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Clinical Sonography & Telecytology
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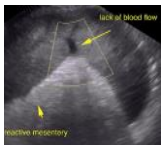
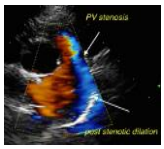
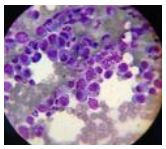
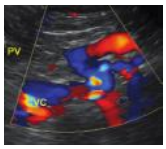

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Rosie Corby

SPECIES
Canine

BREED
Doberman Pinscher

SEX
FS

AGE
8 yr

WEIGHT
96 lb

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

IMAGING PERFORMED BY
Shari Reffi CVT

HOSPITAL NAME
Andover Animal Hospital

REFERRING VET
Dr. Hummel

INVOICE
10894ag

DATE
06/22/2022

PRESENTING CLINICAL SIGNS

History: Possible FB ingestion (O saw her swallow something 3 days ago). Poor appetite since. Current meds: Proin

ULTRASONOGRAPHIC EXAMINATION OF THE HEART AND 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	<1.3	28-40	40-100	<0.6
PATIENT				2.2	9.4	20	0.94
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				
PATIENT	NM		0.9		5.9	5.2	

Cardiac Presentation

Moderate to severe left ventricular dilation with severely decreased systolic dysfunction was present. Increased EPSS and increased LV sphericity was noted with mildly decreased LV wall thickness. Moderate to severe LA enlargement was noted. The mitral valve appears to be mildly thickened without evidence of overt prolapse or chordae tendinea rupture. Moderate, primarily centralized to mildly eccentric mitral insufficiency was present. Concurrent mild to moderate subjective right atrial and ventricular dilation was noted. No overt or significant TR. The LV outflow tract appeared to be structurally normal with subjective normal laminar systolic outflow. No overt AI. The pulmonic valve was overtly normal with normal RV outflow velocity. No overt PI. No obvious evidence of pericardial or pleural effusion. No obvious cardiac tumors were observed. Consistent tachycardiac was observed.

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra 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.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 6.7 cm in length. The right kidney measured 7.3 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

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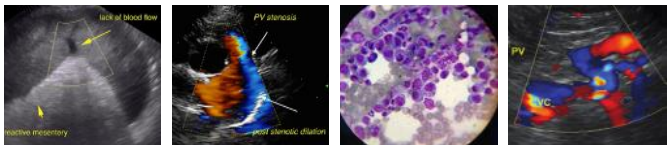

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The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.89 cm width at the caudal pole and 2.7 cm length. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.62 cm width at the caudal pole and 2.8 cm length.

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 was subjectively enlarged in size with normal structure and mildly rounded contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild to moderate coarse echotexture. Subjective evidence of mild congestion most notable at the level of the hepatic vein caudal vena cava junction. The gallbladder was non-distended in size. The gallbladder wall was thickened in appearance consisting of an echogenic double rim corresponding to the inner and outer portions of the wall. This is consistent with gallbladder wall edema. Possible causes may include acute inflammation, edema and anaphylaxis.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate primarily nonshadowing ingesta/chyme likely consistent with post prandial presentation 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.

Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

Free Abdomen

Mild to moderate volume peritoneal free fluid and generalized reactive mesentery was observed.

ULTRASONOGRAPHIC FINDINGS

- DCM like cardiomyopathy with tachycardia
- Moderate to mildly eccentric MR
- Hepatomegaly with concurrent gallbladder wall edema consistent with likely congestion
- Edematous pancreas, potential for low grade inflammation
- Mild to moderate volume peritoneal free fluid and generalized reactive mesentery
- Gastric ingesta

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The echocardiogram for this patient is consistent with significant cardiomyopathy, left and right heart

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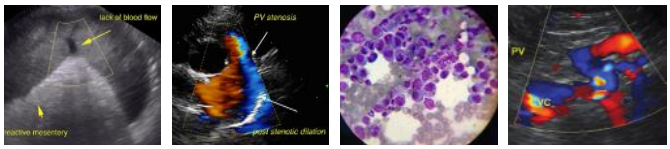

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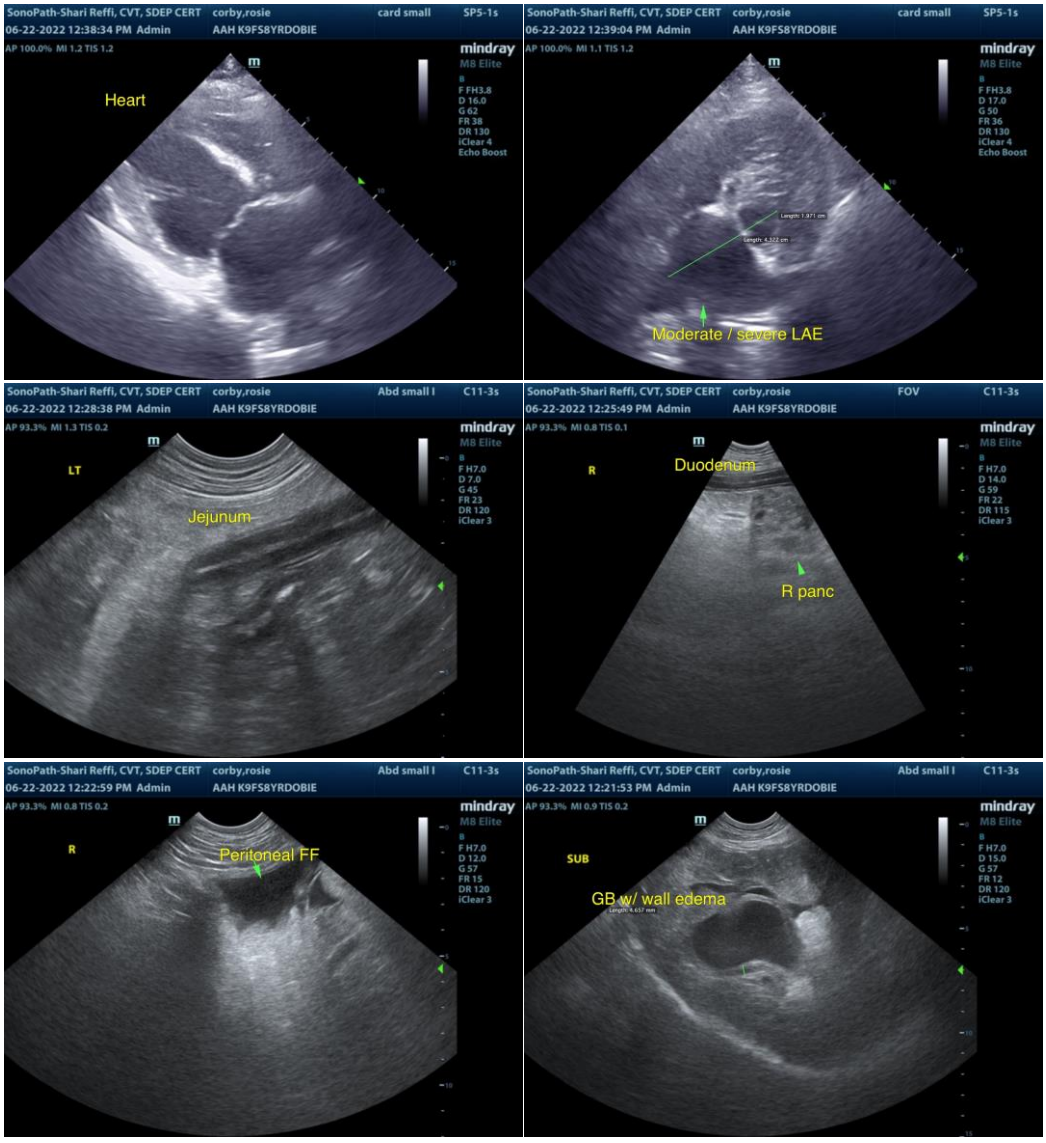
chamber enlargement and significant LV systolic dysfunction consistent with DCM like cardiomyopathy. Concurrent tachycardia is present. The left heart chamber enlargement and volume overload predispose to pulmonary edema while the tachycardia predisposes to RHF. ECG assessment is highly recommended due to risk for atrial fibrillation, ventricular tachycardia etc. This may be primary in nature (DCM) or possibly secondary to taurine deficiency, hypothyroidism, myocarditis, tachycardia induced cardiomyopathy or infiltrative disease such as lymphoma. The ascites is most likely secondary to right sided heart disease. Correlation with assessment of ALB levels as well as ascites analysis +/- C/S if clinically indicated is recommended. Consider hospitalization for stabilization or referral for 24 hour supportive care. Pimobendan 0.3 mg/kg PO BID and Lasix/Spironolactone combination 1-2 mg/kg PO BID with continued monitoring of renal parameters and systemic BP is warranted. This patient will be at continued high risk for CHF, malignant arrythmias and/or sudden death. A very guarded to poor long-term prognosis is indicated.

A recheck echocardiogram could be considered in 3-4 months, sooner if continued episodes of CHF or other abnormalities.



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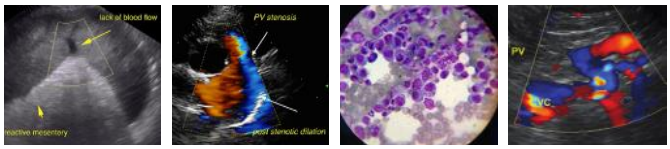

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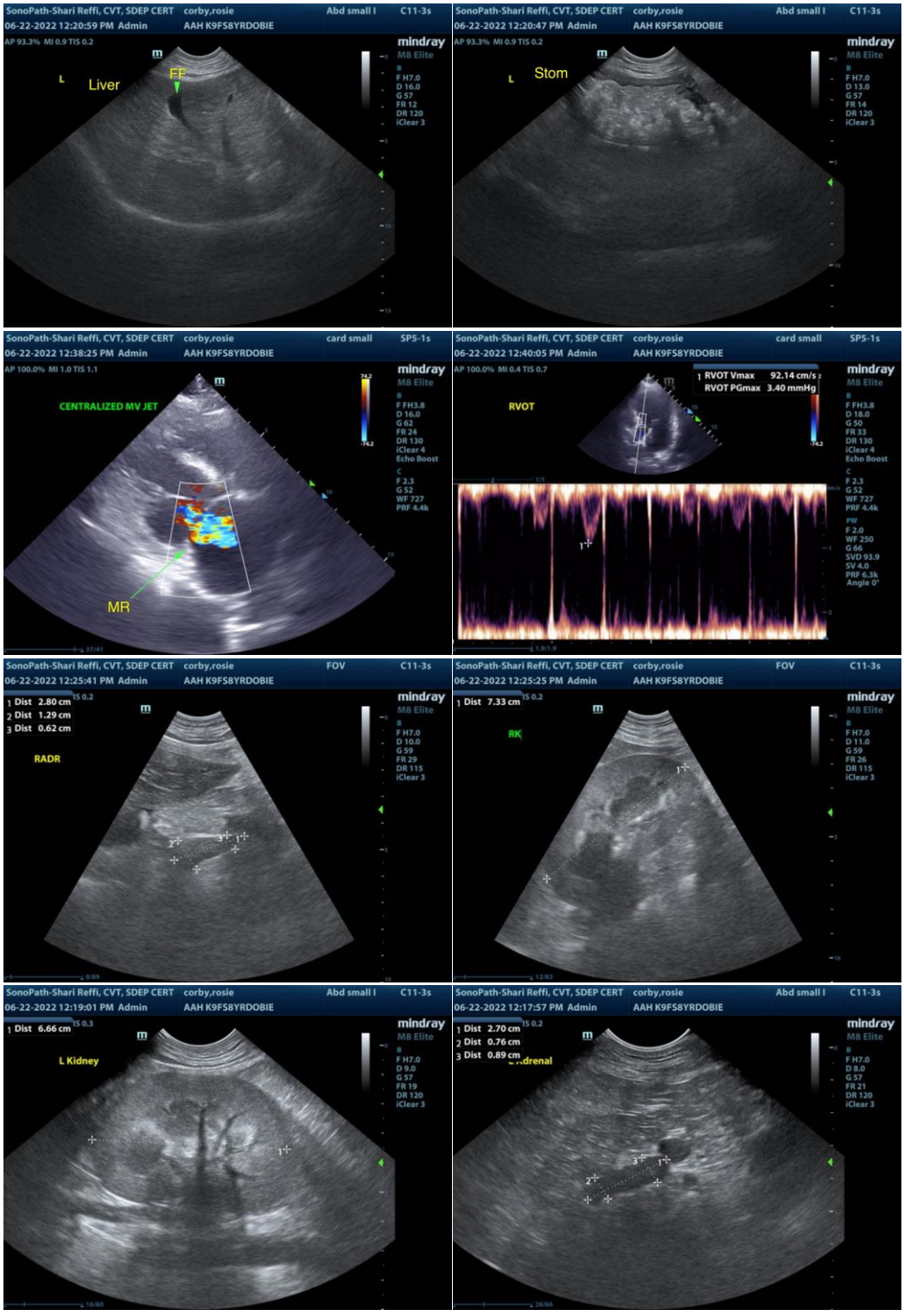
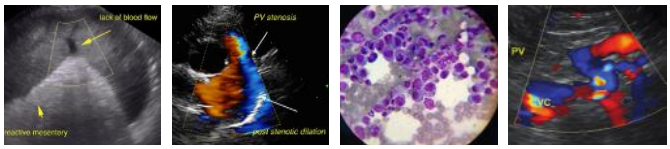


The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I



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can be of any further assistance please contact me.

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