

**PATIENT**

Pal Bonito

**SPECIES**

Canine

**BREED**

Cavalier King Charles  
Spaniel

**SEX**

Neutered Male

**AGE**

12 Years 2 Months

**WEIGHT**

31.2 Pounds

**INTERPRETED BY**

Eric Lindquist, DMV,  
DABVP (Canine &  
Feline), Cert. IVUSS

**IMAGING  
PERFORMED BY**

Dr Jenni Tudini, MRCVS,  
SDEP Cert (Abdo)

**HOSPITAL NAME**

Fetch The Vet MVP

**REFERRING VET**

Dr. Holly Guenther

**INVOICE**

36783

**DATE**

12/6/25

**PRESENTING CLINICAL SIGNS**

History of mitral valve disease. Heart murmur first heard in Jan 2024. Patient diagnosed with MVD and is on pimobendan 5 mg BID. He also gets gabapentin 100 mg SID to BID. This is for his arthritis pain. He developed arthritis at a young age. O's primary care vet (Spring Grove) added in furosemide in August because he was coughing. This proved not to be beneficial and so was discontinued and cough resolved naturally. Last echo was done in April 2025. They recommended a follow up echo in 6 months. Patient appears clinically stable at this time.

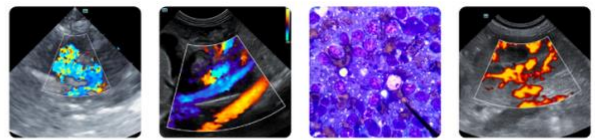
Abnormal PE/Chem/CBC/UA Results: P/e: Cardiovascular Notes: - Grade 4/6 heart murmur - Occasional APC's audible and clear sinus arrhythmia - Strong synchronous pulses Lungs: WNL - CBC - HCT 38.4, reticulocytes 179 - Chem - TP 5.3 (low normal globulin and albumin), ALP 217 - proBNP - 1079 - abnormal - UA - SG 1.025, pH 8.5, trace protein, UPC 0.1, occasional struvite crystals - 4DX - negative - Fecal - negative.

**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	--	2.5	1.5	>2.0	54	85	0.4
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	150	1.50	.90	31.2 lbs	5.1	4.22	--

**Cardiac Presentation**

The **left atrium** and left ventricle presented mild to moderate residual volume overload. Complete filling of the left atrium was noted on color flow assessment. Prolapse of the anterior mitral valve leaflet was noted. Doppler indicated measurable insufficiency. 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 **right atrium** and auricle revealed normal size, structure and content. No evidence of masses was noted or chamber overload. **Tricuspid** insufficiency was noted. The **right ventricle** was of normal size



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(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.

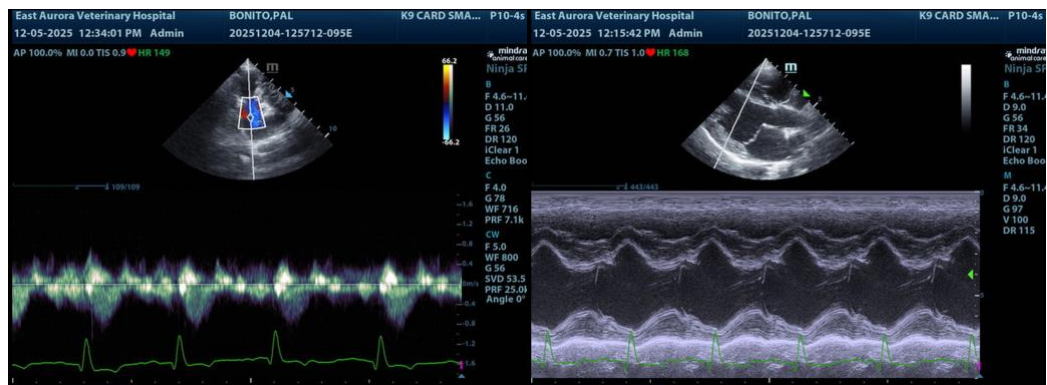
## ULTRASONOGRAPHIC FINDINGS

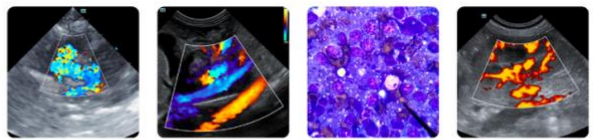
- Stage B-2 – B-2+ valvular disease.
- Mild to moderate volume overload of the left atrium and left ventricle

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the tachycardia and mild to moderate volume overload of the left atrium and left ventricle, recommend proactively introducing ace inhibitor at a dose of 0.5 mg/kg SID, progressing to BID dosing, and spironolactone at a dose of 1-2 mg/kg SID, to the current pimobendan protocol.

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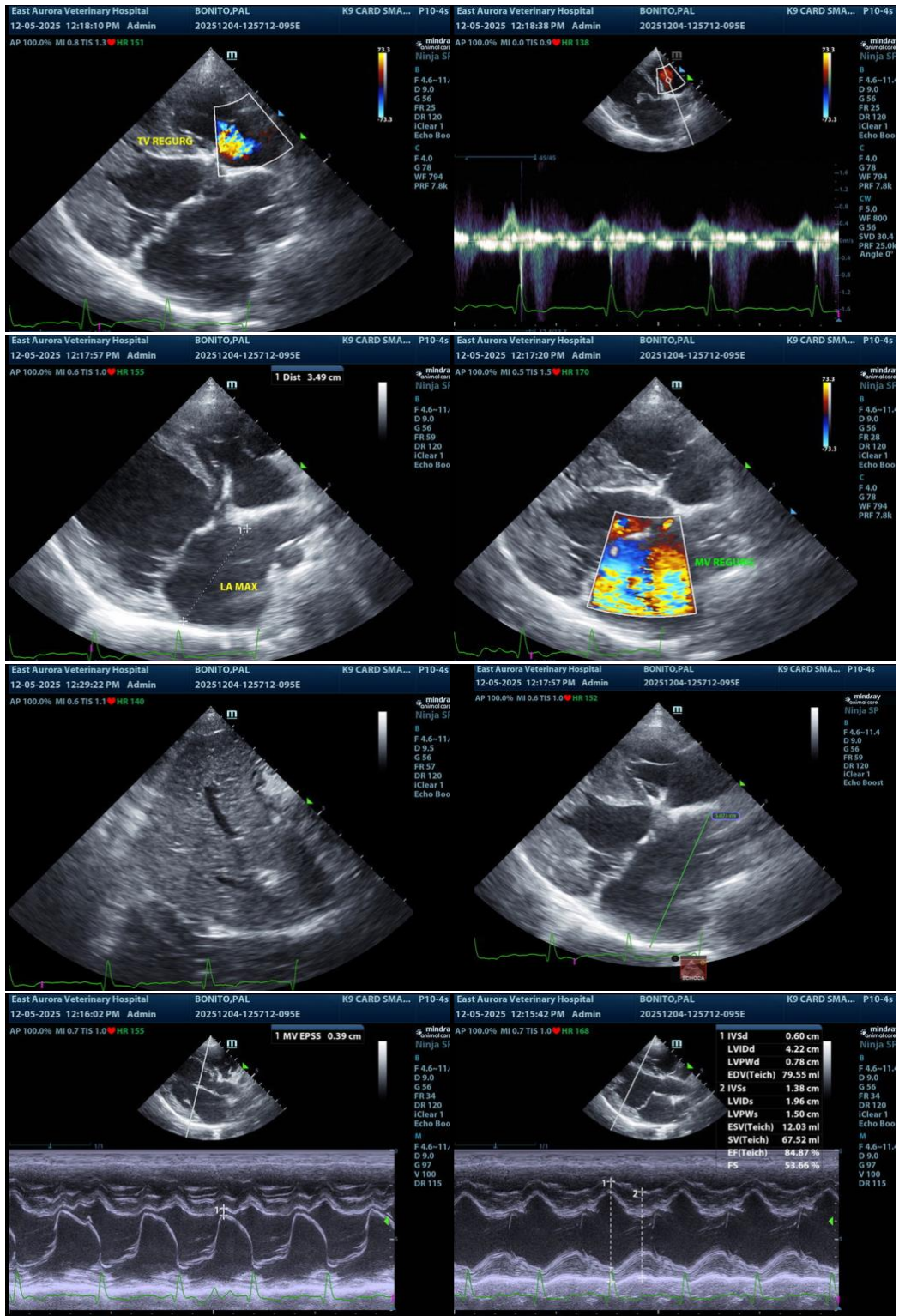
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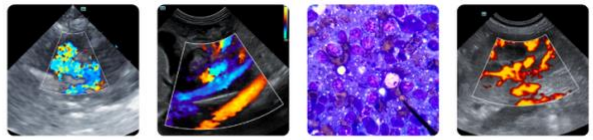
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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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(CFM), Cert. IVUSS,  
CEO, Owner, Founder -- SonoPath.com  
[info@SonoPath.com](mailto:info@SonoPath.com)