hepatic biopsies for histopathology are required for definitive diagnosis. Empirical therapy for possible mild hypomotile gastritis and esophagitis, which may include Omeprazole trial, 1.0 mg/kg, SID to BID with canned novel protein or hydrolyzed diet trial over the next 14 days may prove beneficial. Concurrent hepatosupportive medications are recommended. Upper gastrointestinal endoscopy with potential for biopsies may be considered. Screening cortisol level to rule out occult Addison's disease is suggested.



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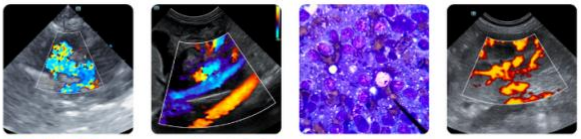

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Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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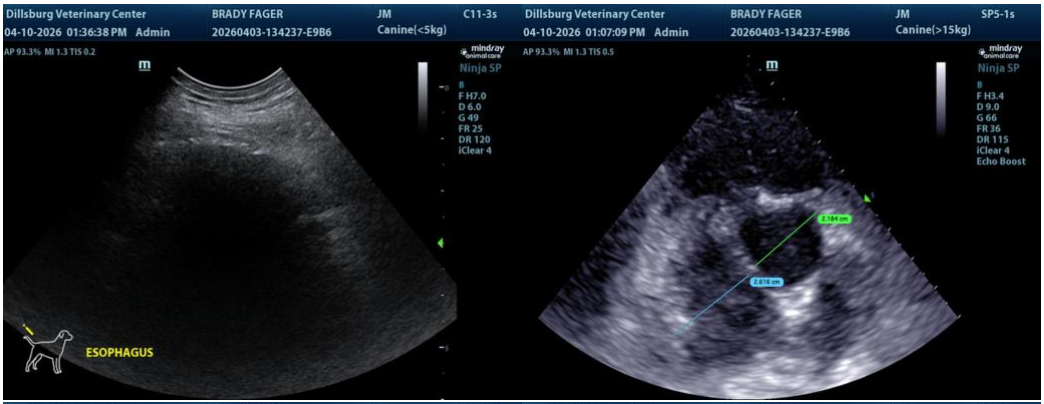

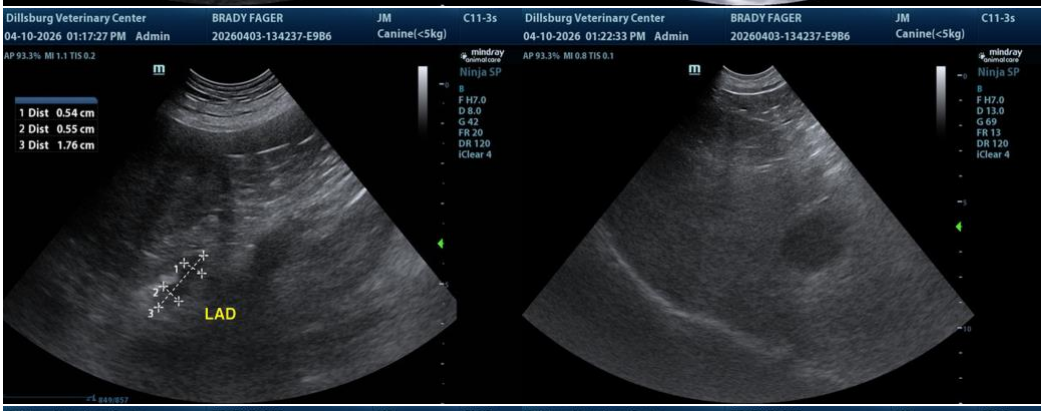

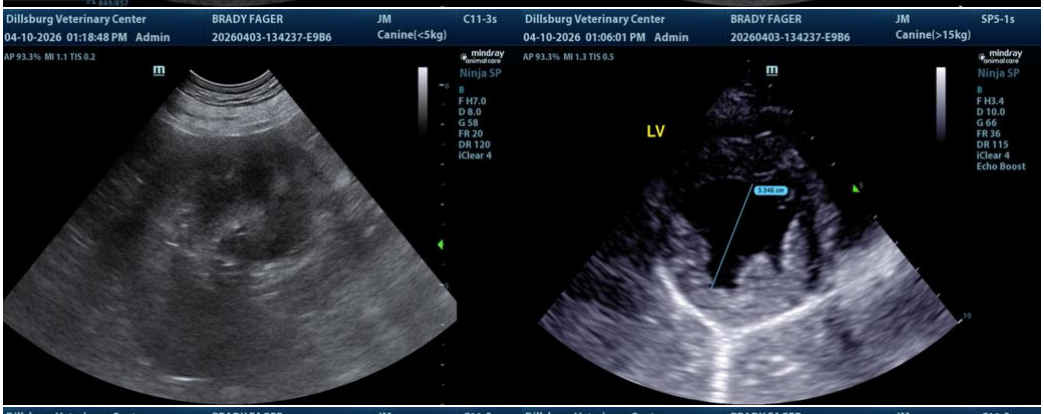

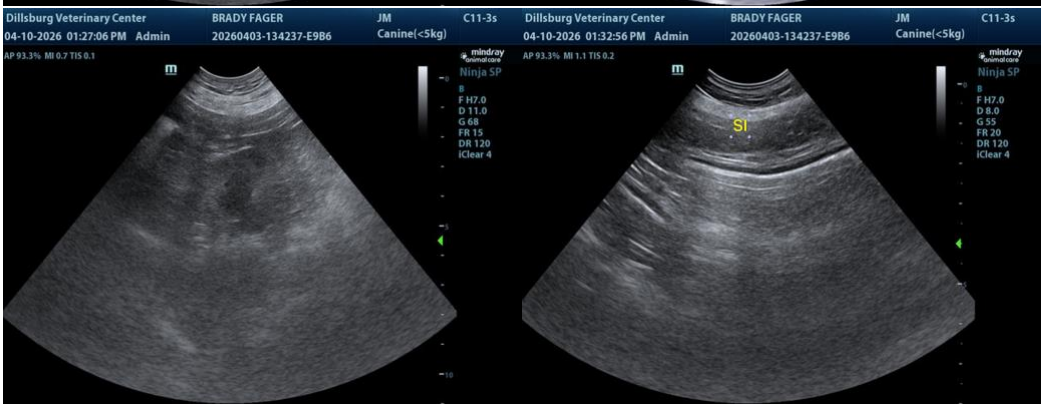

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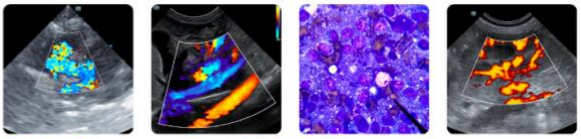

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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