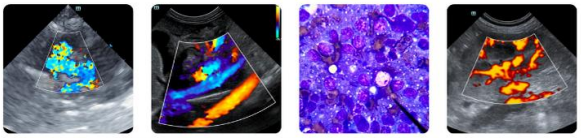

SonoPath www.SonoPath.com info@sonopath.com 800.838.4268

PATIENT
Riley Dilone

SPECIES
Canine

BREED
Cocker Spaniel

SEX
NM

AGE
12Y, 6M

WEIGHT
32lbs

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

IMAGING PERFORMED BY
Rebecca Hamilton

HOSPITAL NAME
Animal Paradise Hospital

REFERRING VET
Dr. Elshafie

INVOICE
75550

DATE
6-17-26

PRESENTING CLINICAL SIGNS

R/O causes for leukocytosis and neutrophilia and assess pancreas and cardiac function. and assess anesthetic risks. Xray report: equivocal left atrial enlargement, hepatomegaly. Meds: Posatex Otic 15g (6 drops in both ears SID 7 days)
Abnormal PE/Chem/CBC/UA Results: ALP 263, ALT 125, BUN 27, CBC- WBC 18.72, Neu 15.23, Mon 1.98, CPL 972 high, T4 1.8

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			--	1.1	45	78	0.14
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	140	1.4	0.8	32	3.5	3.4	

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 revealed measurable mild to moderate eccentric MR 5.8 m/s. 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. 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). Mild pulmonic insufficiency on Doppler. 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

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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 residual prostate appeared normal and free of pathology

The area of the iliac 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 5.7 cm in length. The right kidney measured 6.6 cm in length.

Adrenal Glands

The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.76 cm width in the caudal pole. The right adrenal gland measured 0.66 cm width in the caudal pole.

Spleen

The spleen was normal in size and contour with a primarily homogeneous parenchyma. Mild expansive nonhomogeneous to hypoechoic mid to cranial splenic nodule was present measuring 1.3 cm diameter. Concurrent hyperechoic mildly expansive mid splenic nodule was also present measuring 1.2 cm diameter. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis.

Liver/ Gallbladder

The liver presented hepatomegaly exhibiting nonhomogeneous mildly increased parenchyma exhibiting variable coarse echotexture. Indistinct portal vascular borders were noted. Intermittent discrete hyperechoic intraparenchymal nodules were present. An example of a nodule measured 1.1 cm diameter.

The gallbladder was non-distended in size with thin walls and mild nonorganized to slightly striated gallbladder debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty without evidence of retained ingesta, fluid, or foreign material.

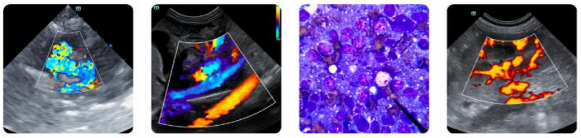
The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material.

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

Pancreas

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

Free Abdomen



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No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Chronic mitral valve disease (B1).
- Mild pulmonic valve insufficiency - not hemodynamically significant.
- Mild chronic renal changes.
- Variably echogenic splenic nodules - hyperechoic nodule consistent with probable myelolipoma, hypoechoic nonhomogeneous nodule may indicate lymphoid hyperplasia, hematopoiesis, hematoma, infection, emerging neoplasia.
- Enlarged nonhomogeneous discretely hyperechoic nodular liver - chronic vacuolar, cholestatic, or inflammatory hepatopathy, suspect nodular hyperplasia, lipogranulomas. Hepatic primary or metastatic neoplasia thought less likely.
- Early immature gallbladder mucocele.
- Prominent nonhomogeneous pancreas - mixed pattern chronic/chronic active pancreatitis with parenchymal remodeling +/- early fibrosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of the murmur is chronic degenerative valvular changes with secondary eccentric mitral valve insufficiency. The lack of left atrial enlargement implies that the risk of complication secondary to mitral valve insufficiency is low at this time and, without current clinical signs, indicates that medical therapy is not required. Prognosis is considered variable and sonographic monitoring is recommended. Recheck echo cardiogram is suggested in 6-12 months, sooner if clinical signs arise. No cardiac anesthetic contraindications.

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.

Assuming normal clotting status and using a 25-gauge needle, hypoechoic splenic nodule and hepatic parenchyma FNA cytology could be considered for further clarification.

Adrenal workup warranted despite lack of adrenal pathology and if clinical signs consistent with Cushing's syndrome.

Hepatosupportive medications and empirical therapy for chronic pancreatitis if concurrent gastrointestinal signs are recommended.

Sonographic monitoring of the liver and spleen for evidence of progressive nodular changes would be more conservative.

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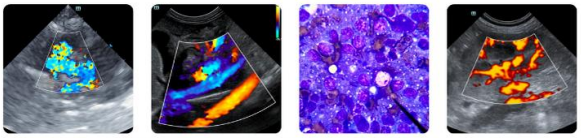

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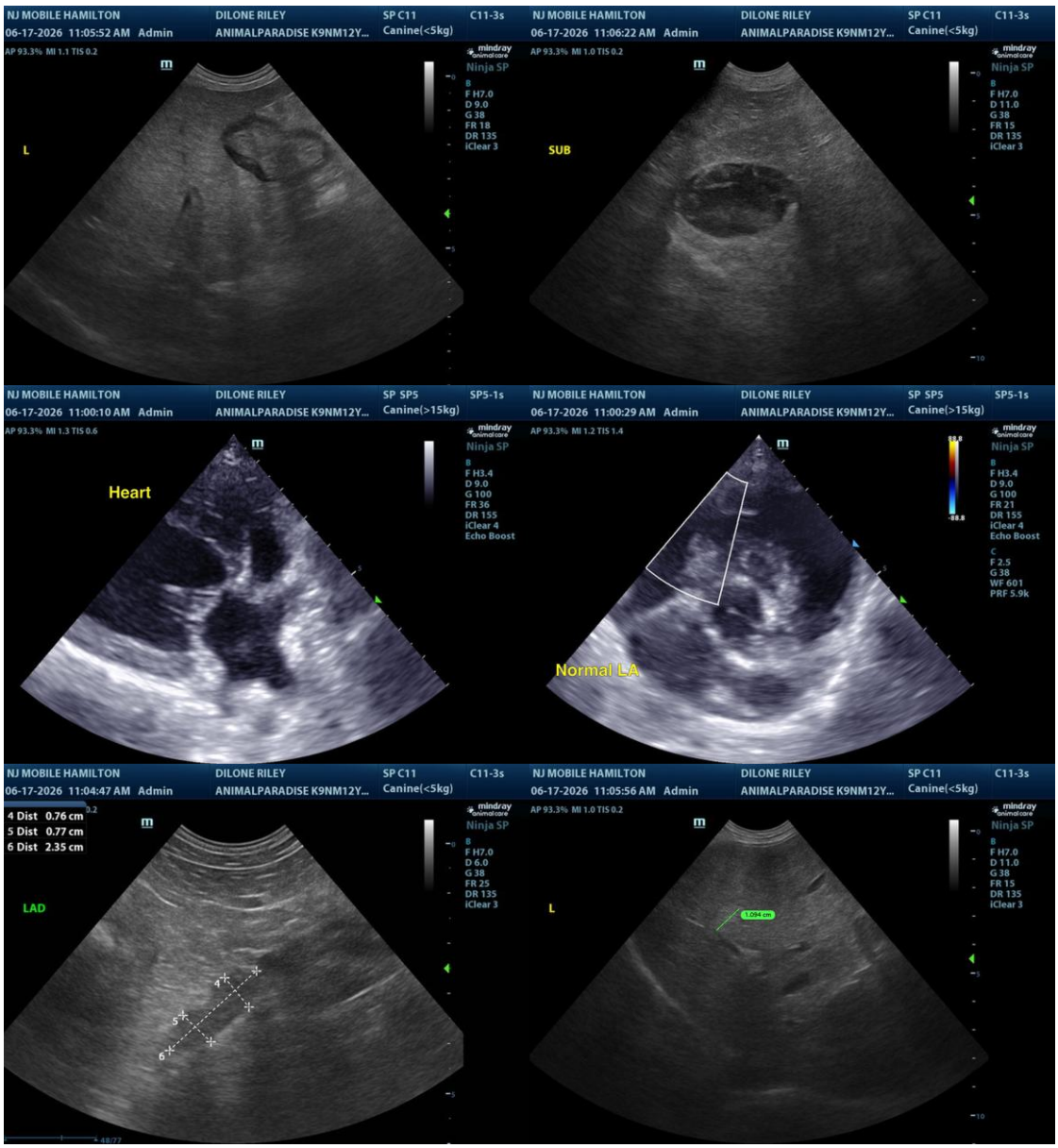

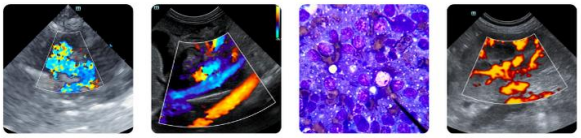

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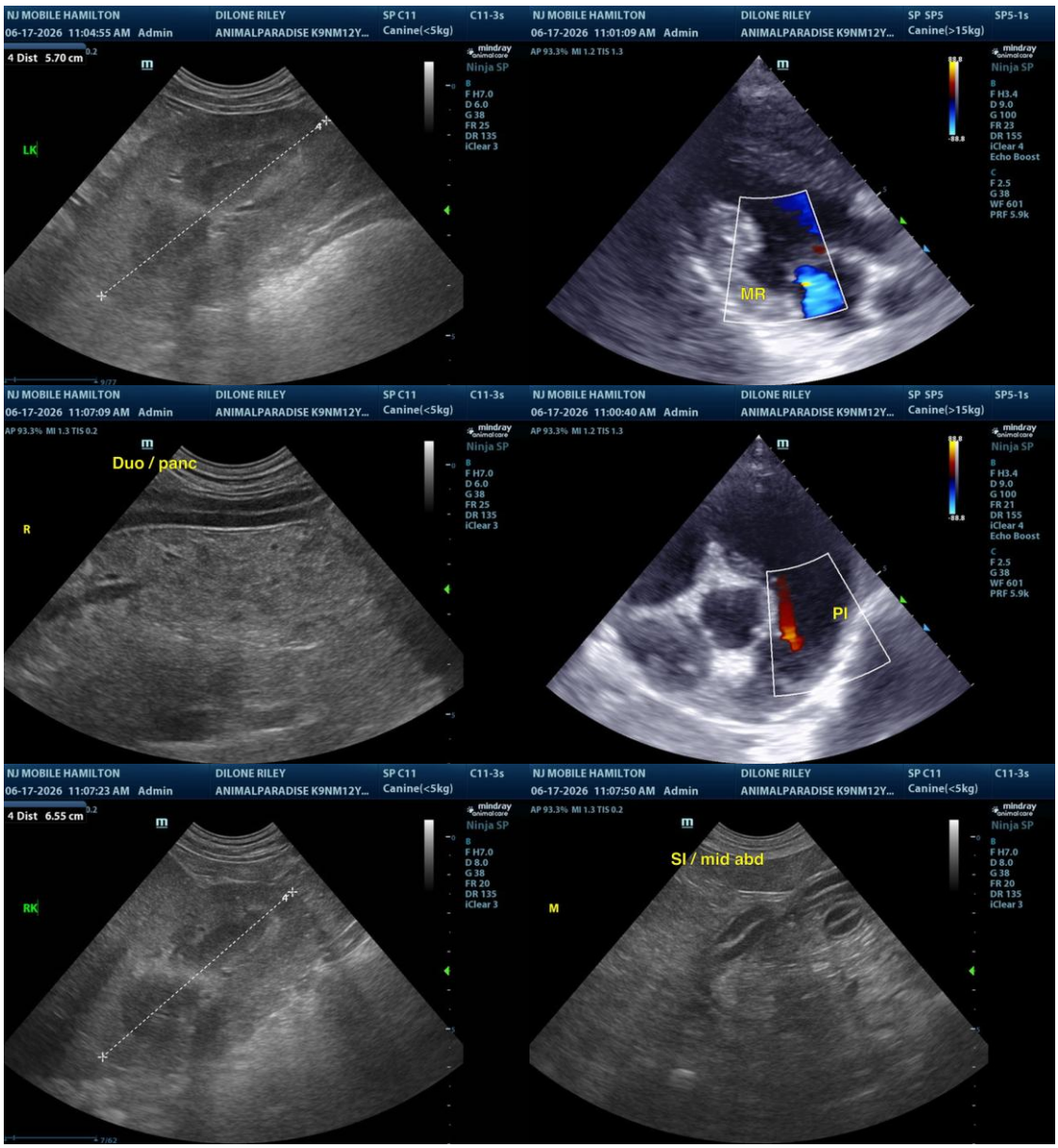

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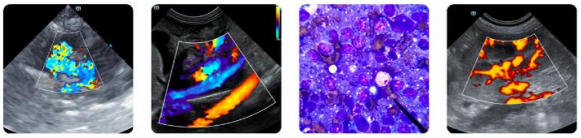

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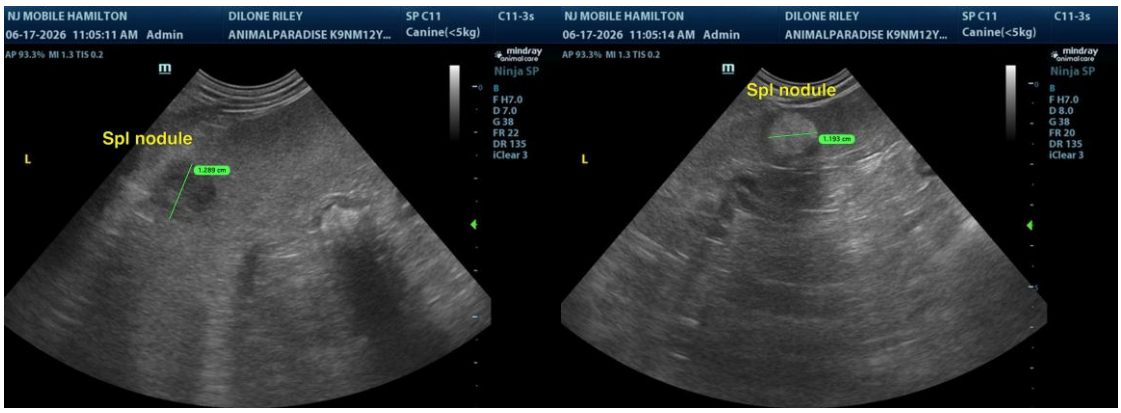

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@sonopath.com