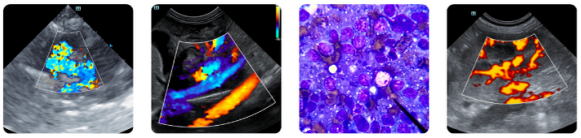


PATIENT

Cannon Pellegrino

SPECIES

Canine

BREED

Mix

SEX

Female Spayed

AGE

10y 4m

WEIGHT

51 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Kerri Becker

HOSPITAL NAME

Marsh AH

REFERRING VET

Dr. Armani

INVOICE

13412

DATE

4/16/26

PRESENTING CLINICAL SIGNS

History: WT loss and severe PU PD

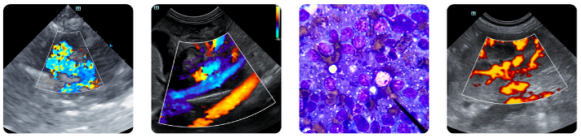
Abnormal PE/Chem/CBC/UA Results: LDDS normal ALP-1124 ALT-158 USG-1.009

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	--	--	--	1.45	35	68	0.3
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	NM	1.2	1.0	--	3.5	3.8	--

Cardiac Presentation

The echocardiogram in this patient demonstrated normal **left atrial** size based on 2 different LA measurement methods. The cranial and caudal **mitral** valve leaflets presented mild thickening consistent with endocardiosis. Doppler indicated entralized to eccentric MR. 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. Normal measured LVOT velocity with previously noted aortic valve insufficiency on doppler. 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). Normal measured RVOT velocity. No overt previously noted pulmonic valve insufficiency. No visible **pericardial** or free pleura fluid was noted. No echographically detectable evidence of cardiac / pericardial tumors was visible.



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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 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 – cm in length. The right kidney measured – cm in length.

Adrenal Glands

The bilateral adrenal glands were indistinctly visualized without overt evidence of enlargement exhibiting subjective mild asymmetrical contour and homogenous parenchyma. The left adrenal gland subjectively measured 0.57 cm width at the caudal pole. The right adrenal gland subjectively measured 0.69 cm width at 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

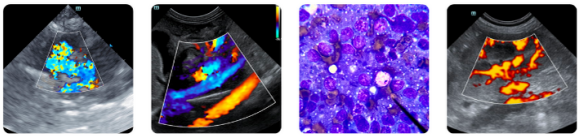
The liver presented mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non distended in size with mild, non-organized, mildly hyperechoic, variably congealed yet non-organized, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

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.



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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.

ULTRASONOGRAPHIC FINDINGS

- Persistent compensated mitral valve insufficiency (B1)
- Static mild aortic valve insufficiency
- Mild age-related renal and subjective adrenal changes
- Static hepatopathy – subjective benign
- Non-organized gallbladder debris (non-mucocele)
- Sonographically unremarkable gastrointestinal tract

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No overt evidence of definitive cardiac or abdominal visceral pathology as a definitive cause of the patient's weight loss and clinical signs. The continued lack of LA enlargement indicates the current and future risk of complication secondary to MR remains low. In a patient non-clinical for cardiac disease, no indication for cardiac medications. Assessment of systemic BP for hypertension given aortic valve insufficiency is recommended. If hypertension is present, sedated recheck of the bilateral adrenal glands to assess for non-obvious or subtle pathology is recommended. Cardiac anesthetic risk is considered low to mild. If required the, following protocol is suggested. 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.

The liver continues to indicate benign criteria consistent with previous study. Definitive evidence of adrenal pathology in conjunction with normal adrenal testing. Assuming normal clotting status, hepatic FNA cytology, bile acid profile and leptospirosis titer/PCR, if clinically indicated, may be considered. A GI panel to include PLI/TLI/Cobalamin/Folate as well as three view chest radiographs, neurological / musculoskeletal examination and rule out competitive eating environment are recommended to assess for or rule out occult disease or contributing factors which may cause weight loss. Hepato-supportive medications may prove beneficial.

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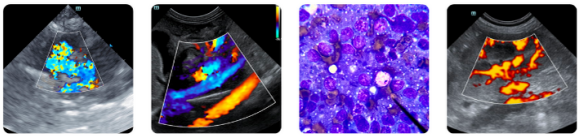

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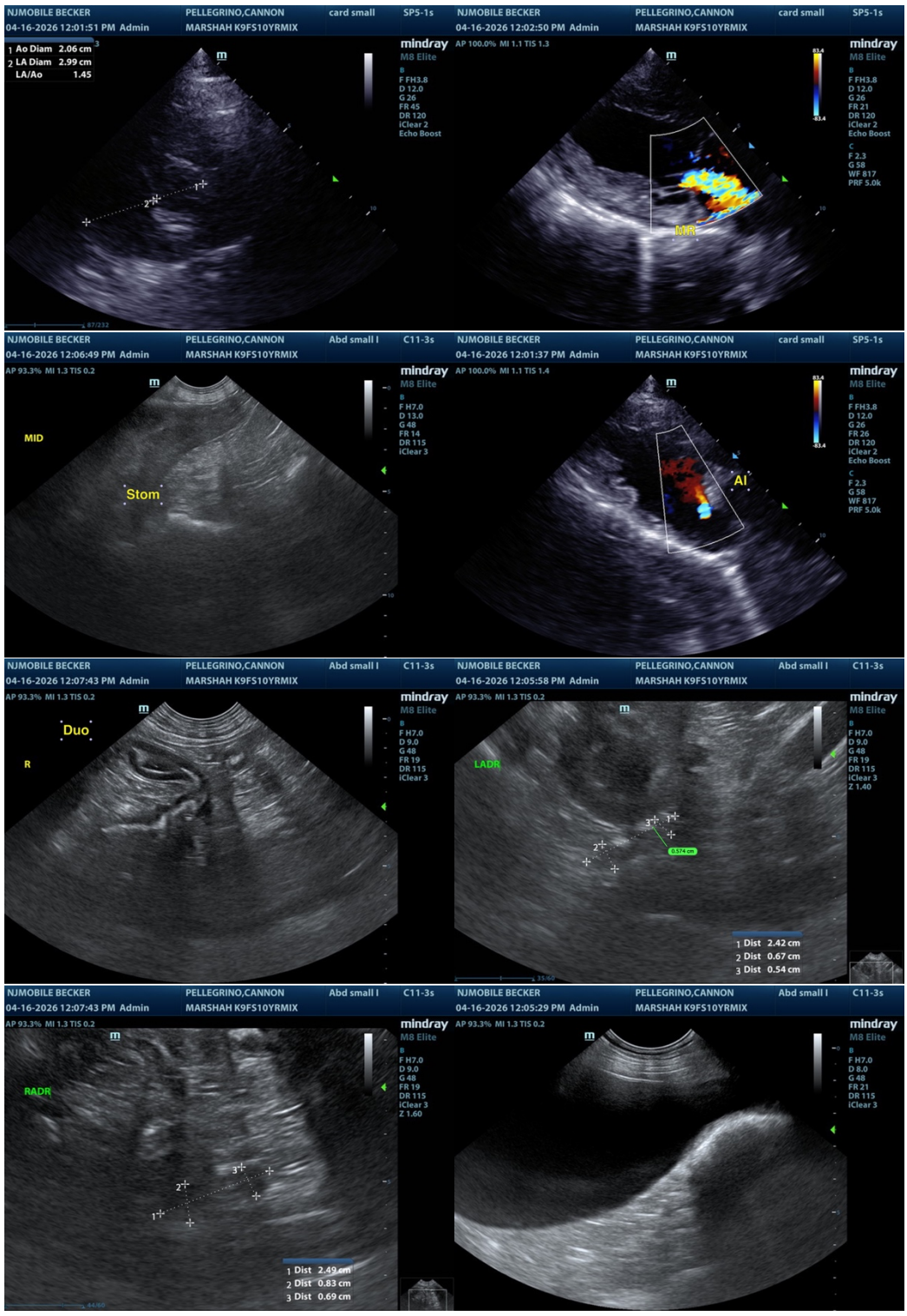

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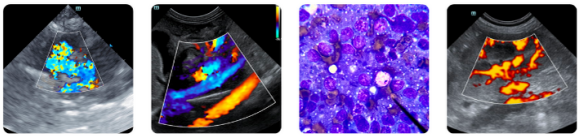

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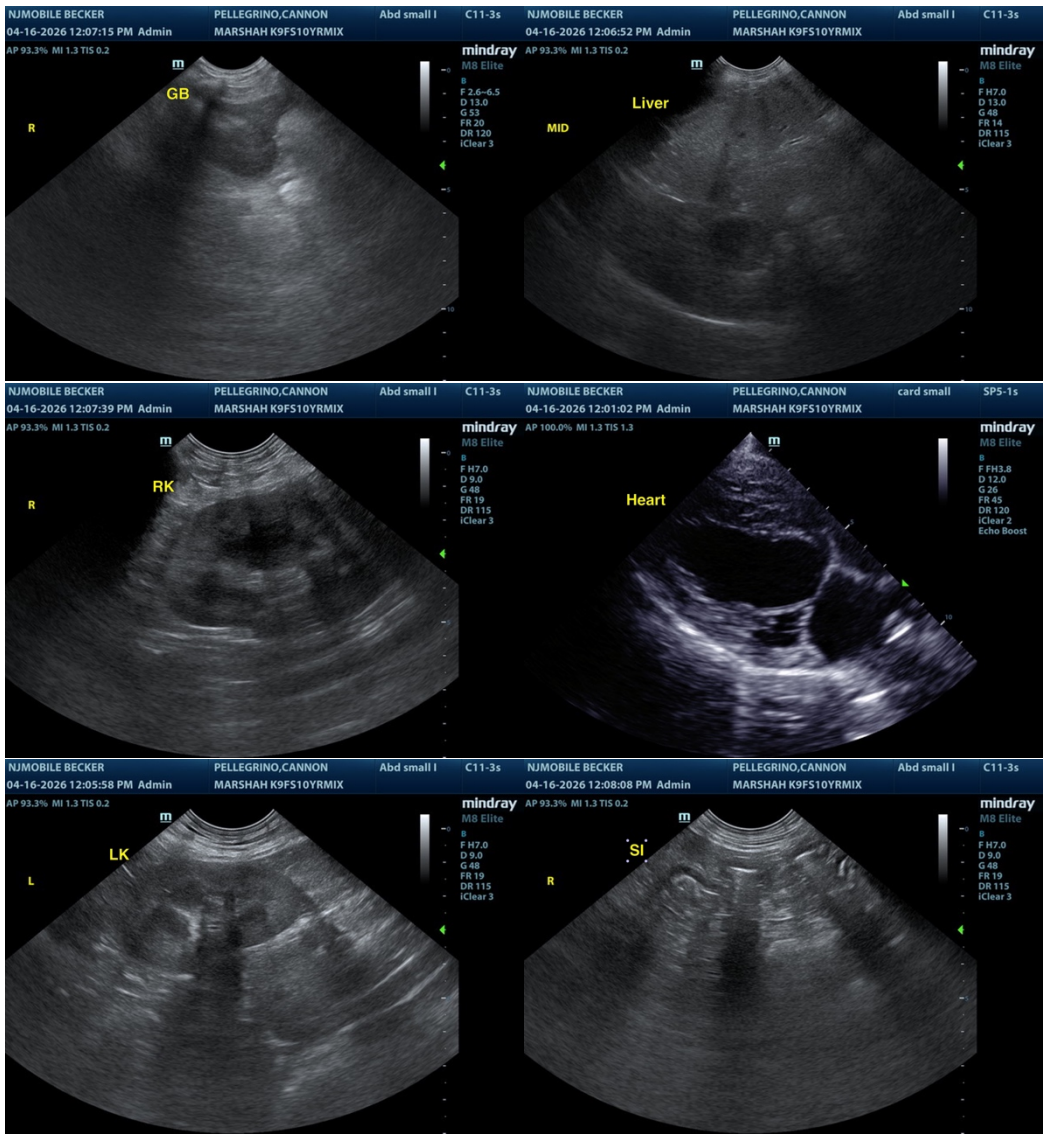

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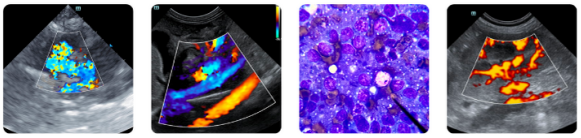

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

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