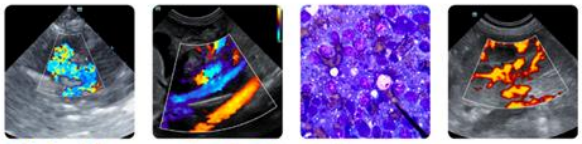

PATIENT

Cuddles Clagett

SPECIES

Canine

BREED

Maltese

SEX

FS

AGE

12yr

WEIGHT

4.8lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr Megan Bray

HOSPITAL NAME

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PRESENTING CLINICAL SIGNS

HX of Heart Murmur (Gr2/6) (diagnosed 6/11/26), Diabetic Cataracts OU, MPL: Gr3 RH/GR2 LH, Diabetes Mellitus, and Immune-mediated Thrombocytopenia. P is on Vetsulin U-40 1u BID. On PRN Gabapentin for anxiety (not given today). An AUS was done 12-07-2022 at a previous vet clinic which revealed "unremarkable findings but could have been consistent with enterocolitis or, less likely, concurrent pancreatitis, Liver changes are typical for diabetics."

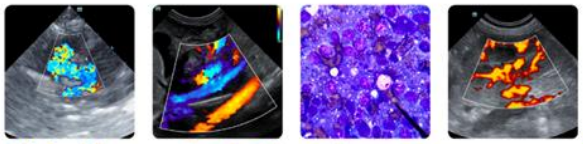
Abnormal PE/Chem/CBC/UA Results: Thoracic radiographs were done today, sent out to be reviewed by radiologist. Doppler BP - See attachment. P having increased respiratory rate (>34) . As of 6/11/26: - Blood Glucose Curve: Revealed PERSISTENT HYPERGLYCEMIA with values in the 400s. - Chemistry: - ALT: 320 U/L (ref 12-118) - ELEVATED - AST: 135 U/L (ref 15-66) - ELEVATED - ALP: 550 U/L (ref 5-131) - ELEVATED - GGT: 19 U/L (ref 1-12) - ELEVATED - 4Dx Test: POSITIVE for Anaplasma exposure. - Physical Exam Findings: A NEW low-grade heart murmur was auscultated.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN AND HEART

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	--	--	--	1.3	44	76	0.34
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	1.6	0.7	4.8lb	2.0	1.9	--

Cardiac Presentation

The echocardiogram in this patient demonstrated normal left atrial size based on 2 different LA measurement methods. Chamber volumes and echogenicity were normal. The cranial and caudal mitral valve leaflets presented mild thickening consistent with mild endocardiosis. Doppler indicated mild eccentric insufficiency. The left ventricle presented thicknesses with linear contour and was not dilated nor restricted. Aortic valve insufficiency on Doppler. Normal measured LVOT velocity. 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



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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 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. No evidence of arrythmia.

Urinary System

The urinary bladder was normal in size and tone. A solitary sessile based, non-homogenous non-mineralized urinary bladder lesion was visualized measuring ~ 0.56 cm x 0.77 cm. The 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 evidence of urine/lumen sediment, mineral, or calculi.

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 moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Minor right kidney pyelectasia was present. Bilateral areas of mild medullary mineral were present. The left kidney measured 3.8 cm in length. The right kidney measured 3.9 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.41 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.43 cm width at the caudal pole.

Spleen

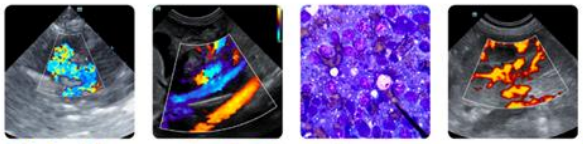
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/Gallbladder

The liver presented subjective borderline 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. Normal vascular volume. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with mild to moderate, non-dependent, non-organized debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact mildly prominent wall, owing to prominent gastric mucosa. The lumen of the stomach was empty with mild gas and no signs of obstruction or foreign material.



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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 mechanical/metabolic ileus, obstruction or foreign material. Non-specific mild hyperechoic intestinal mucosal speckling was present.

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

Pancreas

The parenchyma of the pancreas was hyperechoic to adjacent omental fat with diffuse parenchyma remodeling. The capsule of the pancreas was mildly asymmetrical in contour without evidence of peripancreatic inflammation. These changes may suggest chronic inflammation, fibrosis, or saponification if previous history of pancreatitis. No overt signs of pancreatic neoplasia.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Chronic mitral valve disease (B1)
- Aortic valve insufficiency
- Hepatopathy-subjective benign, metabolic/ diabetic hepatopathy, inflammatory disease, non-obstructive cholestasis, or combinational all potentials, no evidence of hepatic neoplastic criteria
- Non-organized gallbladder debris (non-mucocele)
- Chronic pancreatitis / fibrosis
- Subjective mild gastroenteritis pattern
- Normal adrenal glands
- Mild chronic renal changes with mild right kidney pyelectasia
- Small urinary bladder sessile base lesion- focal cystitis, sessile base polyp, emerging tumor possible

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The lack of left atrium enlargement indicates that hemodynamic effects of the mitral insufficiency at this stage are low. No evidence of clinical pulmonary hypertension. Clinical signs associated with cardiac disease are not anticipated. The respiratory signs of this patient appear non-cardiogenic in origin. Correlation with 3 view chest radiographs is recommended. No indication for cardiac medications. Sonographic monitoring advised with recheck echo suggested in 6 months, sooner if clinically indicated. Assessment of systemic BP for hypertension given aortic valve insufficiency is recommended.

Hepatogastrointestinal support and empirical therapy for chronic pancreatitis if non-reported gastrointestinal signs is recommended. Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered. A screening BRAF assay and sonographic monitoring of the urinary bladder lesion for evidence of progression is recommended.

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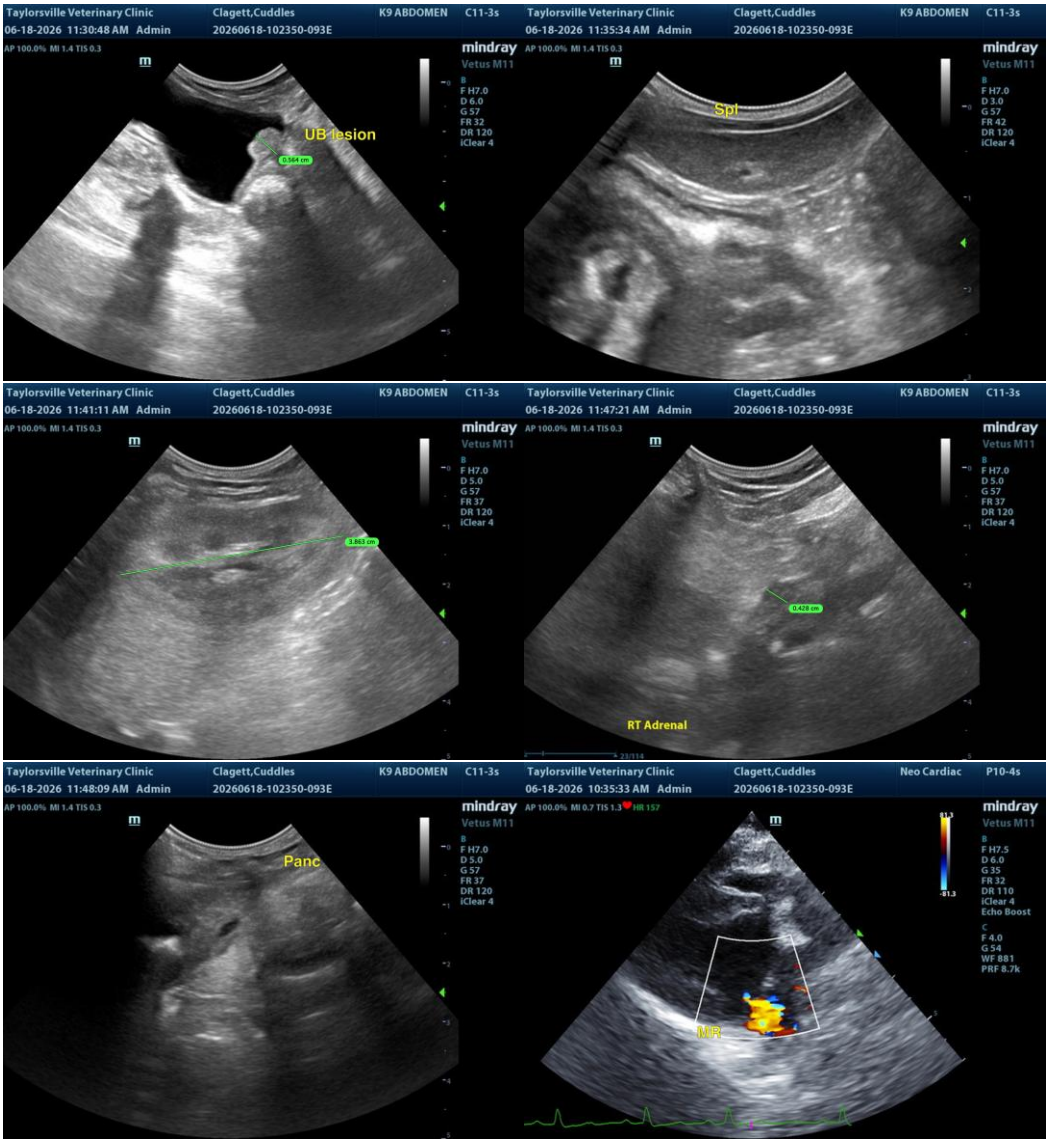

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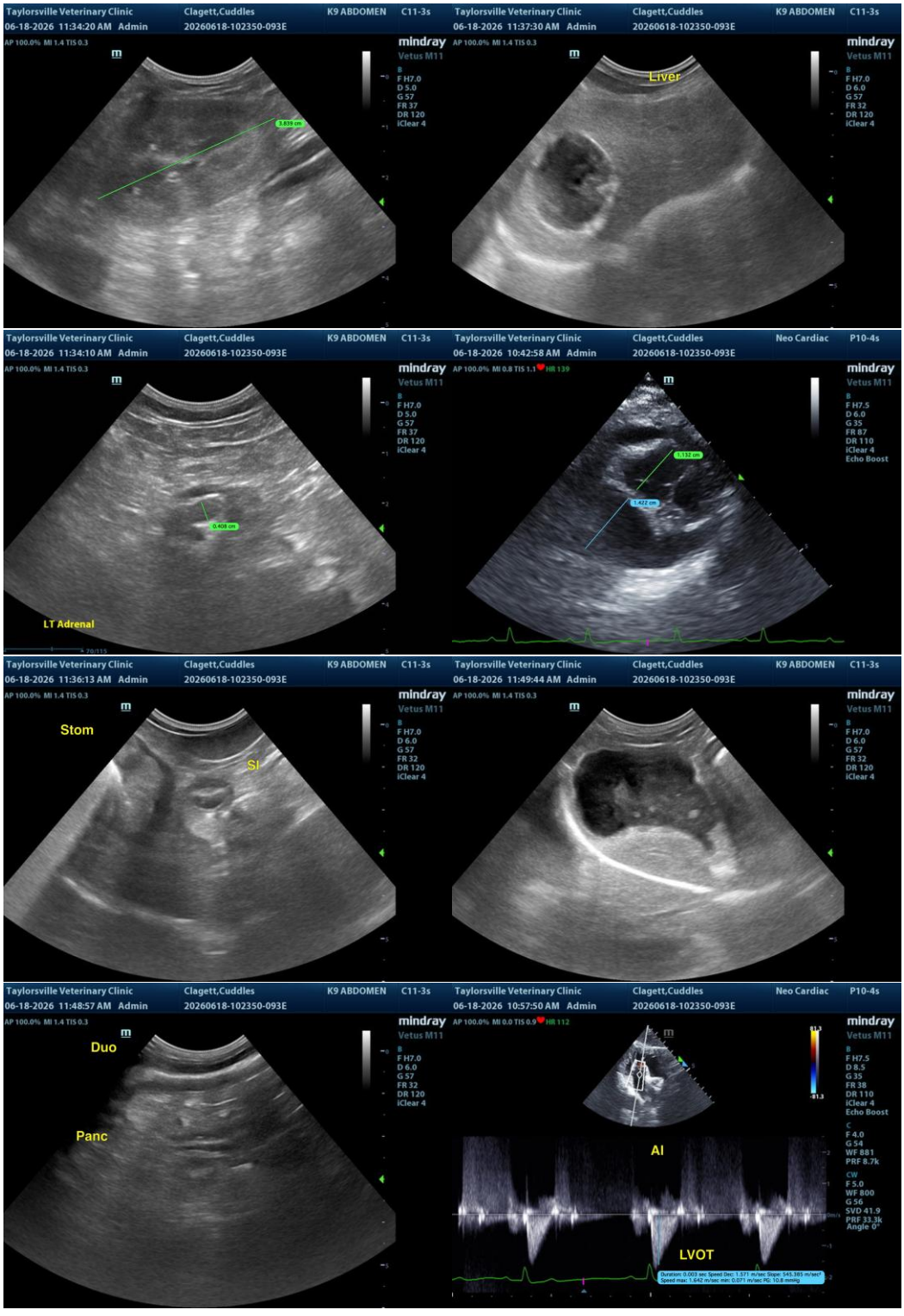

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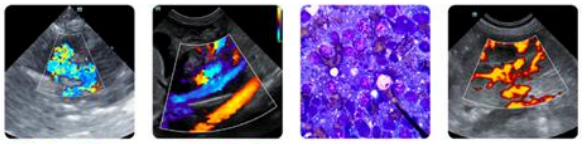

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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