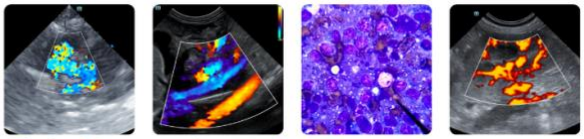

PATIENT

Penny Jolie

SPECIES

Canine

BREED

Cavalier King Charles Spaniel

SEX

Spayed Female

AGE

12 Years

WEIGHT

15.2 pounds

INTERPRETED BY

Eric Lindquist, DMV, DABVP(CFM), Cert. IVUSS

IMAGING PERFORMED BY

Dr. Megan Bray

HOSPITAL NAME

Taylorsville Veterinary Clinic

REFERRING VET

Dr. Ashleigh Bisset

INVOICE

15170

DATE

04/16/26

PRESENTING CLINICAL SIGNS

February of 2024 a 1/6 HM was auscultated. March of 2025 a 2/6 HM was auscultated. March of 2026 a 5/6 HM was auscultated. Owner reports that Penny has an intermittent cough that occurs in periods but is not a daily event and is non-productive.

Abnormal PE/Chem/CBC/UA Results: GRADE 5/6 SYSTOLIC HEART MURMUR NOTED, LOUDEST ON LEFT AND RIGHT APEX AND STERNUM. PALPABLE PRECORDIAL THRILL. Femoral pulses strong and synchronous. -Penny's blood work was generally positive, with normal thyroid, glucose, kidney, and liver values, as well as healthy red and white blood cell counts. However, platelet clumping was observed, likely due to sample handling. The urinalysis revealed fine granular casts, which could indicate early kidney disease, although all other kidney values appeared normal.

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	5.8	3.8	1.3	1.0	--	--	0.1
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	167	1.7	--	15.2	2.1	2.3	--

Cardiac Presentation

The **echocardiogram** presented a prominent **right heart** with mild **right ventricular** hypertrophy. T**ricuspid** regurgitation was evident and moderate with relatively contained **right atrial** size. No evidence of neoplasia was noted in the right auricle, or elsewhere in the heart. The **pulmonary artery** was uniformly prominent. 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 respiratory disease or other causes of increased thoracic vascular pressure. The **left heart** demonstrated a linear **ventricular septum**. Contractility was functionally adequate demonstrated by the FS% measurement. The **mitral valve** revealed mild moderate eccentric insufficiency, and no significant **left atrial** dilation was evident. 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. Hepatic veins were not dilated. Minor flattening of the left ventricular septum was noted.

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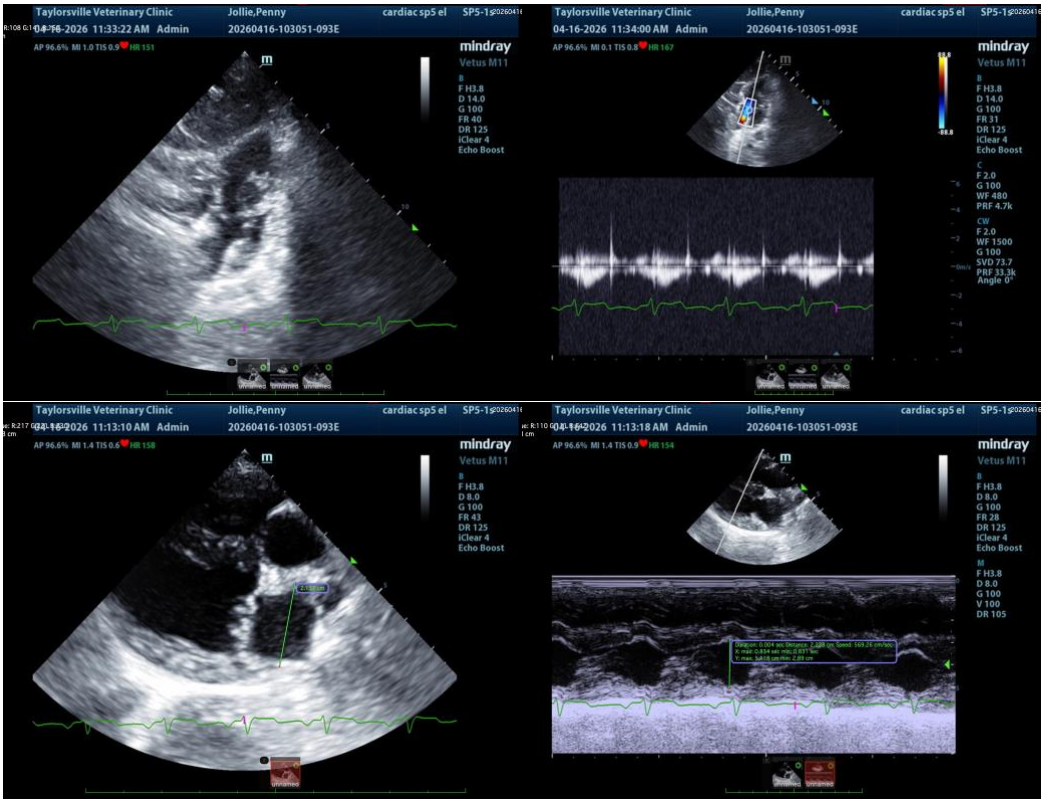
ULTRASONOGRAPHIC FINDINGS

- Mitral and tricuspid regurgitation with moderate pulmonary hypertension.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The heart is stable without clinical disease. No overt contraindication for anesthesia of brief to moderate duration. I suggest Torbutrol premed, Propofol induction, Isoflo maintenance or similar protocol if anesthesia is desired. Blood pressure, EKG and chest radiographs are recommended if not already performed. 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 6-12 months, earlier if murmur grade increases or clinical signs initiate.

No evidence of right-sided failure at this point. Monitoring blood pressures and chest radiographs are warranted if not already performed to assess for pulmonary disease which may be influencing the right-sided pressures. No treatment at this time. Unless exercise intolerance is an issue, then a sildenafil trial could be considered at 1.0 mg/kg BID, however, without any clinical signs, I do not recommend initiating treatment for pulmonary hypertension, given that hepatic veins are not dilated.



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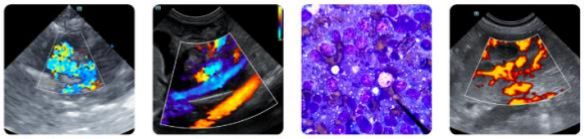

Clinical Sonography & Telecytology
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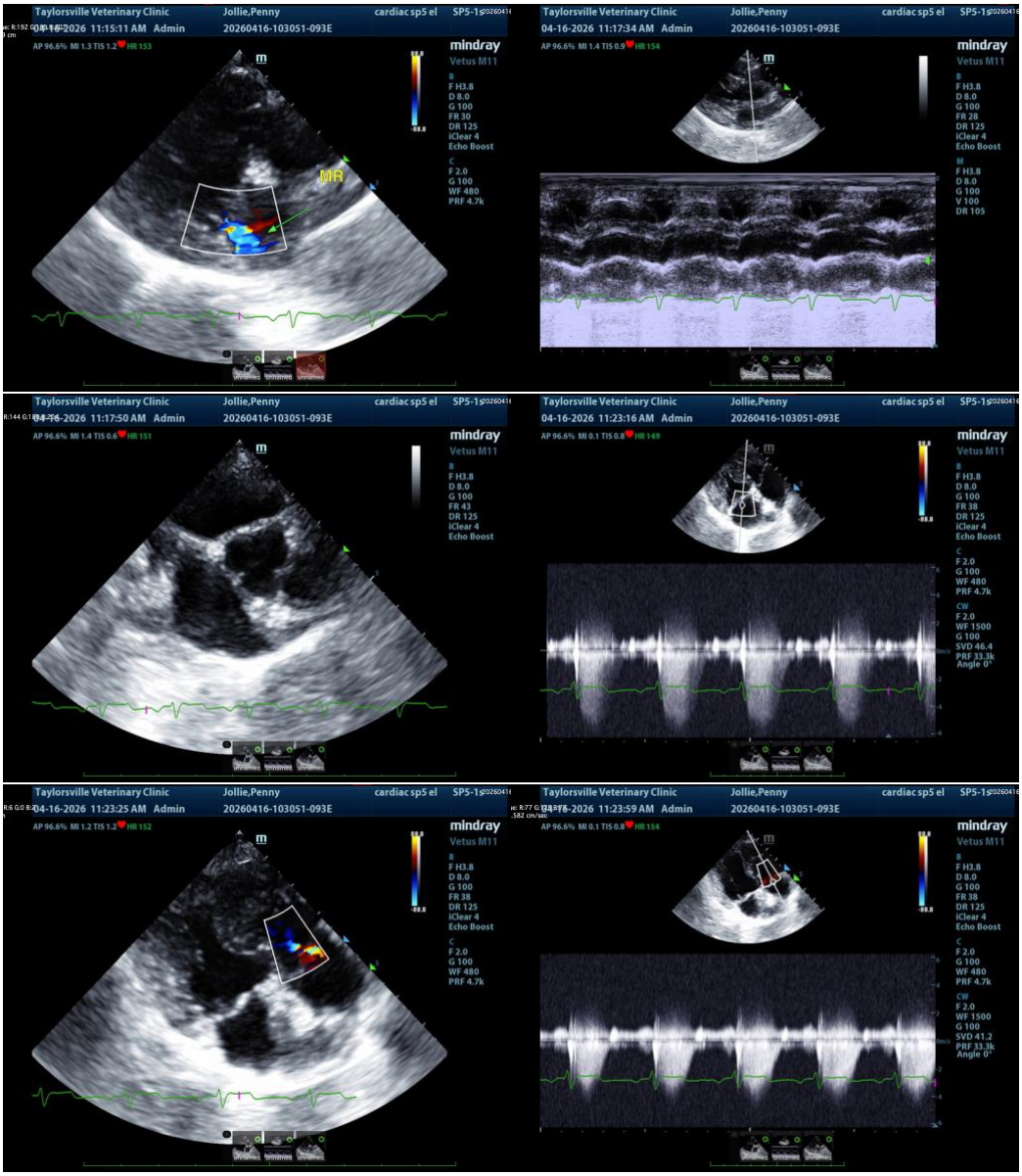

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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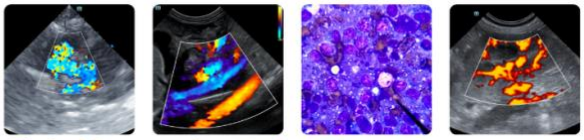

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