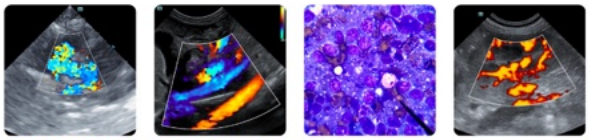

PATIENT

Jackie Powlis

SPECIES

Canine

BREED

Jack Russell Mix

SEX

Spayed female

AGE

14 years

WEIGHT

11.4 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Kylie Tatro

HOSPITAL NAME

Myrtle Avenue VH

REFERRING VET

Dr. Tatro

INVOICE

69564

DATE

12/23/25

PRESENTING CLINICAL SIGNS

History: Heart murmur grade 3/6. O reports persistent cough; O reports pt improved initially on Temaril-P, but cough slowly returns. Currently taking Vetmedin.

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

The echocardiogram in this patient demonstrated enlarged **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. Slight prolapse of the anterior mitral valve leaflet was noted. The **left ventricle** presented normal 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 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 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. Periodic arrhythmia was noted.

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	-	-	1.4	1.7	50	-	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	-	-	11.4 lbs	3.1	2.6	

ULTRASONOGRAPHIC FINDINGS

Presumed mitral insufficiency.

Mild left atrial volume overload, consistent with minor stage B2 valvular disease.

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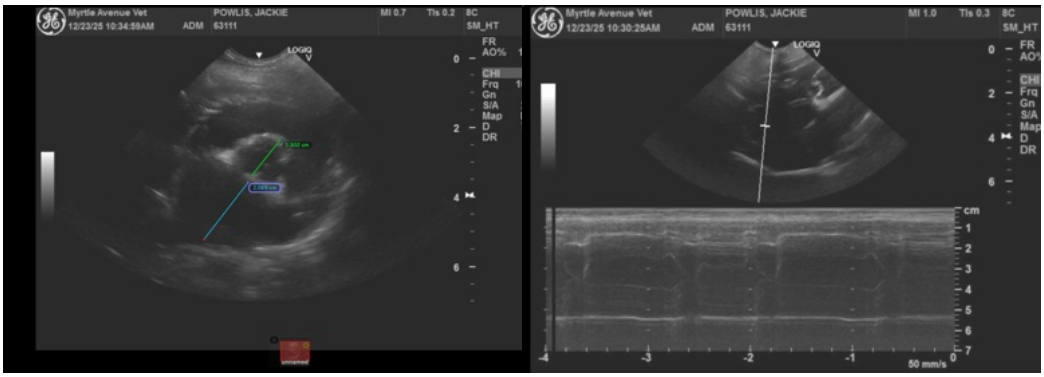
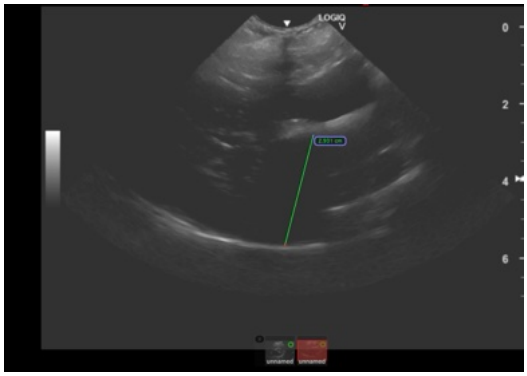
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Adjustment on the medications by adding an ace inhibitor can be considered; however, I do not believe that the cough is primarily cardiogenic at this point. Ace inhibitor +/- Spironolactone can be considered given the persistent mild left atrial enlargement. However, I do not believe that the cough is cardiogenic. Management primarily based on radiographic findings is indicated. Recheck echocardiogram is recommended in 6 months or earlier if clinical signs are indicated.

The heart has minor volume overload and is working to compensate for the valvular insufficiency. Target respiratory rate is < 20 resp/minute after therapy. After initiating or adjusting 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. Minor anesthetic risk for a brief procedure at this time. Repeat preanesthetic echo is ideal if anesthesia is eventually necessary. A suggested anesthetic combination would involve Torbutrol premed, propofol induction, Isoflurane maintenance or equivalent protocol.





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 (CFM), Cert. IVUSS, CEO of SonoPath.com

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