



PATIENT

Jenny Bruster

SPECIES

Canine

BREED

Cavalier King Charles
Spaniel

SEX

Spayed Female

AGE

9

WEIGHT

19.2

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Susan Lincoski

HOSPITAL NAME

University Drive VH

REFERRING VET

Dr. Susan Lincoski

INVOICE

35903

DATE

2/20/26

PRESENTING CLINICAL SIGNS

- New murmur grade III/V noted at annual exam, patient needs dentistry.
- Assess anesthesia safety
- Abnormal PE/Chem/CBC/UA Results: Labwork all pending. Grade 3/5 murmur, holosystolic PMI mitral area.

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	>5.0	--	>1.8	~2.0	34	64	0.1
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT	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	1.30	--	--	19.2	3.0	2.63	--

Cardiac Presentation

The echocardiogram for this patient presented excessive **left atrial size** expressed both in the LA/AO and LA max measurements Chamber volumes and echogenicity were normal. The cranial and caudal **mitral** valve leaflets presented vegetative thickening consistent with endocardiosis. Doppler indicated measurable insufficiency. 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.



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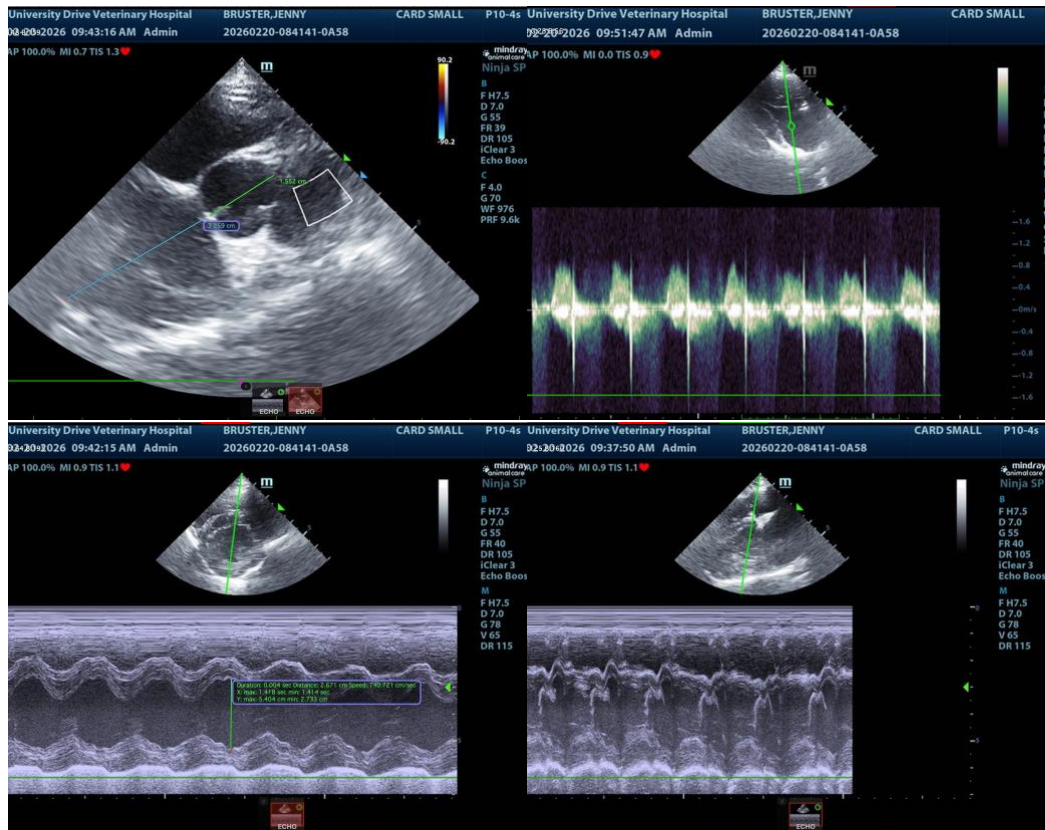
ULTRASONOGRAPHIC FINDINGS

- Stage B-2 valvular disease

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is some anesthetic risk in this patient. Recommend initiating pimobendan at a dose of 0.3 mg/kg BID, ace inhibitor at a dose of 0.5 mg/kg SID, progressing to BID, and spironolactone at a dose of 1-2 mg/kg SID. Recheck echocardiogram after 10 days of therapy and reassessment for potential anesthesia. If anesthesia is absolutely urgent, then torbutrol premed, propofol induction, and isoflurane maintenance is the recommended protocol, however, there is some anesthetic risk. Minimal amount of anesthesia time is recommended.

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 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.





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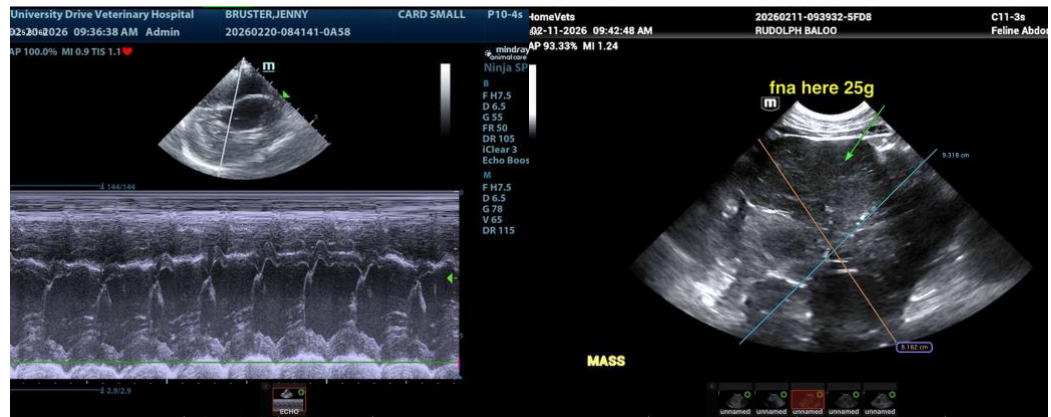
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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,
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