SonoPath
Clinical Sonography & Telecytology
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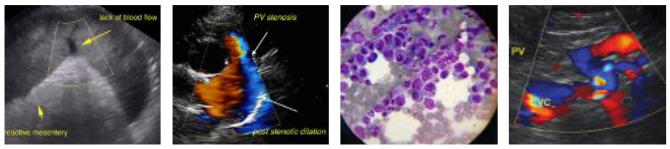


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Kilo Drury

SPECIES
Canine

BREED
Staffordshire Terrier

SEX
Intact Male

AGE
12 Years

WEIGHT
50 Pounds

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

IMAGING PERFORMED BY
Diane McFadden

HOSPITAL NAME
Animal Mansion VH

REFERRING VET
Dr. Parker

INVOICE
37893

DATE
5/23/22

PRESENTING CLINICAL SIGNS

significant weight loss (20# since April), anorexia, vomiting, lethargy. BW done in April wnl. Is on Cerenia 60 1/2 sid and Mirtazapine 15 mg sid. grade 6/6 murmur not mentioned in April. No diarrhea.
R/) neoplasia vs maldigestion dz vs other
Abnormal PE/Chem/CBC/UA Results: pending

ULTRASONOGRAPHIC EXAMINATION OF THE HEART & ABDOMEN

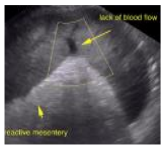
CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (Boon method)	LA/AO (Heart Base; Swe)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	<1.6	28-40	40-100	<0.6
PATIENT	6.0	2.7	NM	1.1	37.8	68.9	0.33
CANINE CARDIAC PARAMETERS	**HR** (BPM)	**AV VMAX** (m/s)	**PV MAX** (m/s)	**BODY WEIGHT** (kg)	**LA** 2D short axis Base view (cm)	**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	BELOW	BELOW	BELOW	BELOW
PATIENT	158	1.0	0.9		3.4	3.54	

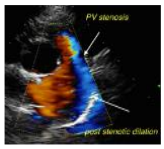
Cardiac Presentation

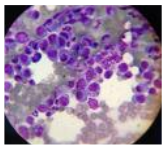
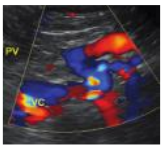
The echocardiogram in this patient demonstrated normal **left atrial** size based on 3 different LA measurement methods. Chamber volumes and echogenicity were normal. The cranial and caudal **mitral** valve leaflets presented vegetative thickening consistent with endocardiosis. Doppler indicated measurable 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 adequate linear morphology. 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

The urinary bladder 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.





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The prostate was enlarged in size with intact, symmetrical capsule contour. The margins of the gland were intact and able to be differentiated from the surrounding tissue. The prostatic parenchyma was mildly echogenic to heteroechoic without parenchymal mineralization. The prostate measured 5.6 cm in diameter. Anechoic, thinly walled parenchyma cysts were present.

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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 6.2 cm. The right kidney measured 6.3 cm.

The area of the aortic trifurcation was free of pathology. No evidence of medial iliac or sublumbar lymphadenopathy.

Adrenal Glands

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. The capsule was smooth and regular without apparent expansion. A solitary, non-disruptive hyperechoic nodule noted, consistent with benign myelolipoma. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age related remodeling with minor potential for inflammatory or neoplastic disease.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a 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 mild, echogenic, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach exhibited intact yet mild prominent wall layering. Mild retained gastric echogenic fluid and chyme were present.

The small intestine presented intact wall layering with primarily maintained 1:3 muscularis/mucosa ratio. Segmental moderate to marked retained echogenic, non-shadowing chyme present along with subjective empty segments of small intestine. Focal to segmental strongly shadowing intestinal echo was present, measuring approximately 2.4 cm in diameter.

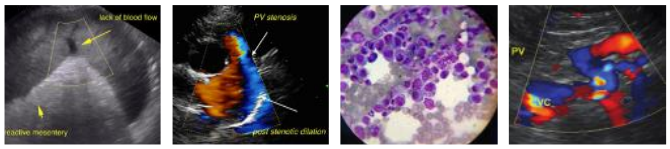
Normal visible colon wall layers were present with apparent formed feces in lumen.

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

Intermittent, mildly prominent to enlarged mesenteric nodes were present. Example measured 1.9 cm x 0.60 cm. The lymph node was essentially isoechoic to adjacent omentum without evidence of



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peripheral inflammation and maintaining a normal width: length ratio (<0.5).

No overt evidence of peritoneal free fluid. The omentum was of uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

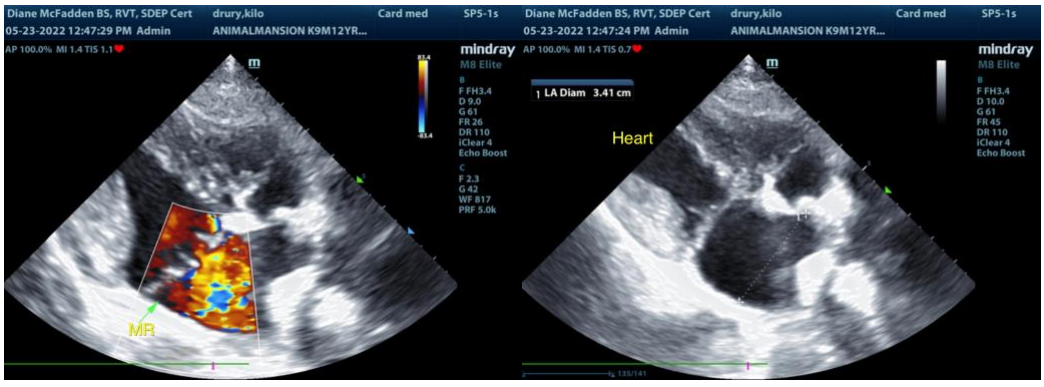
- Compensated mitral valve disease (ACVIM B1)
- Mild TR – estimated pulmonary pressure gradient approximately 30 mmHg, not consistent with clinical pulmonary hypertension.
- Prostatomegaly exhibiting non-homogeneous to cystic parenchyma – benign prostatic hyperplasia with parenchymal cysts, mild potential for prostatitis.
- Benign splenic nodule.
- Strongly shadowing intestinal luminal echo with concurrent segmental moderate to marked retained non-shadowing chyme.
- Concurrent mild retained gastric fluid/chyme.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastrointestinal presentation in this patient is consistent with intestinal foreign body with segmental obstructive pattern, likely proximal. The potential for concurrent underlying structurally insignificant intestinal disease (if not previous history of PICA) cannot be definitively excluded. No overt evidence of intraabdominal or gastrointestinal neoplastic criteria. Exploratory laparotomy for further assessment and expectation toward enterotomy with intestinal biopsies strongly suggested, despite exploratory findings.

The cause of the murmur is secondary to mild chronic degenerative valvular changes with secondary eccentric MR and mild TR. The lack of left atrial enlargement indicates that the current and future risk going forward at this stage is relatively low, yet prognosis is highly variable and serial sonographic monitoring is required for further assessment. No indication for cardiac medications at this stage. No anesthetic contraindications, yet this patient may be at mild increased risk for fluid overload under anesthesia. The following anesthetic protocol is suggested with judicious IV fluid use.

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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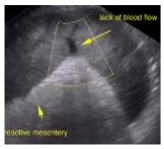
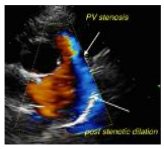
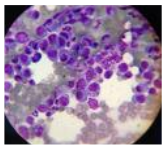
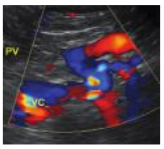

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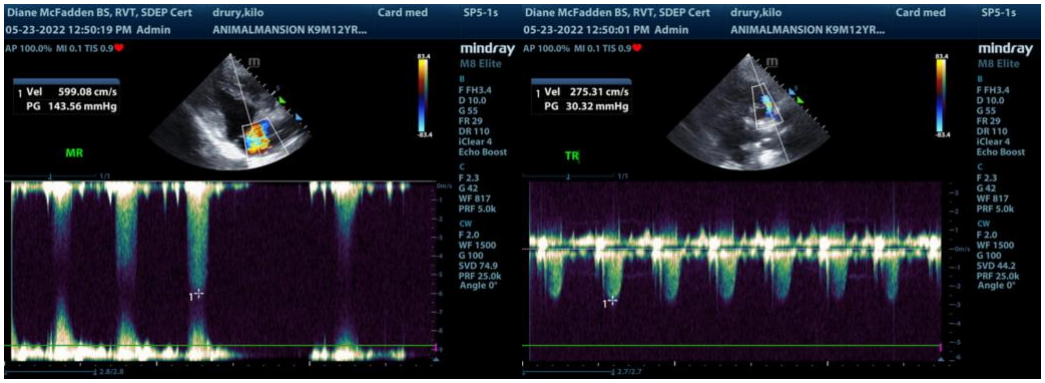

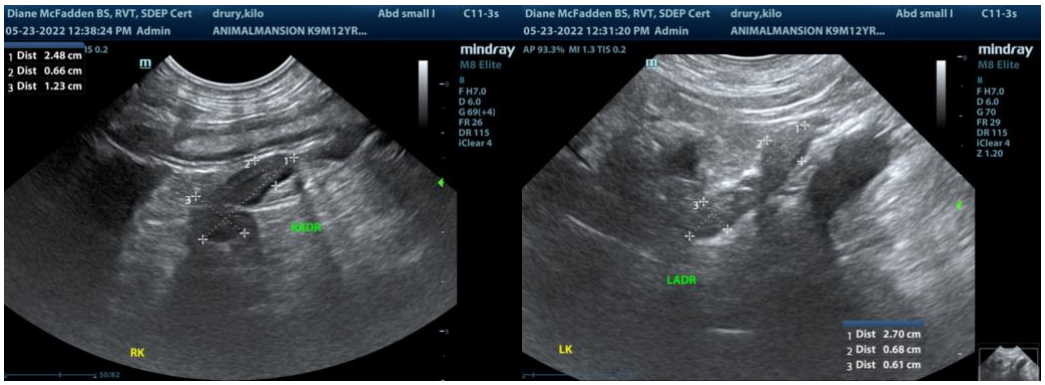

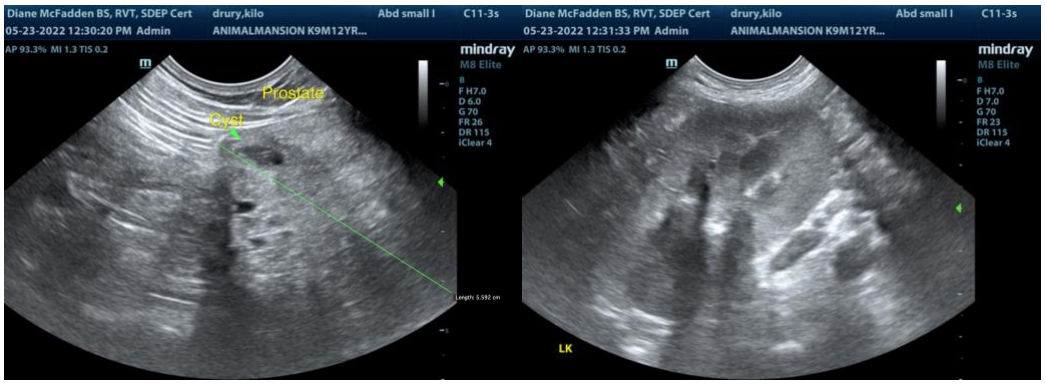

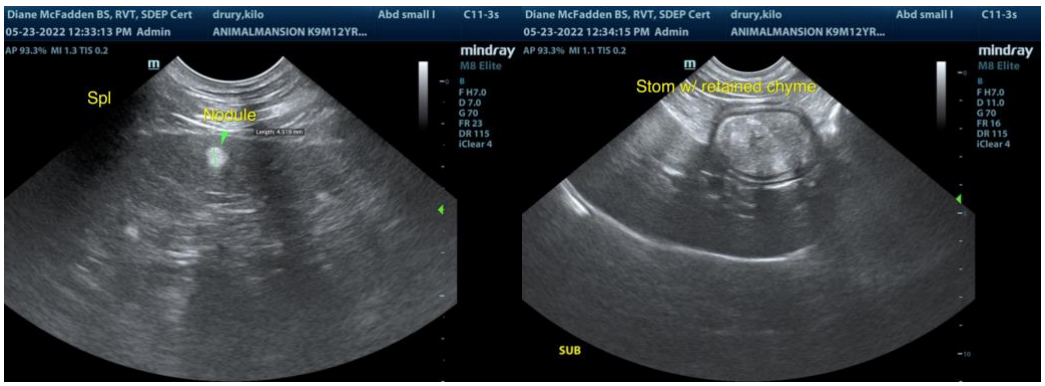

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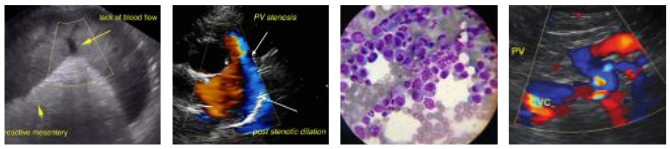

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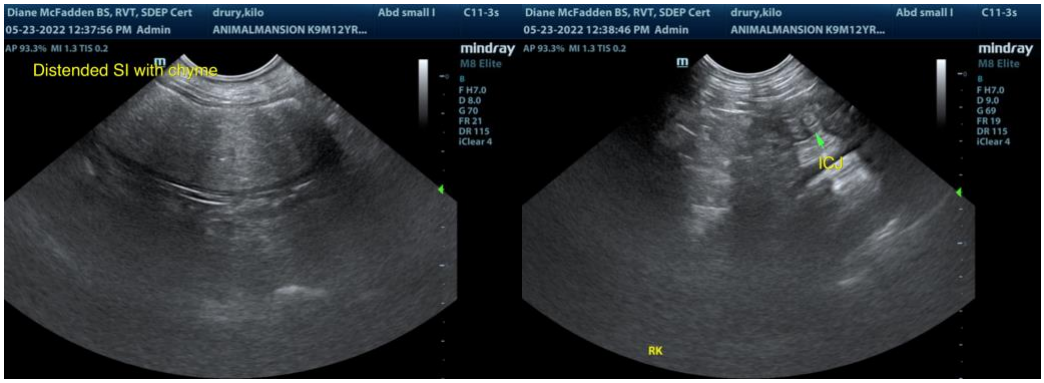

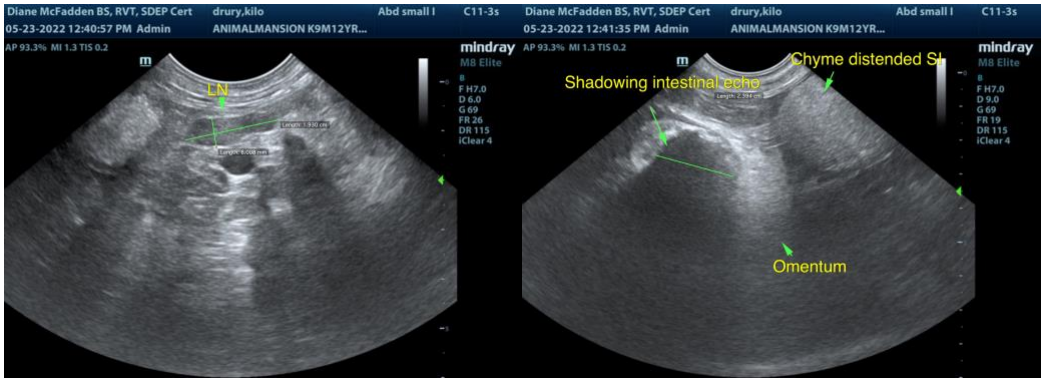

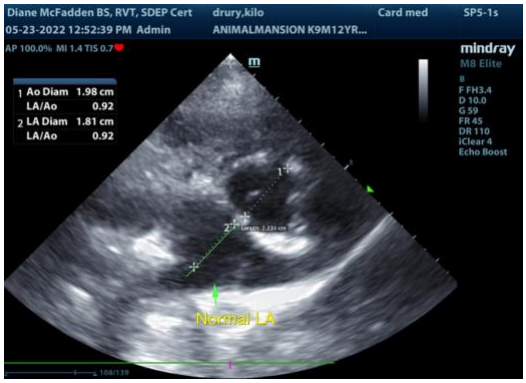

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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