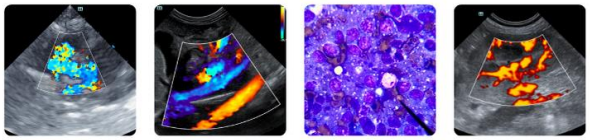

PATIENT
Hunter Schmick

SPECIES
Canine

BREED
Coton de Tulear

SEX
MN

AGE
14 y

WEIGHT
10.6 lb

INTERPRETED BY
Keith Blass, DVM, MS, DACVIM (Cardiology)

IMAGING PERFORMED BY
Dr. Jennifer Todd

HOSPITAL NAME
Lambs Gap AH

REFERRING VET
Dr. Todd

INVOICE

DATE
12/22/25

PRESENTING CLINICAL SIGNS

Grade 4/6 murmur. Coughing a few times a day over the past few months. Had an echocardiogram and ECG in August 2024. Currently receiving furosemide 4 mg BID, benazepril, pimobendan, and spironolactone 5 mg BID.

ECHOCARDIOGRAPHIC FINDINGS

2D, M-mode, and Doppler study.

There is severe left atrial dilation. The mitral valve leaflets are thickened and exhibit systolic prolapse. A severe jet of eccentric mitral regurgitation is present. There is moderate to severe left ventricular dilation. Left ventricular systolic function is hyperdynamic. The aorta and aortic valve are normal. Right atrial and right ventricular dimensions are normal. The tricuspid valve leaflets are mildly thickened, and a mild jet of tricuspid regurgitation is present. TR velocity is consistent with the presence of mild pulmonary hypertension (PG 38 mmHg). The pulmonary artery and pulmonic valve are normal. No pericardial effusion or cardiac masses are seen.

LA – 41.5 mm
LVIDd – 38.2 mm
LVIDs – 18.6 mm
FS – 51.3%
LVOT – 0.80 m/s
RVOT – 0.56 m/s
TR – 3.09 m/s

ELECTROCARDIOGRAPHIC FINDINGS

A single lead ECG is submitted for review.

HR: 100 bpm
Rhythm: Sinus

Normal sinus rhythm is present throughout this recording. All complex amplitudes and intervals are within normal limits. No premature beats or conduction blocks are seen.

ASSESSMENT/RECOMMENDATIONS

Degenerative mitral and tricuspid valve disease
Pulmonary hypertension

This examination demonstrates regurgitation of blood across Hunter's mitral and tricuspid valves resulting from degenerative valve disease. Hunter's tricuspid valve disease is mild, and appears to be well-compensated at this time. His mitral valve disease is significantly more advanced, as Hunter has severe mitral regurgitation present, with severe secondary dilation of both his left atrium and left ventricle, as well as mild secondary pulmonary hypertension. Given this, it's very likely that mainstem bronchial compression is contributing to Hunter's cough. In addition to coughing, Hunter is at high risk for the development of exercise intolerance, syncope, and labored breathing, therefore, careful monitoring for these is recommended.

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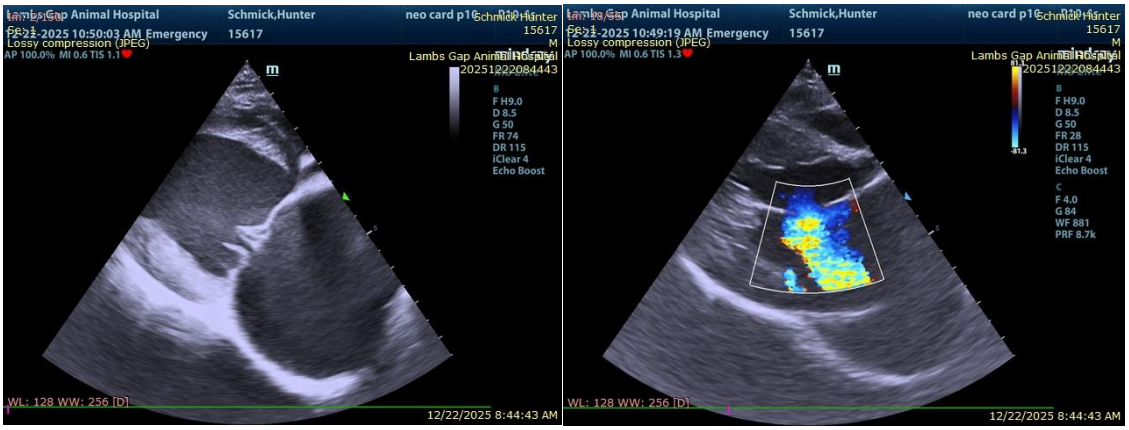
No abnormalities are appreciated in Hunter's ECG.

I recommend adding a cough suppressant, such as hydrocodone (1.25 mg PRN, up to every 6 hours), to Hunter's current medications. Should this fail to improve his cough, consideration can be given to increasing Hunter's furosemide dose to 6 mg BID.

If Hunter's furosemide dose is increased, a renal/electrolyte profile is recommended 1-2 weeks after doing so. A recheck echocardiogram is recommended in 6 months. Thoracic radiographs are recommended if Hunter's cough worsens, or if he experiences difficulty breathing.



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.

Keith Blass, DVM, MS, DACVIM (Cardiology)

info@SonoPath.com