

**PATIENT**

Lola Conway

**SPECIES**

Canine

**BREED**

Border Collie Mix

**SEX**

Female Spayed

**AGE**

12.10 years

**WEIGHT**

71.3lbs

**INTERPRETED BY**

Maggie Machen Lamy,  
DVM, DACVIM  
(Cardiology)

**IMAGING PERFORMED BY**

Loetitia Saint-Jacques,  
LVT

**HOSPITAL NAME**

Fairgrounds Animal  
Hospital

**REFERRING VET**

Dr. Johnson

**INVOICE**

47294

**DATE**

3/24/26

**PRESENTING CLINICAL SIGNS**

History: history of mild to moderate fear and anxiety during clinic visits. She is overweight with a body condition score of 7/9. On 01-23-2026, a grade 2/6 systolic heart murmur was detected on physical exam. Laboratory results from 01-23-2026 were within normal limits and heartworm antigen was negative. Mild to moderate dental calculus was noted and multiple masses were identified. Assess prior to anesthesia. BP: BM3vet pro machine at 1:38pm Cuff #4 LFL; 1) 223/150 (174), 2) 229/135 (166), 3) 246/150 (182).

**RADIOGRAPHIC FINDINGS** \*NOTE: Images submitted for supplemental information only.

Normal cardiac silhouette. No obvious evidence of CHF.

**ELECTROCARDIOGRAPHIC FINDINGS**

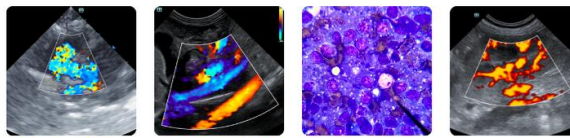
A six lead ECG is available at 25mm/s; 10mm/mV. The average heart rate is 80bpm. The rhythm is sinus in origin, with a p for every QRS complex and vice versa. The P wave morphology is positive with a normal dimension. Normal PR. The QRS morphology is positive with normal dimension. MEA is normal. No ectopic beats, pauses or dysrhythmias observed. ECG diagnosis: Profound respiratory sinus arrhythmia with significant heart rate variability.

**ECHOCARDIOGRAM FINDINGS**

2D, m-mode, color flow and doppler imaging is available. Mild diffuse thickening of mitral valve leaflets with no prolapse into the left atrial lumen. No mitral regurgitation with no left atrial dilation. Normal LV diameter with adequate myocardial function. The tricuspid valve appears mildly thickened with mild to moderate tricuspid regurgitation. Velocity consistent with moderately elevated pulmonary pressures. Mild right heart prominence. The pulmonic and aortic valves are normal in morphology and mobility. Mildly elevated pulmonic and aortic outflow velocities. The MPA appears normal in diameter. Proximal to the pulmonic valve, a discrete hypoechoic soft tissue lesion is seen. The origin is suspected to be the proximal aspect of the pulmonic valve; however, the RVOT is not ruled out; 2.2 x 1.3cm in best-viewed cross section. No pericardial or pleural effusions are seen.

**CARDIAC CHART**

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	NA	3.9	NM	1.2			NM
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	NM	1.8	2.2	32.3	2.6		
*Normal chamber parameters expressed as a mean value (SD)				3	1.27 (5.3)	2.46 (2.46)	1.36 (5.5)
<b>BODY WEIGHT DEPENDENT PARAMETERS</b>				5	1.40 (4.5)	2.74 (5.2)	1.60 (4.7)
				10	1.50 (3.8)	3.27 (3.5)	2.06 (3.1)



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*\*Note: All measurements based upon multi-modal images and methods. An average value is reported.*

Adapted from June Boon, Veterinary Echocardiography, 1998  
Rishniw M and Hollis NE, J Vet Intern Med 2000; 14:429-435  
Hansson et al, Vet Rad and Ultrasound 2002  
Bonagura et al. Echocardiography: principles of interpretation, Vet

15	1.83 (2.0)	3.71 (2.4)	2.43 (2.1)
20	2.02 (1.9)	4.14 (2.2)	2.80 (2.0)
25	2.18 (2.4)	4.48 (2.9)	3.10 (2.5)
30	2.33 (3.3)	4.83 (3.9)	3.39 (3.4)
35	2.48 (4.3)	5.17 (5.0)	3.69 (4.5)
40	2.62 (5.2)	5.48 (6.1)	3.96 (5.4)
50	2.88 (7.1)	6.07 (8.3)	4.46 (7.4)

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The cause of the murmur is a soft tissue lesion associated with the RVOT/pulmonic valve that is occluding flow through the pulmonary artery. Rule outs for this type of soft tissue lesion include a tumor, blood clot, embolus, etc. This is a highly unusual finding, and any further growth will lead to right-sided enlargement and congestive signs. Early pressure overload of the right heart is apparent with increased pulmonary pressures and mild right heart prominence. Despite this, the patient is asymptomatic, which is good news. Going forward, the most common issue with this type of lesion would be syncope, which is not reported. This patient is at high risk for development of collapse episodes, right-sided congestion, and/or malignant arrhythmias/sudden death going forward. The remainder of the study is unremarkable with no evidence of left-sided disease. The ECG is also normal with a respiratory sinus arrhythmia.

The next step in this case would be further systemic work up, with the goal of identifying any ancillary lesions which may be amenable to sampling. This includes CXR, AUS and/or potentially a CT scan. If a presumptive diagnosis can be made, chemotherapy or RT may be possible. Palliative medical therapy is not required at this time given a lack of congestion or clinical signs; however, Plavix may be reasonable given an increased risk for clot formation. If the mass grows even a small amount in the near future, my assumption is right-sided congestive signs and/or syncope will develop, and this should be monitored for at home. That said, we do not understand rate of growth yet in this case (i.e. this may have been present at this size for some time) and outcome in the short term is difficult to speculate.

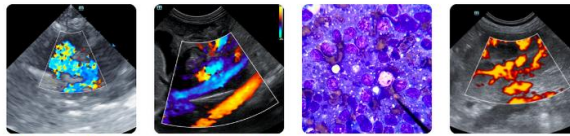
Monitor for development of a cough, labored breathing, exercise intolerance or collapse episodes.

Anesthesia is not advised at this time.

**PLAN:**

Consider full systemic work up as discussed. Consider oncology consult. Consider referral in this unusual case for advanced evaluation.

A recheck echocardiogram is recommended in 3 months to reassess the lesion, sooner signs of cardiac compromise be noted in the future.



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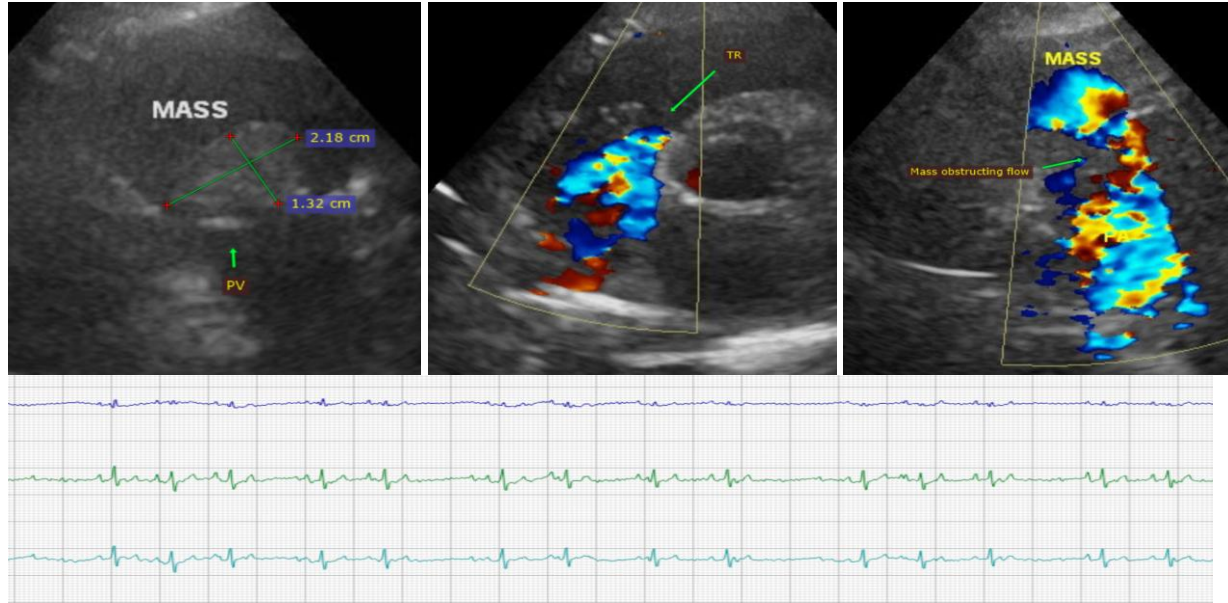
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### IMAGES



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

Thank you for this referral. This report was generated using transcription software, and minor dictation errors may be present. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

**Maggie Machen Lamy, DVM**  
**Diplomate of the American College of Veterinary Internal Medicine (Cardiology)**  
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