



PATIENT

Paris Stachnick

SPECIES

Canine

BREED

Mini Australian Shepherd

SEX

Spayed Female

AGE

12 Years 6 Months

WEIGHT

16.8 lbs

INTERPRETED BY

Eric Lindquist, DMV,
DABVP (CFM), Cert.
IVUSS

IMAGING PERFORMED BY

Dr. Ken Leal

HOSPITAL NAME

Hackettstown Animal Hospital

REFERRING VET

Dr. Dana Nause

INVOICE

72083

DATE

1/8/26

PRESENTING CLINICAL SIGNS

3/6 heart murmur and arrhythmia Coughing more frequently Medications: was on Doxycycline trial
Abnormal PE/Chem/CBC/UA Results: WNL

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (M-Mode)	LA/AO (Heart Base; Swe)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	Up to 1.6	28-40	40-100	<0.6
PATIENT	6.2	--	NM	1.8	--	--	0.1
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT (lbs)	LAD LA MAX 4 Chamber	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	90	1.2	--	16.8	3.7	--	--

Cardiac Presentation

The echocardiogram for this patient presented excessive **left atrial size** expressed both in the LA/AO and LA max measurements Chamber volumes and echogenicity were normal. The cranial and caudal **mitral** valve leaflets presented vegetative thickening consistent with endocardiosis. Doppler indicated minor insufficiency. Prolapse of the anterior mitral valve leaflet noted. 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 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. **Pulmonic** 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. No echographically detectable evidence of infiltrative disease was visible. The cranial **mediastinum and pericardial regions** were free of masses in the visible window.

ULTRASONOGRAPHIC FINDINGS

- Mitral insufficiency with prolapse, tricuspid insufficiency and left atrial enlargement - Very early left-sided heart failure and Stage B2+ to C1 valvular disease.



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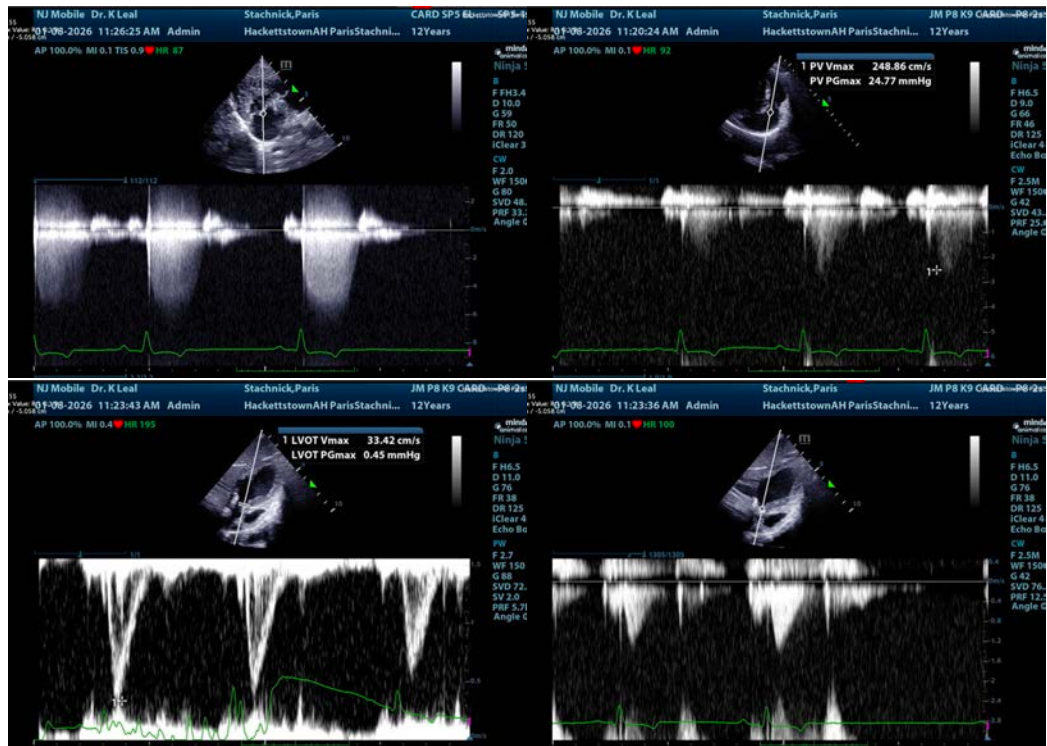
Dr. Dana Nause

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommend initiating Pimobendan and 0.3 mg/kg BID, ACE inhibitor 0.5 mg/kg SID progressing to BID, and Spironolactone 1-2 mg/kg SID. There is likely both a cardiac and bronchial component in this patient. Recheck echo in 6 months if stable, earlier if clinical signs are progressing.

The heart is in a somewhat precarious state with volume overload and a heart that is working to compensate for the valvular insufficiency. Target respiratory rate is < 20 resp/minute after therapy. After initiating therapy, I recommend recheck on the clinical exam, BUN, Creatinine, USG, Chest radiographs & Blood pressure in 5-7 days. Recheck echo in 1 month. Earlier if clinical decompensation is occurring. I do not recommend anesthesia at this time until stabilization has occurred on the recommended medications. Repeat preanesthetic echo is ideal if anesthesia is eventually necessary.

Radiographs: Mild left atrial enlargement, slight pulmonary edema, slight chronic bronchial changes.



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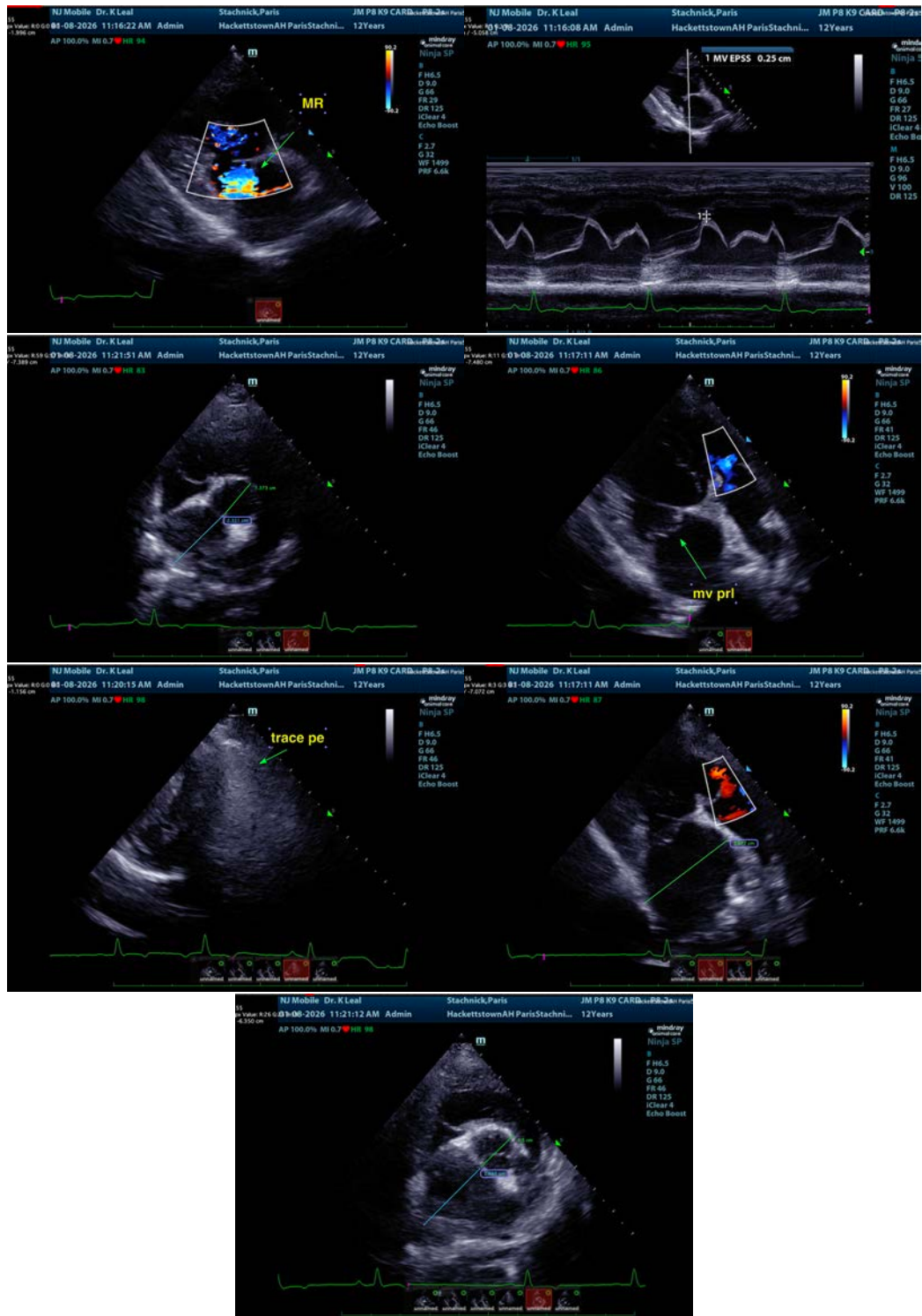
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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Eric Lindquist, DMV, DABVP(CFM), Cert. IVUSS,
CEO, Owner, Founder -- SonoPath.com

info@SonoPath.com

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