



PATIENT

Justice Feeney

SPECIES

Canine

BREED

maltese

SEX

Neutered Male

AGE

15 Years

WEIGHT

8 Pounds

INTERPRETED BY

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

IMAGING

PERFORMED BY

Dr. Kylie Tatro

HOSPITAL NAME

Myrtle Avenue VH

REFERRING VET

Dr. Kylie Tatro

INVOICE

36820

DATE

4/24/26

PRESENTING CLINICAL SIGNS

History: Heart murmur present; holosystolic; grade 3-4/6; tachycardic. Increased RR, owner reports SRR= 28 recently. Expiratory push a subtle dyspnea; no crackles heard. Concern for progression to stage B2 to C MVI.

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	>3.0	69	95	0.1
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT (8 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	80	--	--	8	4.2	--	--

Cardiac Presentation

The echocardiogram in this patient demonstrated normal **left atrial** size based on 3 different LA measurement methods. Chamber volumes and echogenicity were normal. 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. **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. Periodic arrhythmia was noted.



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ULTRASONOGRAPHIC FINDINGS

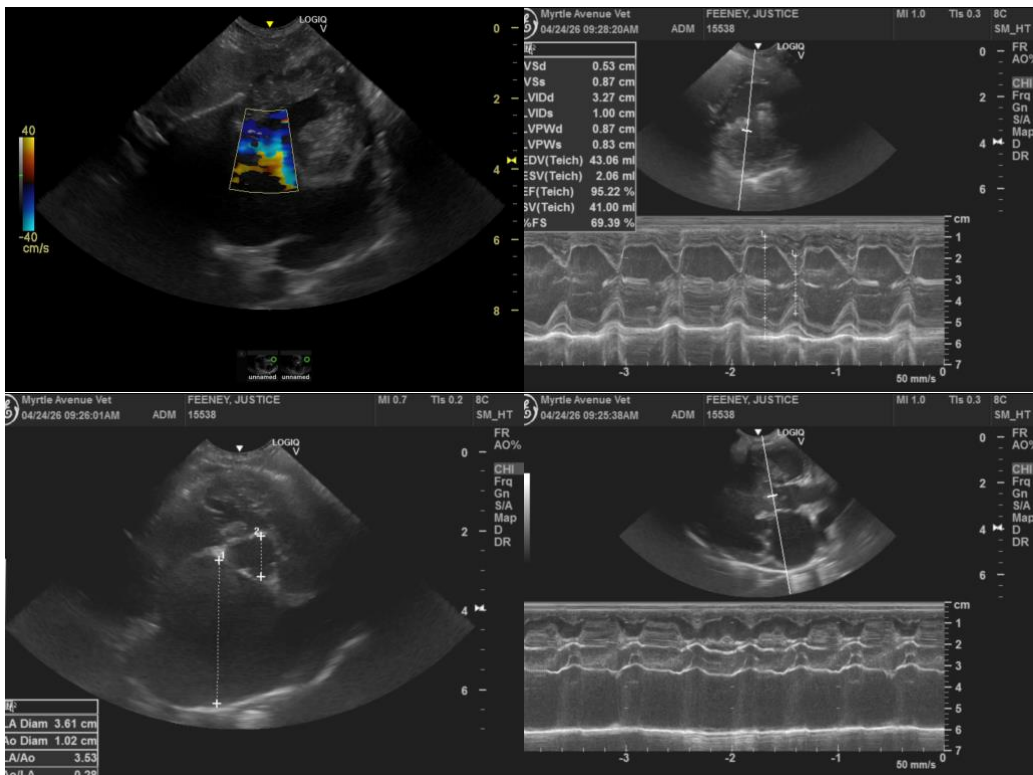
- Stage B-2+ - C1 valvular disease

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the severe prolapse and volume overload to the left atrium and the clinical signs, recommend treating this patient as emerging left side heart failure. Recommend pimobendan at a dose of 0.3 mg/kg BID, ACE inhibitor at a dose of 0.5 mg/kg SID, progressing to BID, spironolactone at a dose of 1-2 mg/kg SID, and Lasix at a dose of 1-2 mg/kg BID.

Recheck echocardiogram in 1 month, earlier if clinical signs are not abating. BUN, creatinine, blood pressure, basal respiratory rate, and radiographs all should be monitored.

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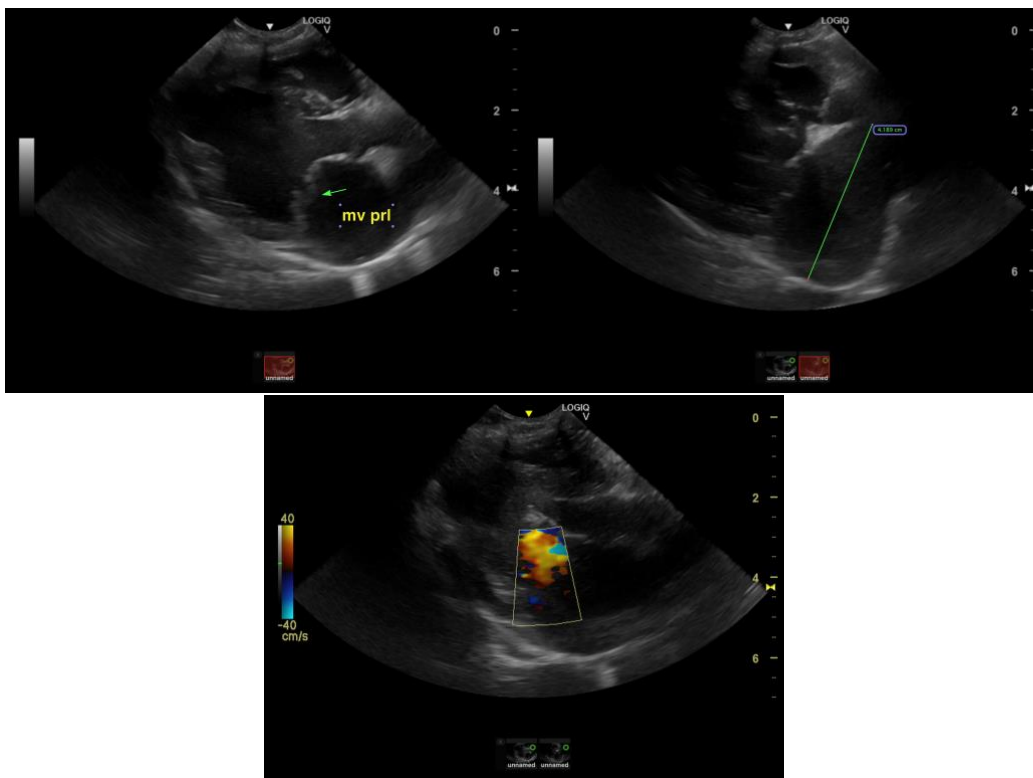
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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