


PATIENT

Star Quinn

SPECIES

Canine

BREED

Beagle Mix

SEX

MN

AGE

12yr

WEIGHT

28.6lb

PRESENTING CLINICAL SIGNS

Follow-up echo, initial echo was performed June 2021 after discovering a grade II/VI murmur during a routine exam and diagnosed with chronic degenerative valve disease causing moderate to mild mitral and tricuspid regurgitation. Screening for progression of disease; anesthetic recommendations.

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	5.87		1.3	1.8	44	77	0.4
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	110	1.41	1.39		4.2	3.55	

Cardiac Presentation

The echocardiogram presented a prominent right heart with mild right ventricular hypertrophy, without significant tricuspid regurgitation, and normal right atrial size. No evidence of neoplasia was noted in the right auricle, or elsewhere in the heart. The pulmonary artery was uniformly prominent with mildly depressed pulmonic velocity measured on PW Doppler. No overt heartworms were noted in the main or visible deep pulmonary arteries. Yet theoretically heartworms could be present in the deep pulmonary vasculature out of visible sonographic range. More likely, however, this prominent right heart is due to excessive intra-thoracic pressures caused by chronic respiratory disease or potentially excessive intra-thoracic fat (Pickwickian syndrome). The left heart demonstrated a linear ventricular septum. Contractility was functionally adequate demonstrated by the FS% measurement. The cranial and caudal mitral valve leaflets presented vegetative thickening consistent with endocardiosis. Doppler indicated measurable insufficiency. No significant left atrial dilation was noted. The left ventricular outflow demonstrated normal flow patterns and velocities through the aortic valve. No evidence of tumor, pericardial or pleural effusion was noted. The visible extra-cardiac tissues were uniformly linear without evidence of masses, infiltrative or inflammatory mediastinal tissue. No evident arrhythmic activity was noted during the exam.

INTERPRETED BY

 Eric Lindquist, DMV
 DABVP, Cert. IVUSS

IMAGING PERFORMED BY
 Dr. Kicker

HOSPITAL NAME

Wauwatosa Vet

REFERRING VET

Dr. Haynes

INVOICE

12534ag

DATE

12/23/2022

ULTRASONOGRAPHIC FINDINGS

- Early stage B2 valvular disease

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The LA was slightly enlarged in this patient with minor prolapse of the anterior mitral valve leaflet was noted. Mitral and tricuspid insufficiency was noted. The hepatic veins were not dilated. The LA/AO



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heart base and LA max measurements are slightly excessive. Given the minor cardiomegaly on radiographs this is early stage B2 valvular disease and considered a mild progression from the prior echocardiogram. Pimobendan 0.3 mg/kg PO BID is recommended. Systemic BP measurements are indicated.

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The heart has some volume overload and 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 3-6 months. Earlier if clinical decompensation is occurring. There is minimal anesthetic contraindication after Pimobendan has been initiated. Torbutrol premed, Propofol induction and Isoflurane maintenance of equivalent is recommended with minimal anesthetic time. Avoidance of excessive excitement upon induction and reanimation is recommended.

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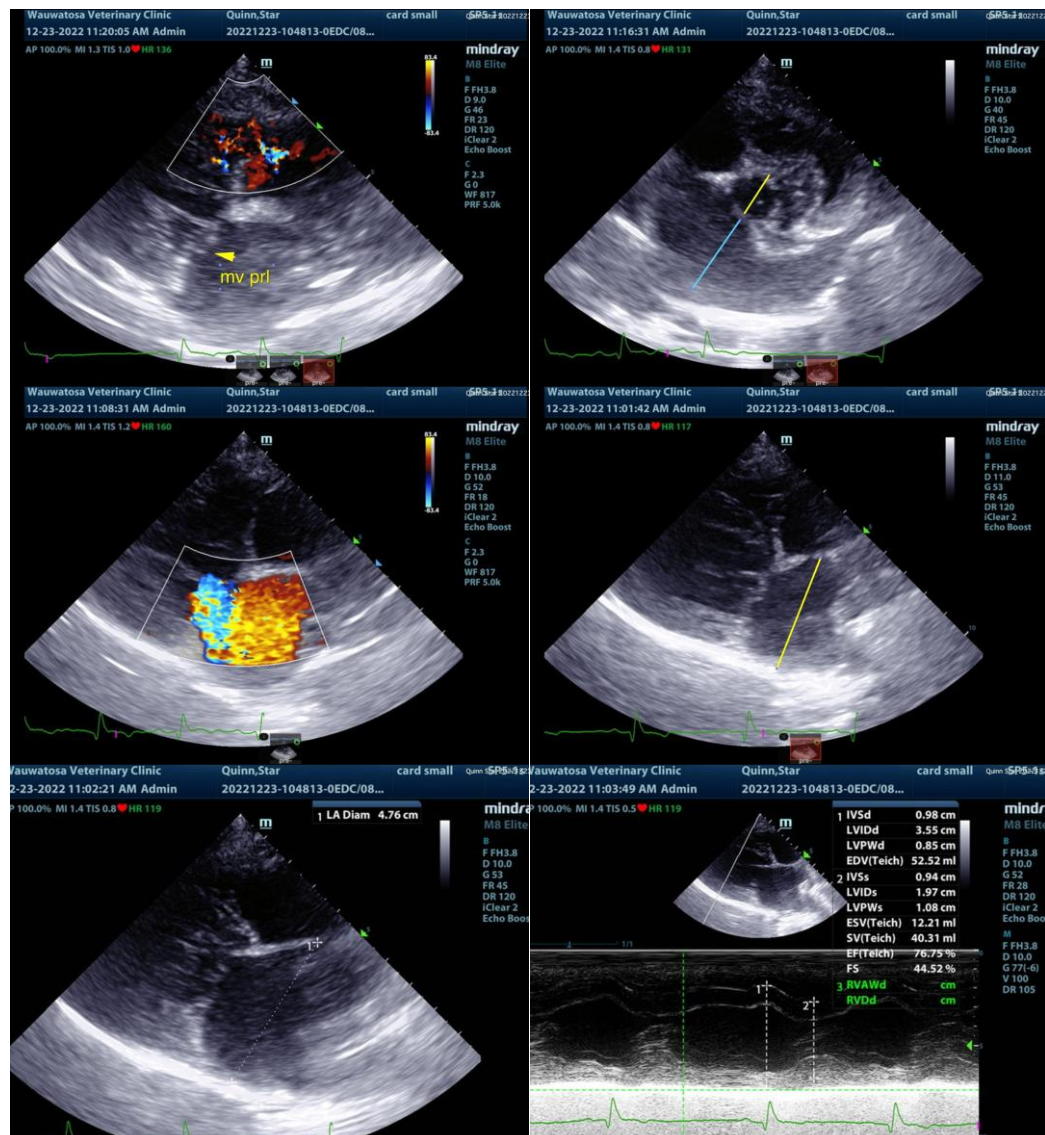
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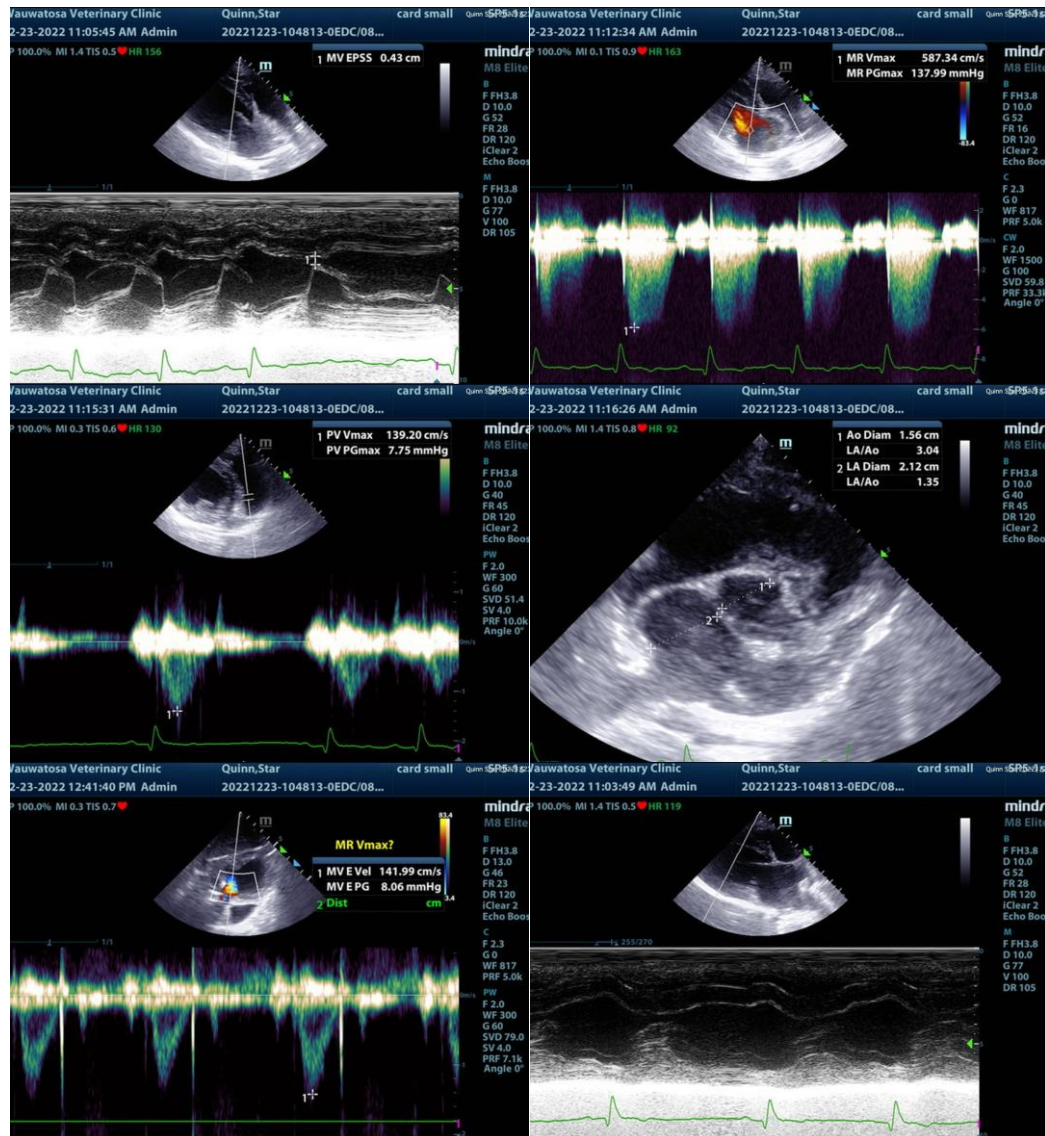
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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Eric.Lindquist@SonoPath.com