



**PATIENT PRESENTING CLINICAL SIGNS**

**Mowgli Price** Hx of PUPD increased ALP - dilute urine - panting (6m) - LDDS not Cushing's. Sudden onset (1 week ago) of very loud heart murmur (owner can hear it from across a quiet room!) - no coughing or obvious exercise intolerance according to owner Previous exam - no HM detectable. BCS 7/9. Exam - weak femoral pulses? - weak shaky in hind. -unsure if this is normal for Mowgli. On thyroid supplement, Murmur VI/VI - PMI left side.

**Canine** Abnormal PE/Chem/CBC/UA Results: BP- from referring DVM 127/88 (108) 75/46 (61) 75/55 (59) 109/55 (98) 194/168 (179)

**BREED**

Retriever Mix

**ULTRASONOGRAPHIC EXAMINATION OF THE HEART**

**SEX**

Neutered male

The echocardiogram in this patient demonstrated normal **left atrial** size based on 3 different LA measurement methods. Chamber volumes and echogenicity were normal. The cranial and caudal **mitral** valve leaflets presented vegetative thickening consistent with endocardiosis. Doppler indicated measurable insufficiency. 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. Minor aortic insufficiency was noted at 2.0 m/sec. 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 or chamber overload. **Tricuspid** valvular assessment demonstrated adequate linear morphology. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. Trivial **pulmonic** insufficiency is present at 0.7 m. No visible **pericardial** or free pleura fluid was noted. No echographically detectable evidence of infiltrative disease was visible. The cranial **mediastinum** and **pericardial regions** were free of masses in the visible window.

**AGE**

13 years

**WEIGHT**

29.7 kg

**INTERPRETED BY**

Eric Lindquist, DMV DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Dr. vanCampen

**HOSPITAL NAME**

Mississippi AH

**REFERRING VET**

Dr. vanCampen

**INVOICE**

95584

**DATE**

1/26/22

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	6.03		1.1	1.2			0.1
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		1.3	0.7	29.7	3.9 max		



**PATIENT**

Mowgli Price

**SPECIES**

Canine

**BREED**

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**ULTRASONOGRAPHIC FINDINGS**

Stage B1 valvular disease.

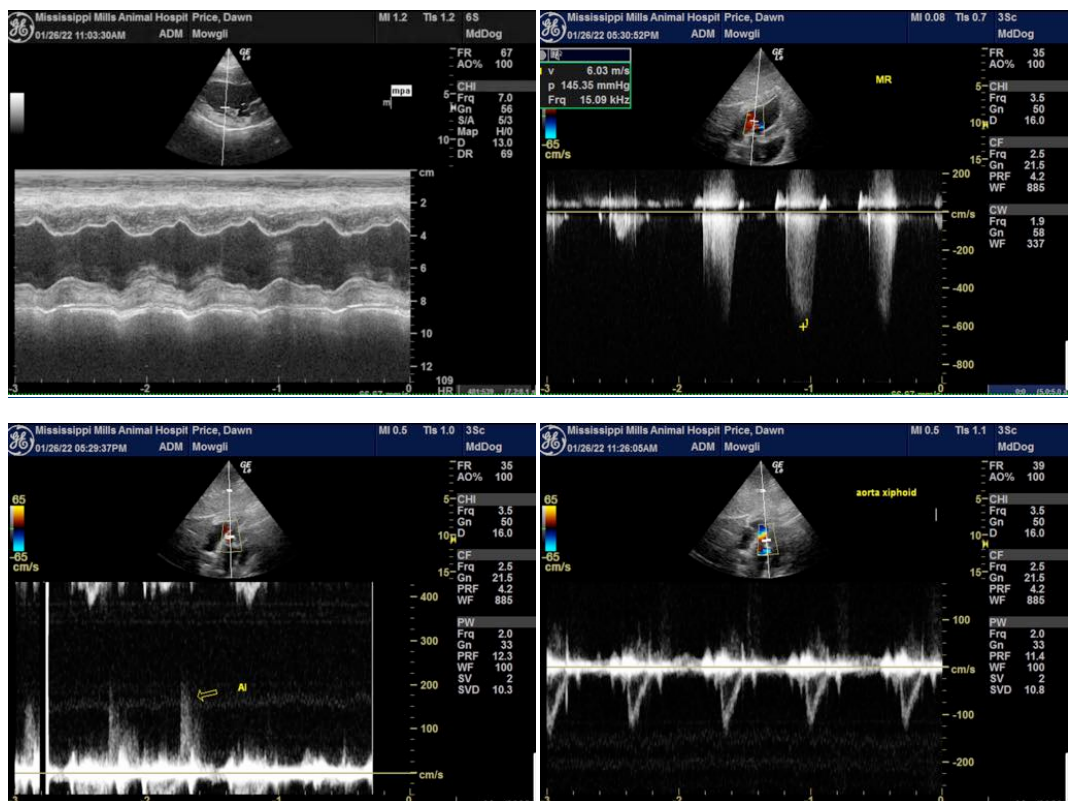
Minor aortic insufficiency.

Trivial pulmonic insufficiency.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

There was no evidence of volume overload.

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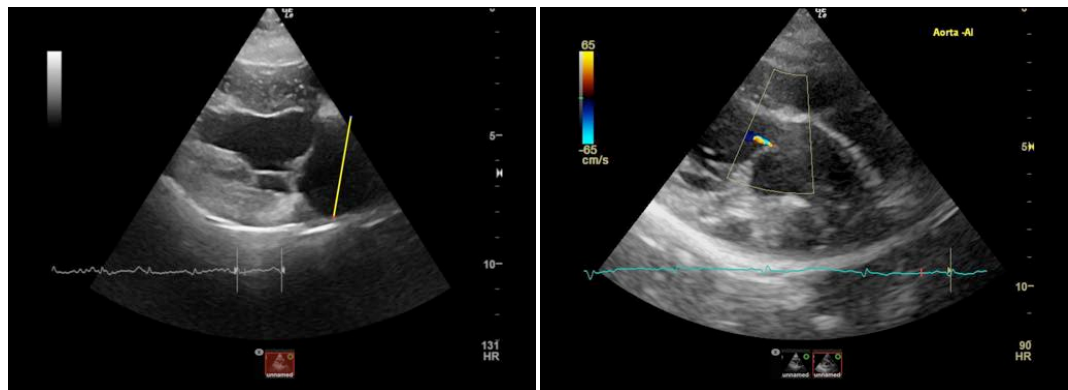
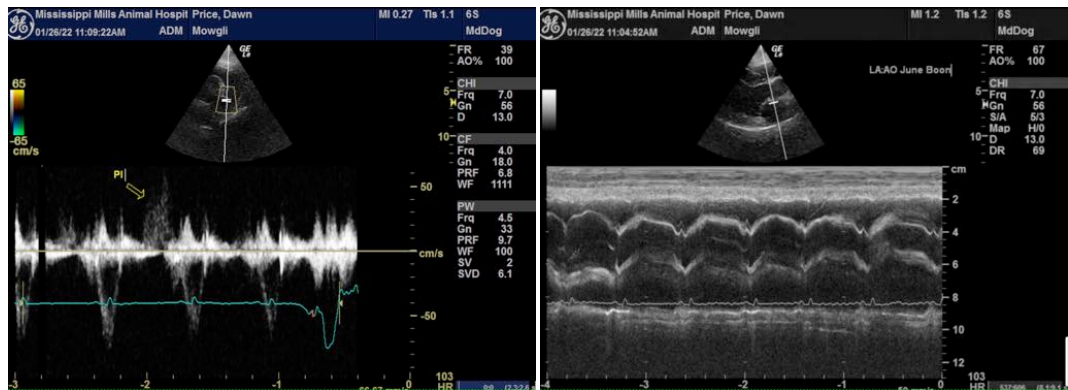
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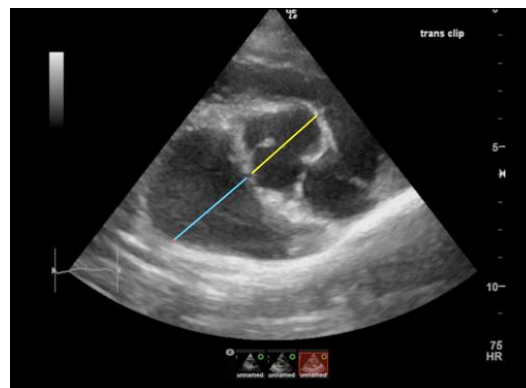
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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