



## PATIENT

Indy Martin

## SPECIES

Canine

## BREED

Border Collie Mix

## SEX

FS

## AGE

10yr

## WEIGHT

48.4

## INTERPRETED BY

Bradley Harris, DVM,  
DACVECC, DACVIM  
(cardiology)

## IMAGING PERFORMED BY

Rebecca Hamilton

## HOSPITAL NAME

VCA McKenzie

## REFERRING VET

Dr Arpaia

## INVOICE

24149

## DATE

03/09/2026

## PRESENTING CLINICAL SIGNS

- Intermittent Hx of pale MM transient and resolve on own since 2023
- Progressive hind limb weakness and muscle atrophy since 12/2024
- New systolic murmur grade 3/6
- Meds: Boswelvia 1 tab BID, thunder calming chew 1 SID, Gaba 300 mg BID, Trixysn 2 pumps BID, Dasaquin 1 tab SID, Incurin 1 tab SID pm, Ursolyx muscle support 1 chew SID PM
- Abnormal PE/Chem/CBC/UA Results: normal

## ULTRASONOGRAPHIC EXAMINATION OF THE HEART

CANINE CARDIAC PARAMETERS	BW	HR BPM	LAD 4 ch Long	RAD 4 ch Long	La/Ao Heart Base	LVIDd	LVIDs
NORMAL PARAMETER		50-100			<1.6		
PATIENT	22.0	150	3.90	2.56	1.09	3.5	2.31
CANINE CARDIAC PARAMETERS	FS	EPSS	PV V MAX (m/s)	AV V Max (m/sec)	MR Vmax	TR Vmax	RPA distensibility (normal >30%)
NORMAL PARAMETER	28-40	<0.6	0.7-1.6	0.7-1.7	4.5-5.5	< 2.7	
PATIENT	34	0.3	0.8	1.4	4.5	NM	NM

## ECG Interpretation

There is a six-lead ECG available for review. The underlying rhythm is regular at an average rate of 150bpm. The rhythm appears to be sinus in origin with narrow QRS complexes (<70ms). There is no atrial or ventricular ectopy and no conduction delay or block identified. This is most consistent with a normal sinus rhythm.

## Cardiac Presentation

The left atrium is normal in dimension. The left ventricle is normal in dimension, with normal systolic function. The right atrium and ventricle are normal in dimension, with normal systolic function. The anterior and posterior mitral valve leaflets are thickened and redundant consistent with myxomatous changes, and there is mild prolapse. There is mild mitral regurgitation identified. The tricuspid valve leaflets are appropriately thin with adequate apposition, intact chordae, no significant tricuspid regurgitation and no evidence of pulmonary hypertension. The left ventricular outflow tract demonstrated normal laminar flow and the visible aorta is unremarkable. The right ventricular outflow tract assessment revealed normal laminar flow, and appropriate diameter and distensibility. There is no pulmonic and trivial aortic valve insufficiency identified. There is no visible pericardial, pleural, or free



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peritoneal fluid documented. No evidence of hepatic venous congestion is noted. The cardiac chambers, pericardial and visible extra-cardiac regions were free of masses, spontaneous echo contrast, or thrombi.

## ULTRASONOGRAPHIC FINDINGS

These findings are consistent with degenerative/myxomatous mitral valve disease with minimal to mild hemodynamic effects consistent with ACVIM Stage B1 disease. It is unlikely that any current morbidity is of cardiac origin.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

### Recommendations:

Given these findings, no cardiac therapy is recommended. There are no cardiac contraindications to anesthesia, fluid therapy, vasopressor therapy, or corticosteroids as indicated for further assessment and treatment. If not already performed, baseline thoracic radiographs and blood pressure are recommended. A recheck echocardiogram is recommended in 6 months.

### Anesthesia considerations:

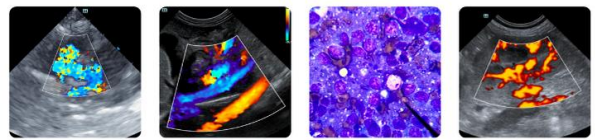
If anesthesia is necessary, alpha-2 agonists, ketamine, high dose acepromazine, and Telazol should be avoided. Fluid therapy during anesthesia should be considered at a conservative rate (e.g., 5 ml/kg/hour) if possible.

### Diet:

A high-quality food from Hills, Royal Canin, Science Diet, Eukanuba, Iams, or Purina that is highly palatable with adequate protein and calories for maintaining optimal body condition is reasonable.

### Activity:

No special considerations are necessary.



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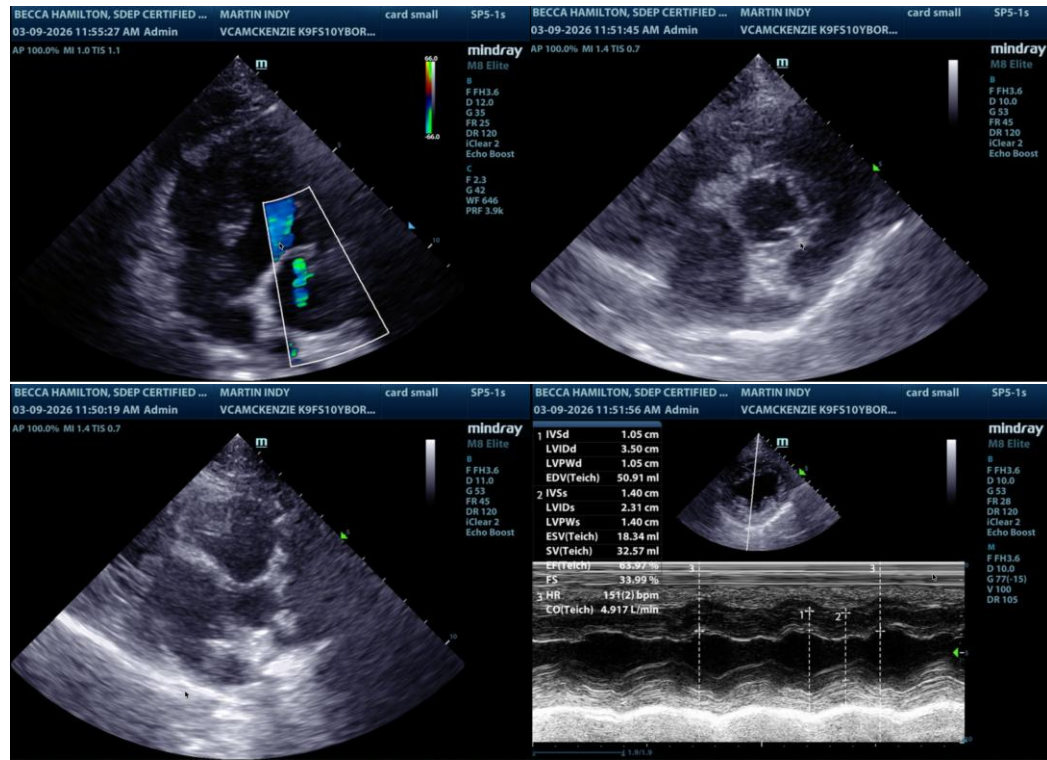
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Bradley Harris, DVM, DACVECC, DACVIM (cardiology)**

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