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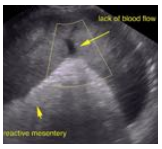
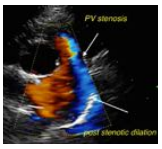
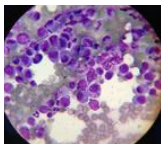
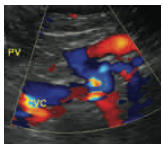

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1-800-838-4268 info@sonopath.com

PATIENT

Tinker Bell Buitt

SPECIES

Canine

BREED

Rat Terrier

SEX

Spayed Female

AGE

10 years

WEIGHT

13.8 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Anderson

HOSPITAL NAME

Elizabeth AH

REFERRING VET

Dr. Anderson

INVOICE

95919

DATE

2/8/22

PRESENTING CLINICAL SIGNS

Long term history of heart murmur. Last week became symptomatic with activity (excess panting). Furosemide started at 12.5mg bid (2mg/kg) and it relieved the symptoms.
Abnormal PE/Chem/CBC/UA Results: PE: 4/6 systolic left > right cardiac ejection murmur. Stage III dental disease. Multiple cutaneous and subcutaneous masses. Advanced sclerosis. Left medical patella luxation. UA: SG 1.009, pH 8.0, quiet sediment CBC: Lym 0.737 K/uL CHEM: Good BNP: 2,396 pmol/L Total T4, Free T4, Fecal, Heartworm 4Dx all good.

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

The echocardiogram in this patient demonstrated normal **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. Prolapse of the anterior mitral valve leaflet was noted. 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. Minor **tricuspid** insufficiency was noted and measured 2.53 m/sec. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. **Pulmonic** velocity was slightly elevated at 2.43 m/sec. 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.

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	<1.6	28-40	40-100	<0.6
PATIENT	5.66	2.53	1.3	1.34	41	74	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				
PATIENT		1.63		13.8 lbs	3.03 ,ax	2.97	

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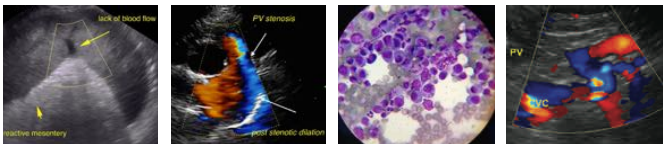

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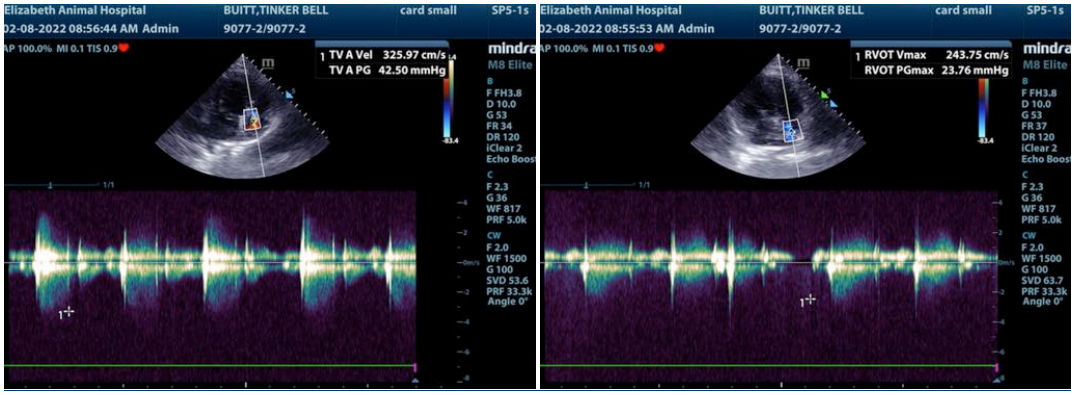
ULTRASONOGRAPHIC FINDINGS

Stage B1 valvular disease.

Mitral and tricuspid insufficiency with mitral valve prolapse, compensated. No volume overload was noted at this time.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

B1: The heart is stable without clinical disease. No overt contraindication for anesthesia of brief to moderate duration. I suggest Torbutrol premed, Propofol induction, Isoflurane maintenance or similar protocol if anesthesia is desired. Blood pressure recommended if not already performed and target white coat negative systolic pressure of < 160 mmHg. If higher than this ACE-inhibitor is suggested to reach this level. Recheck echocardiogram is recommended in 6 months, earlier if murmur grade increases or clinical signs initiate.



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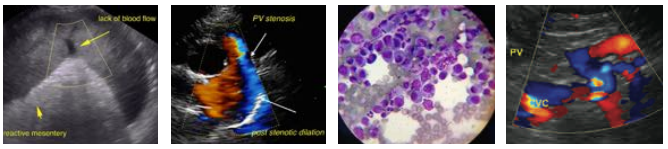

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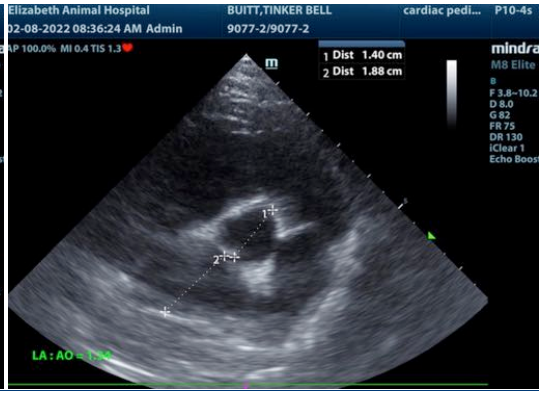

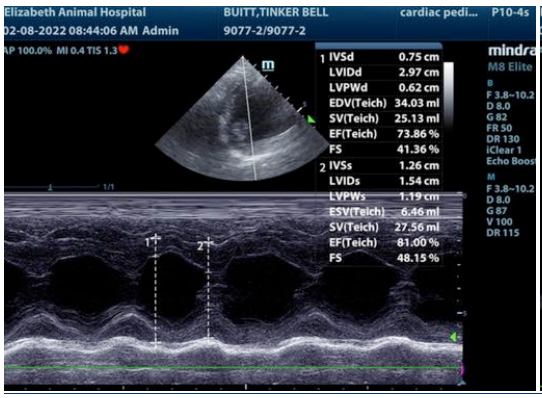

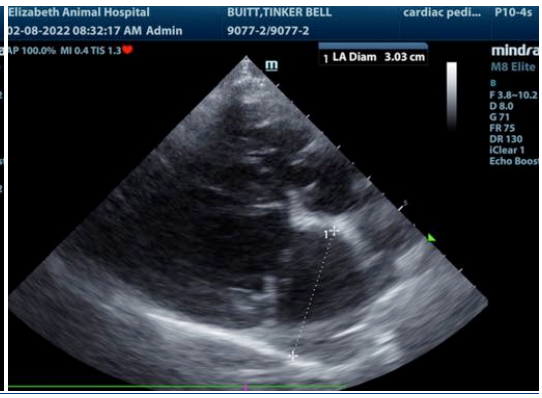

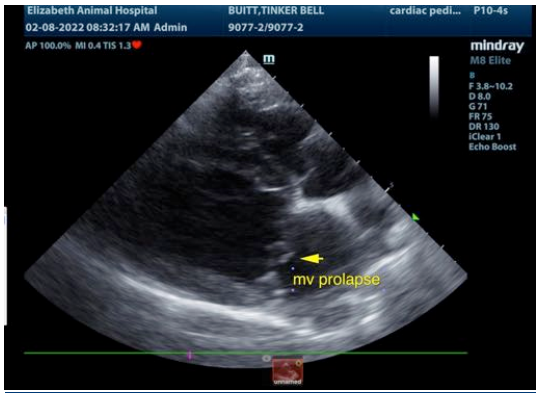

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, Cert. IVUSS, CEO of SonoPath.com
info@SonoPath.com