



PATIENT

Jasper Stoschek

SPECIES

Canine

BREED

Shetland Sheepdog

SEX

Neutered male

AGE

13 years

WEIGHT

15 kg

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Gumley

HOSPITAL NAME

Cedarview AH

REFERRING VET

Dr. Gumley

INVOICE

95543

DATE

1/25/22

PRESENTING CLINICAL SIGNS

One month history of progressive loss of hind leg mobility. Grade 3/6 systolic left apical heart murmur; CP deficits both hind legs, worse in RH. Normal forelegs. No spinal pain. Lungs clear on radiographs, normal vasculature, mild LAE. Fused T12/13 vertebrae with no obvious disc space. very mild non-responsive anemia, elevated cholesterol; low T4 (8); ALT = 216. thyroid panel pending. ECG no rhythm disturbances but tall R wave. Abdominal US shows "kiwi" appearance to GB suggestive of developing GB mucocele.

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

The echocardiogram in this patient demonstrated upper limits of normal **left atrial** size based on 3 separate methods of LA evaluation. However, the atrial septum was flattened. The cranial and caudal **mitral** valve leaflets presented normal linear structure, extension in systole, and union in diastole with normal kinesis. Complete filling of the left atrium was noted on mitral valve Doppler. The **left ventricle** presented thicknesses with linear contour and was not dilated nor restricted. 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. Trivial **tricuspid** insufficiency was noted at 2.3 m/sec. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. **Pulmonary outflow** tract assessment revealed normal valve structure, laminar flow, and diameter (approx.1:1 pa/ao ratio). No visible **pericardial** or free pleura fluid was noted. The cranial **mediastinum** and **pericardial and extra-cardiac** regions were free of masses in the visible window.

| 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 | 5.06 | 2.3 | 1.3 | 1.6 | 31 | 59 | 0.45 |
| 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 | 64 | 2.1 | 0.75 | 15 kg | 3.8 | 4.04 | |

ULTRASONOGRAPHIC FINDINGS

Stage B1 valvular disease.



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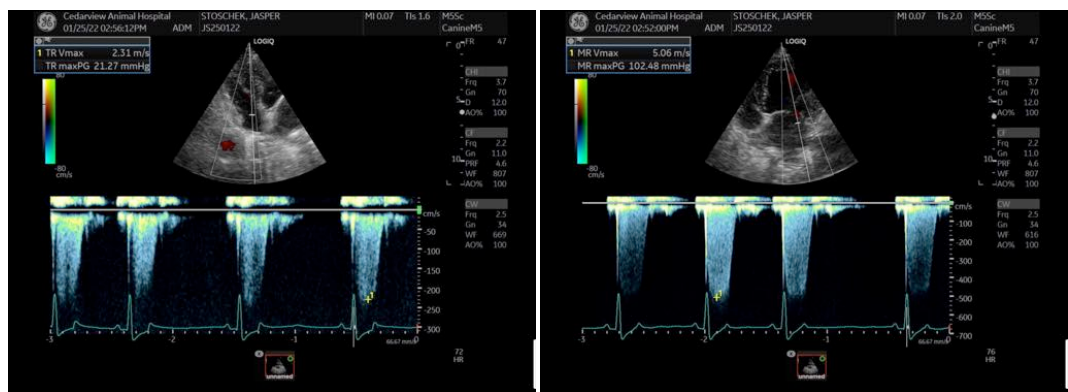
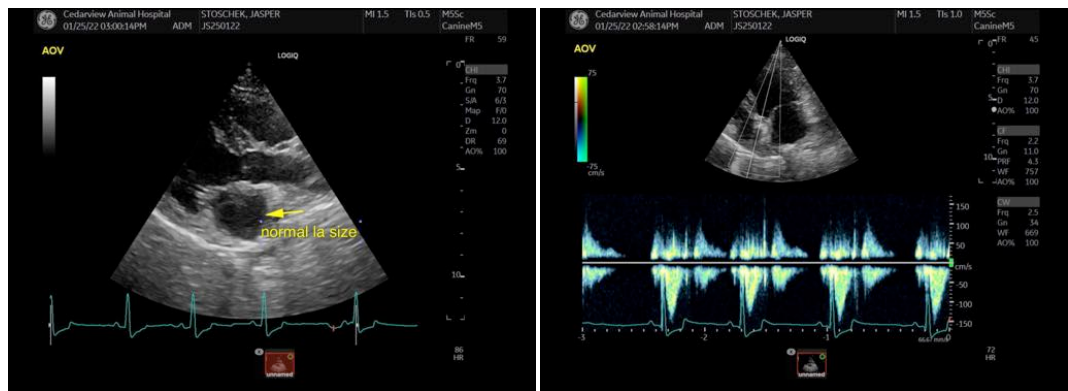
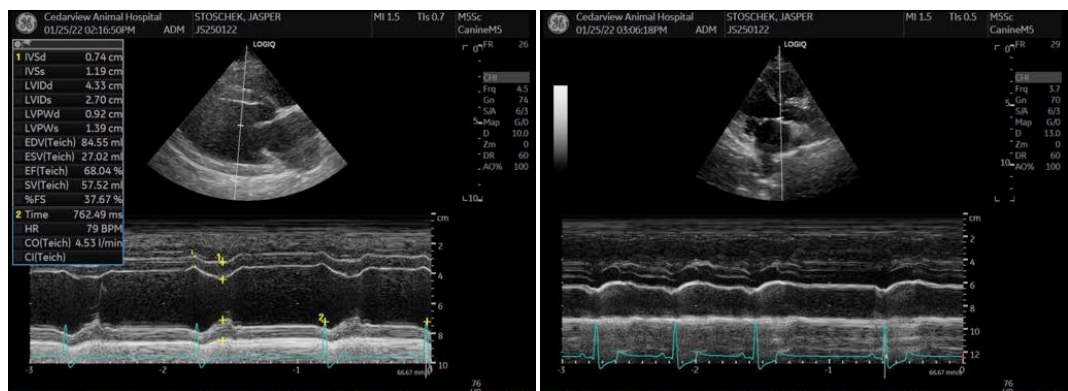
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

B1: The heart is stable without clinical disease. No overt contraindication for anesthesia of brief to moderate duration. I suggest Torbutrol premed, Propofol induction, Isoflurane maintenance or similar protocol if anesthesia is desired. Blood pressure recommended if not already performed and target white coat negative systolic pressure of < 160 mmHg. If higher than this ACE-inhibitor is suggested to reach this level. Recheck echocardiogram is recommended in 6 months, earlier if murmur grade increases or clinical signs initiate.





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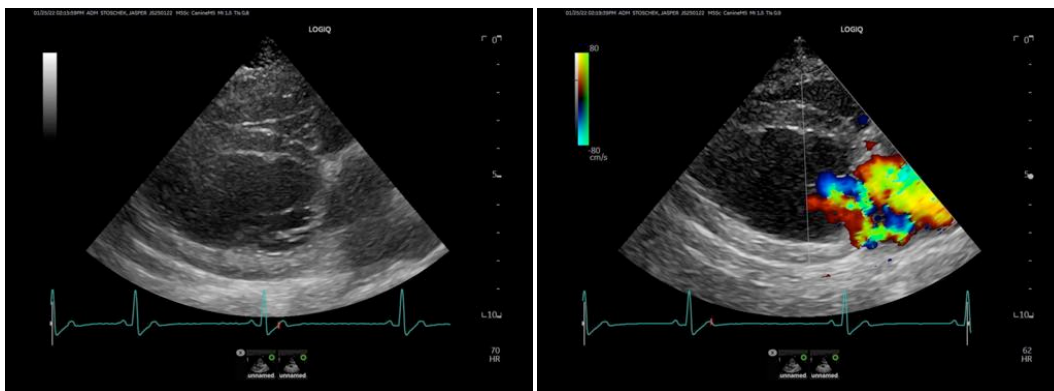
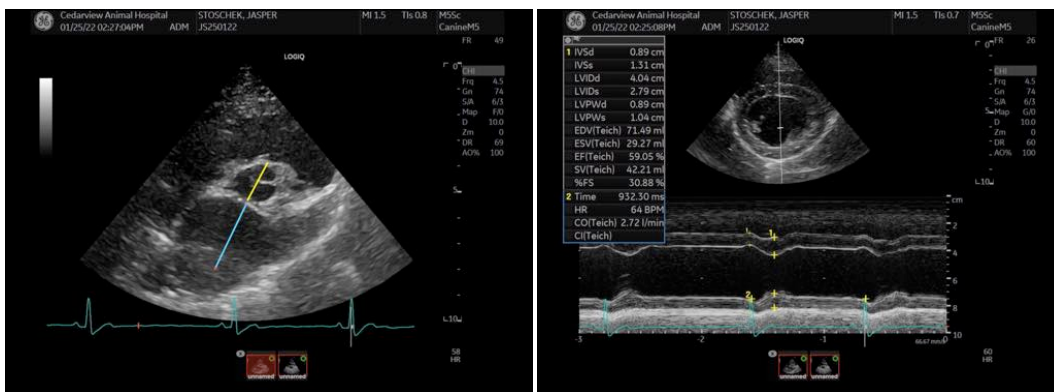
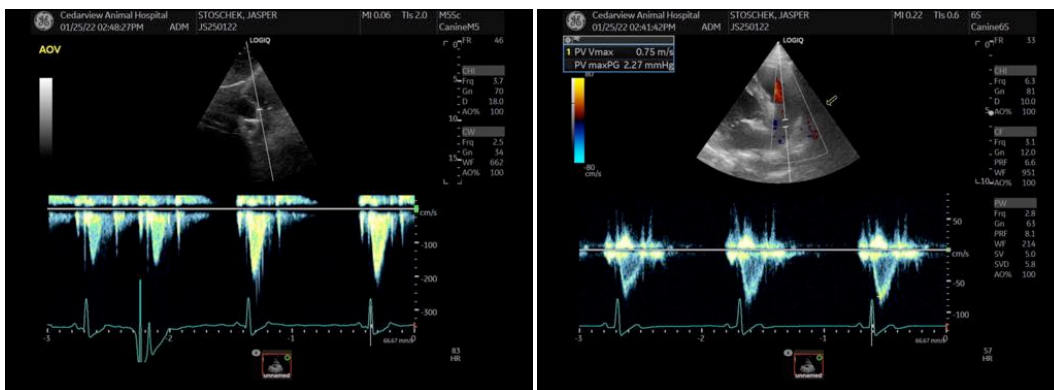
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
info@SonoPath.com