



PATIENT

Kip Shipman

SPECIES

Canine

BREED

Terrier Mix

SEX

Neutered male

AGE

9 years

WEIGHT

63.9 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge AH

REFERRING VET

Dr. Carpenter

INVOICE

74321

DATE

4/8/26

PRESENTING CLINICAL SIGNS

History: Sedated with Butorphanol. Would not allow lead placement. Grade III L and R systolic murmur - first heard in 2020. No changes. Patient remains aclinical. Patient has had echo monitoring (traveling cardiologist) since 2020 q 6 months with minimal changes.

- Chronic meds: Pimobendan 7.5 mg PO BID

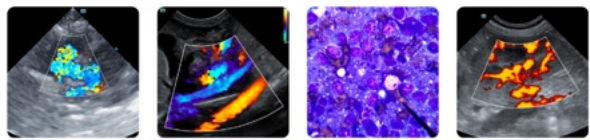
- Previous echo 4/2025 - results attached for comparison

ECHO: The LA is normal (LA 3.21 Ao 2.35, LA:Ao = 1.36:1) and stable. The mitral valve is normal with mitral insufficiency (MR < 3.8-4.0 m/s). The LV end diastolic internal dimension is normal for weight with normal LV contractility (LVID 4.12/2.77 FS 32-33% EF 61-62% IVS 1.24 LVP 1.07 RV .55). There is mild aortic valve calcification with normal aortic flow velocities (LVOT 2.34-2.51 m/s). There is tricuspid insufficiency (TR 2.20 m/s) with normal pulmonary pressures. There is a tiny patent foramen ovale with no shunting noted today.

ASSESSMENT: Mitral and tricuspid valve disease, stage B1. The LA and LV are normal, with no progression. Aortic flow velocities are elevated, but not problematic. There is a tiny ASD (patent foramen ovale). The overall LV contractility is normal. Continue the Pimobendan at 7.5 mg BID

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. Doppler indicated trivial 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 1.5 m/sec. 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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CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO	LA/AO (Heart Base)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	<1.6	28-40	40-100	<0.6
PATIENT	-	2.6	1.3	1.5	42	73	0.1
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT (kg)	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	BELOW	BELOW	BELOW	BELOW
PATIENT	-	2.9	1.38	63.9	3.3	4.5	

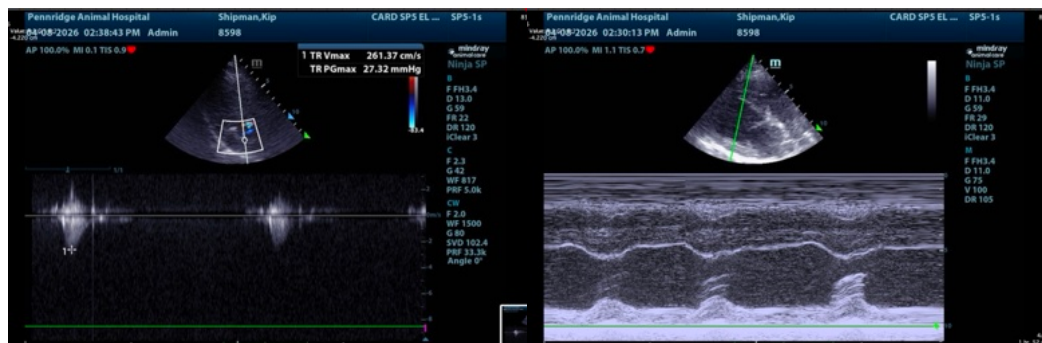
ULTRASONOGRAPHIC FINDINGS

Normal echocardiogram with mildly increased LVOT.

The mitral valve in this patient revealed trivial mitral insufficiency.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This is consistent with a very minor form of stage B1 valvular disease with mild idiopathic increased LVOT velocity. The amount of regurgitant flow in the mitral valve is unlikely to be causing any significant issue in this patient. I do not see any evidence of volume overload and I do not see a need for Pimobendan at this time. The Pimobendan may be secondarily causing increased LVOT velocity. I recommend ideally stopping Pimobendan for 2-4 weeks with a recheck echocardiogram to see if it is necessary at this time. At time temporary volume overload can occur for various reasons that may have indicated Pimobendan in this past; however, I do not see a direct need at this point. This is consistent with minor valvular insufficiency with increased LVOT velocity of unknown cause.





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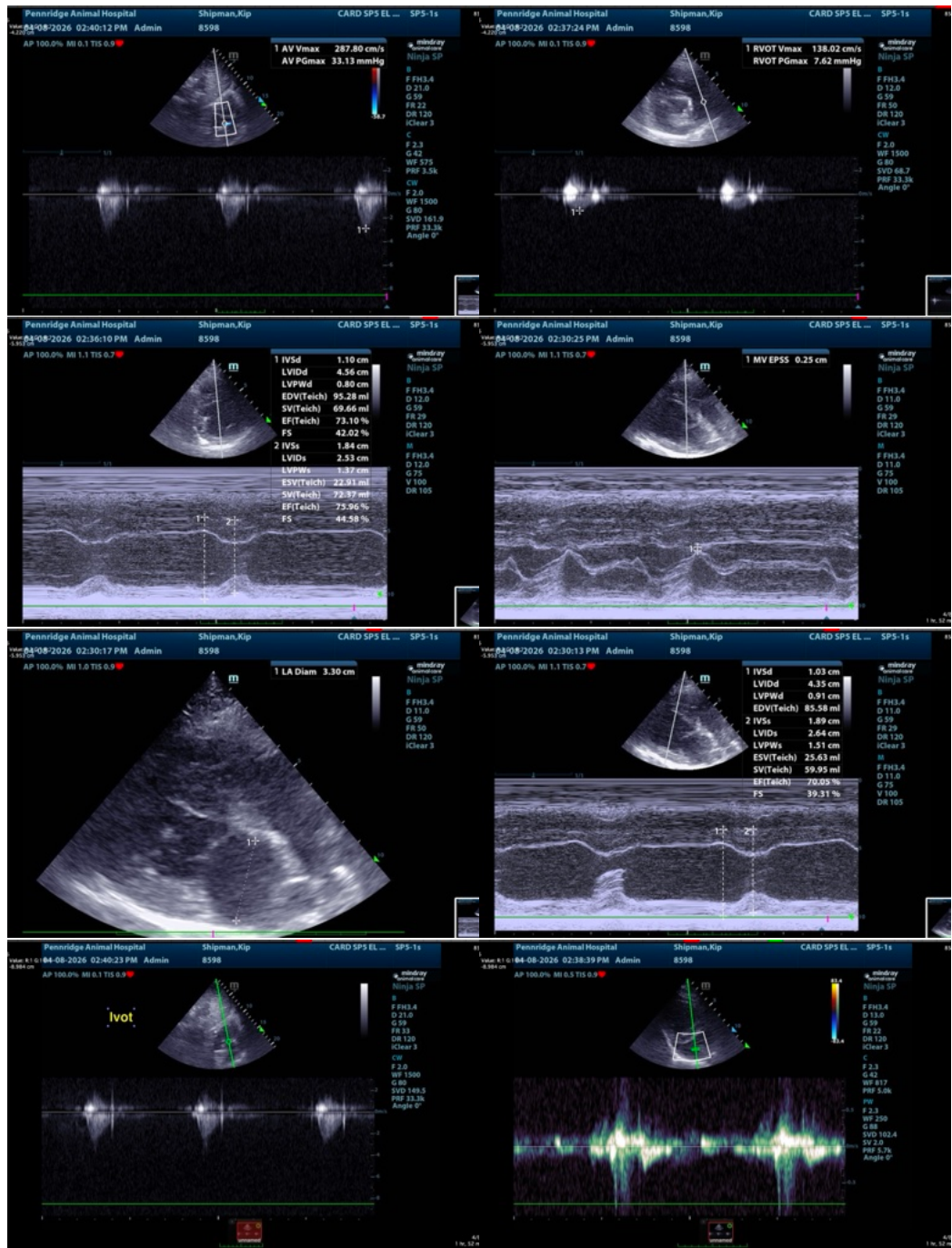
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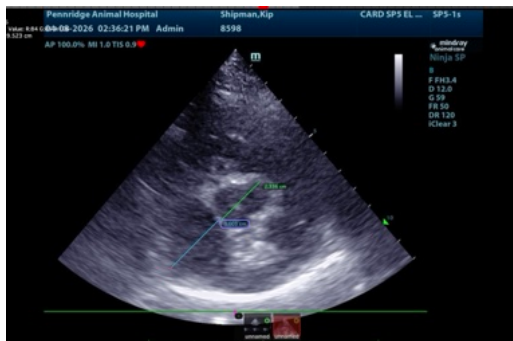
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 of SonoPath.com

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