



PATIENT

Rocky McLeod

SPECIES

Canine

BREED

Havanese

SEX

Neutered Male

AGE

10

WEIGHT

7.20

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Judy McFarlen

HOSPITAL NAME

Van Isle VH

REFERRING VET

Dr. Tom Cook

INVOICE

20152

DATE

12/16/22

PRESENTING CLINICAL SIGNS

History: Grade 3/6 holosystolic murmur, LAE on rads, no congestion, on pimobendan 0.17 mg per kg bid Sedated with torbugesic 0.2 mg/kg with midazolam 0.05 mg per kg IM (minimal effect-co-operative but not sleepy. Does not have cushionoid appearance. Reason for scan: pre-anesthesia/part of scanning practice patients-no charge cardiac with single organ abdominal scan due to cost concerns for client.

Abnormal PE/Chem/CBC/UA Results: 4 -5 X elevated liver ALP/ALT (moderate elevations)-GB mucous, no masses or obstructions, adrenals normal size and shape, single organ ultrasound done only. cost concerns. no focal lesions. mild increase in echo-smooth hyper-echoic.

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

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	<1.3	28-40	40-100	<0.6
PATIENT	5.40	--	2.0	2.07	52	85	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	--	--	1.04	--	3.36	3.07	--

Cardiac Presentation

The echocardiogram for this patient presented excessive **left atrial size** expressed both in the LA/AO and LA max measurements. The cranial and caudal **mitral** valve leaflets presented vegetative thickening consistent with endocardiosis. Doppler indicated measurable insufficiency The mitral insufficiency jet was centralized with complete filling of the left atrium. 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. **ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. Mild pulmonic insufficiency was noted at 1.0 m/s. 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.



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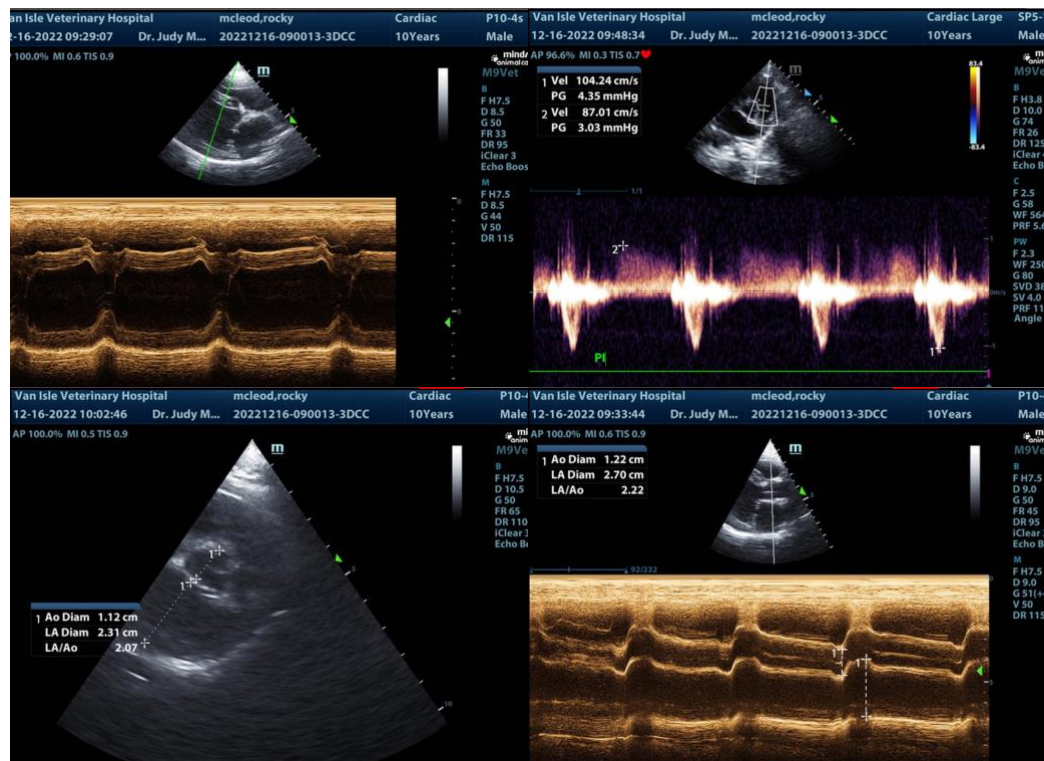
ULTRASONOGRAPHIC FINDINGS

- Mitral insufficiency
- Moderate left atrial enlargement
- Stage B-2 valvular disease

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I recommend initiating with Pimobendan 0.3 mg/kg BID.

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.



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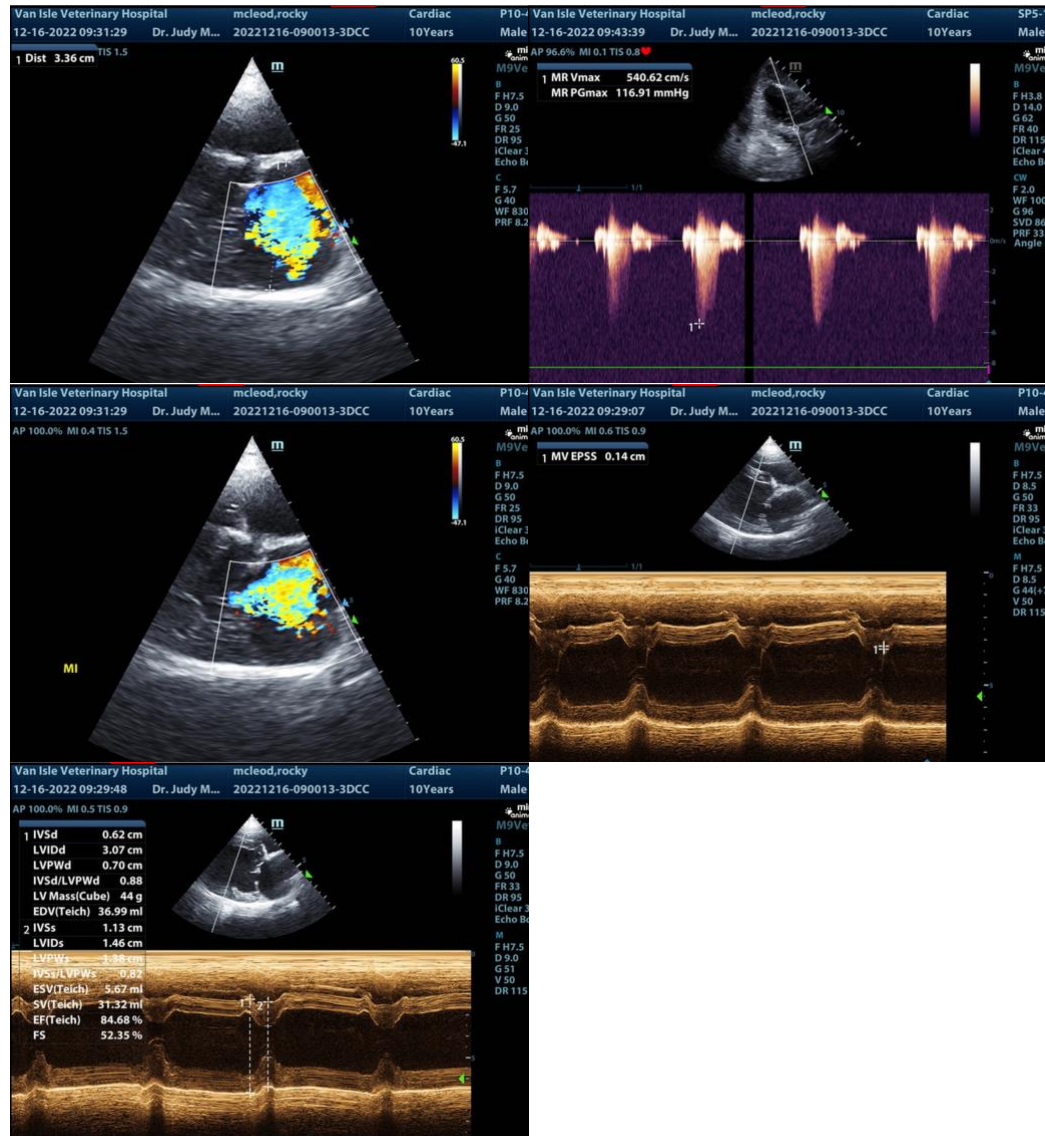
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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