



## PATIENT

Nino Frank

## SPECIES

Canine

## BREED

Yorkie

## SEX

Neutered male

## AGE

13 years

## WEIGHT

9.1 lbs

## INTERPRETED BY

Eric Lindquist, DMV  
DABVP, Cert. IVUS

## PRESENTING CLINICAL SIGNS

History: acute onset of being unsteady and falling over Hx of renal and heart dz 3/6 HM Current meds renal diet and Hydrocodone  
WBC 4K with bands K 5.9 Na 156 Chol 352 Baseline Cortisol 2.94

## ULTRASONOGRAPHIC EXAMINATION OF THE HEART

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. Mild eccentric mitral insufficiency was noted and is not clinically significant. There was no evidence of volume overload or pressure overload. 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. Arrhythmic activity was noted in this patient.

## IMAGING PERFORMED BY

Jenn

## HOSPITAL NAME

Rockaway AH

## REFERRING VET

Dr. Ascot

## INVOICE

68294

## DATE

11/4/25

CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO	LA/AO (Heart Base)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	<1.6	28-40	40-100	<0.6
PATIENT			1.3	1.22			0.1
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT	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	80	1.5	1.16	9.1 lbs	2.3		

## ULTRASONOGRAPHIC FINDINGS

- Mitral insufficiency.



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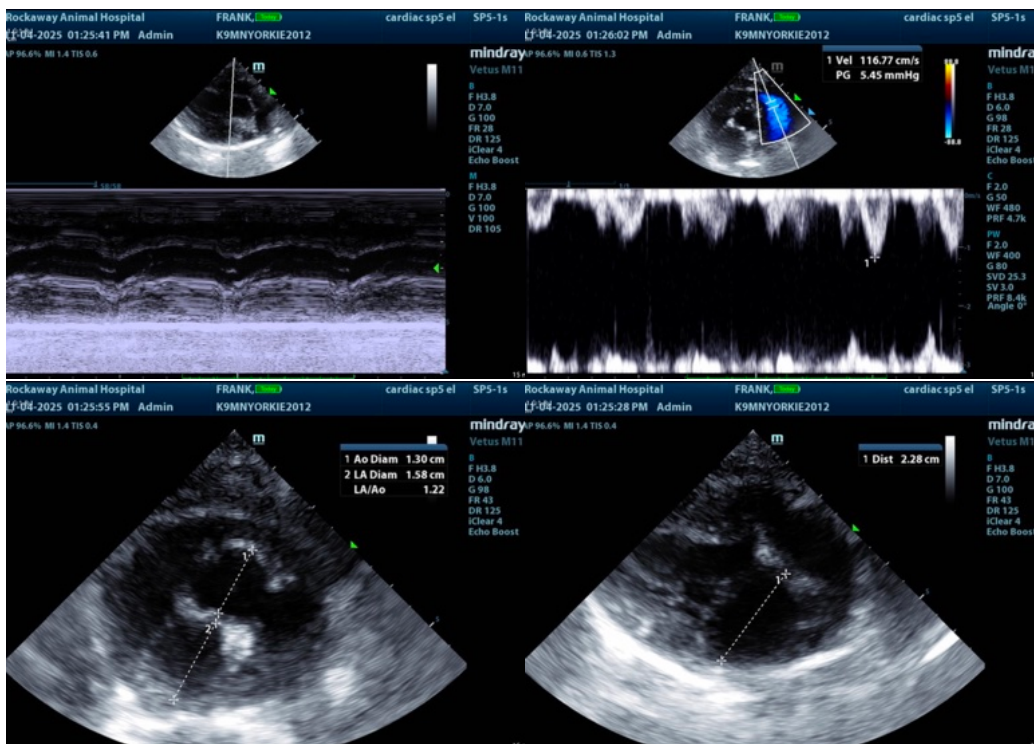
**DATE**

11/4/25

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

EKG or Holter monitor is indicated as paroxysmal arrhythmia may be an underlying issue to cause any clinical signs. Structurally and functionally the heart is unremarkable other than minor stage B1 valvular disease. An abdominal sonogram is recommended if not already performed to assess for primary disease that may be contributing or causing the clinical signs. Blood pressure measurements are also warranted if not already performed.

The heart is stable without clinical disease. No overt contraindication for anesthesia of brief to moderate duration. I suggest Torbutrol premed, Propofol induction, Isoflor 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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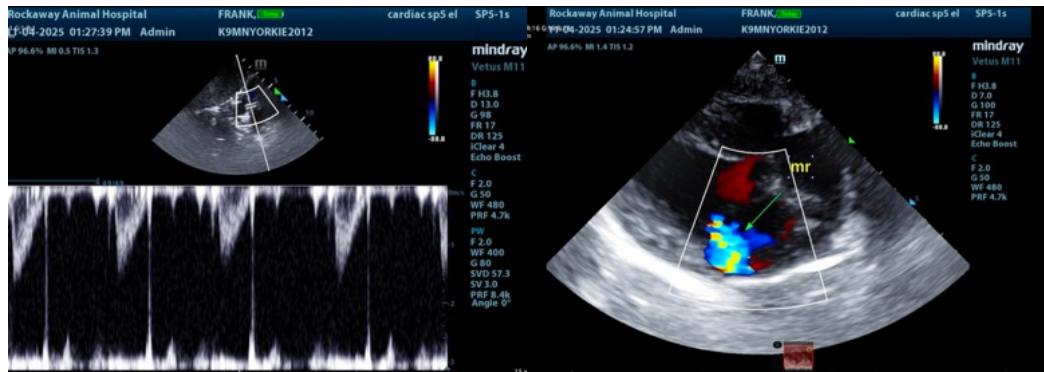
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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](mailto:info@SonoPath.com)