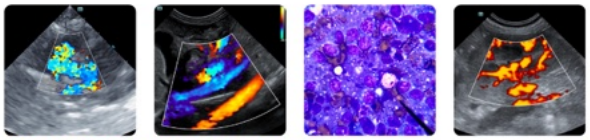

PATIENT

Diva Jenkins

SPECIES

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BREED

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SEX

Spayed female

AGE

9 years

WEIGHT

6.2 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

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HOSPITAL NAME

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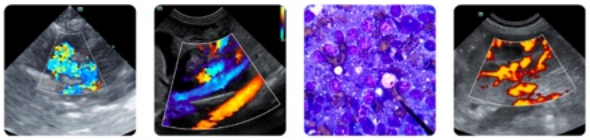
PRESENTING CLINICAL SIGNS

History: • 4-7-2026 presented for coughing frequently when excited or going outside. On Vetmedin 1.25mg 1/2 tab BID - Rx 2/2025 by cardiologist. Started Hydrocodone on 4/6 and is helping cough.Rx Lasix, but has not started yet.
Previous history:
• 6/2024 - Echo KE/SB - B1 MVD, at least mild PH, and mass cranial to LA. RDVM discussed CT, financial constraints for pursuing.
• 2/2025 - Echo and CXR w/MVMC Cardiology - B2 MVD, mild PH, no overt mass visible on echo. Rx Pimobendan
• 7/2025 - Echo KE/SB - Stable B2 MVD, irregular tissue cranial to LA.
PE: Grade 3/6 systolic murmur, mm pink, BAR. BCS 8/9. CXR – main stem bronchus elevation owing to cardiomegaly, vascular volumes appear normal. Prominent right heart. Possible small amt pulmonary edema.

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 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 pulmonary artery was slightly dilated. The **right ventricle** was slightly dilated with mild eccentric hypertrophy. Mild to moderate **tricuspid** insufficiency was noted. At the bifurcation of the pulmonary artery and base of the left atrium a 1.8 cm isoechoic to slightly hypoechoic nodule or mass was noted. This was superimposing the left atrium causing the appearance of left atrial enlargement on radiographs. However, this is a tissue density. The left atrial volume is completely normal. The hepatic veins were not dilated.



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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	5.63	3.4	1.3	1.4	39	73	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	BELOW	BELOW	BELOW	BELOW
PATIENT	135	-	1.15	6.2 lbs	1.9 max	1.86	

ULTRASONOGRAPHIC FINDINGS

Cardiac presentation is most consistent with stage B1 valvular disease with an expansive, isoechoic tissue mass. Potential ectopic thyroid carcinoma.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I realize there are prior echocardiograms on this patient; however, this lesion is very isoechoic to the surrounding tissue and blends in with fat and air artifact. Often these types of lesions need to grow into the acoustic window to be distinctly visible. The cranial mediastinum revealed fat density and no overt pathology.

The right heart is likely slightly enlarged owing to increased pulmonary pressures owing to the heart base lesion. Tissue densities in this region are not typically hemangiosarcoma. Connective tissue or stromal tumor is likely. These are typically slow growing, but can be expansive and cause deviation of the main stem bronchus. Chest CT would be ideal as it may extend further then the acoustic window from a sonographic standpoint. Serial blood pressure measurements and EKG are indicated if not already performed. No specific cardiac medications are recommended as this is a physical tissue impingement upon the main stem bronchus and not a volume overload issue.

T4 assessment is warranted if not already performed. Mesenchymal tumor, chemodectoma are differentials and less likely hemangiosarcoma.

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 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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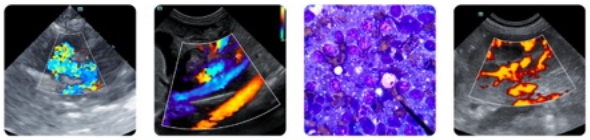

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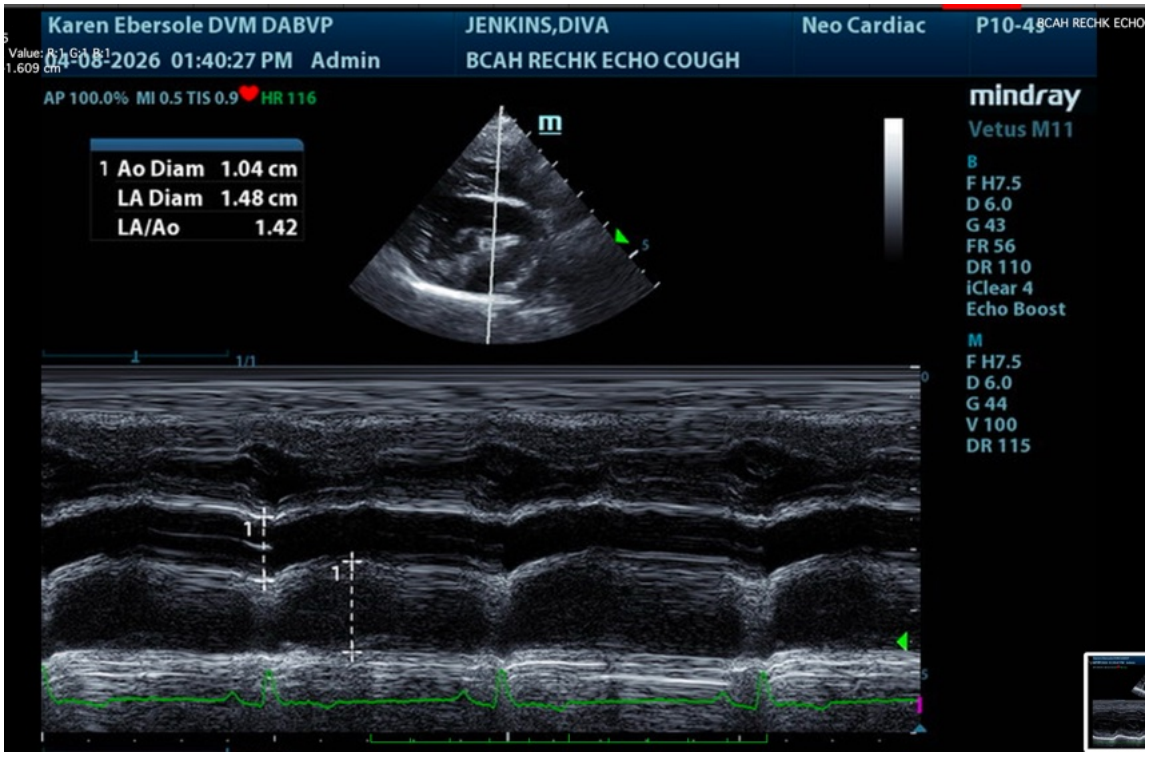

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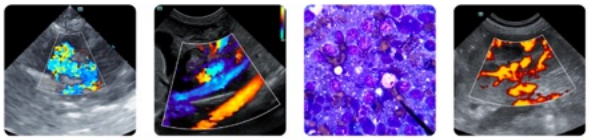

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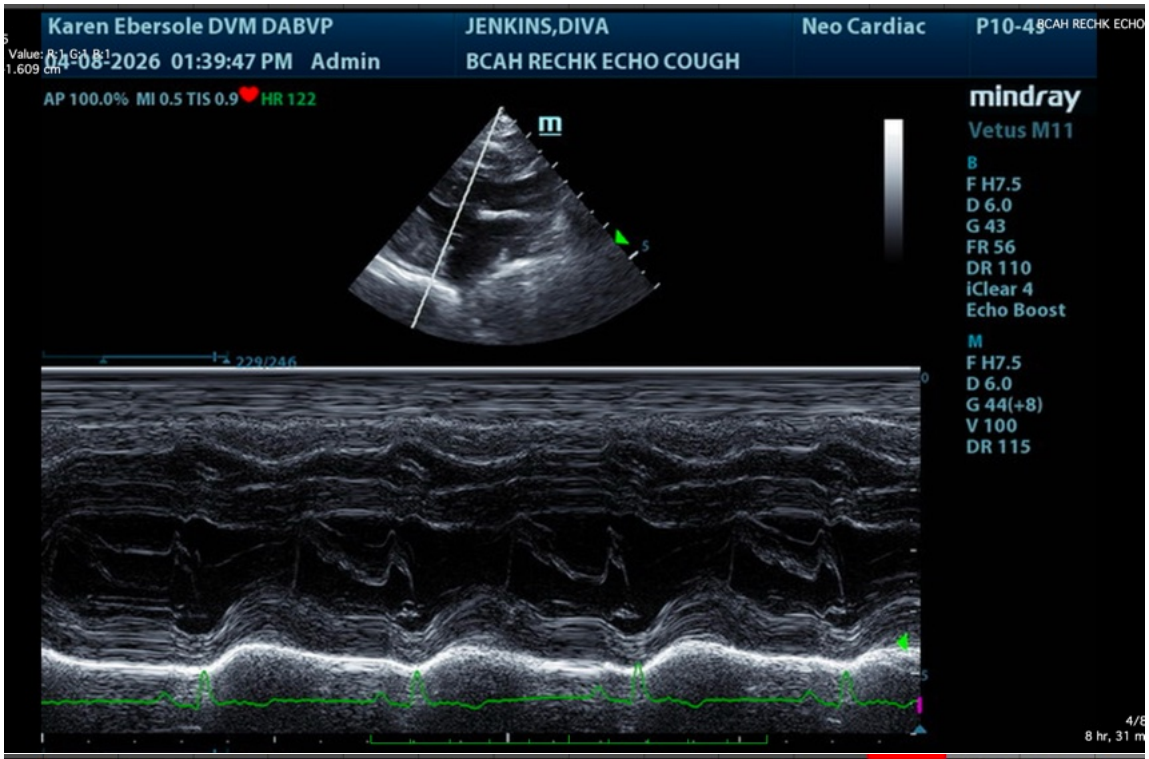

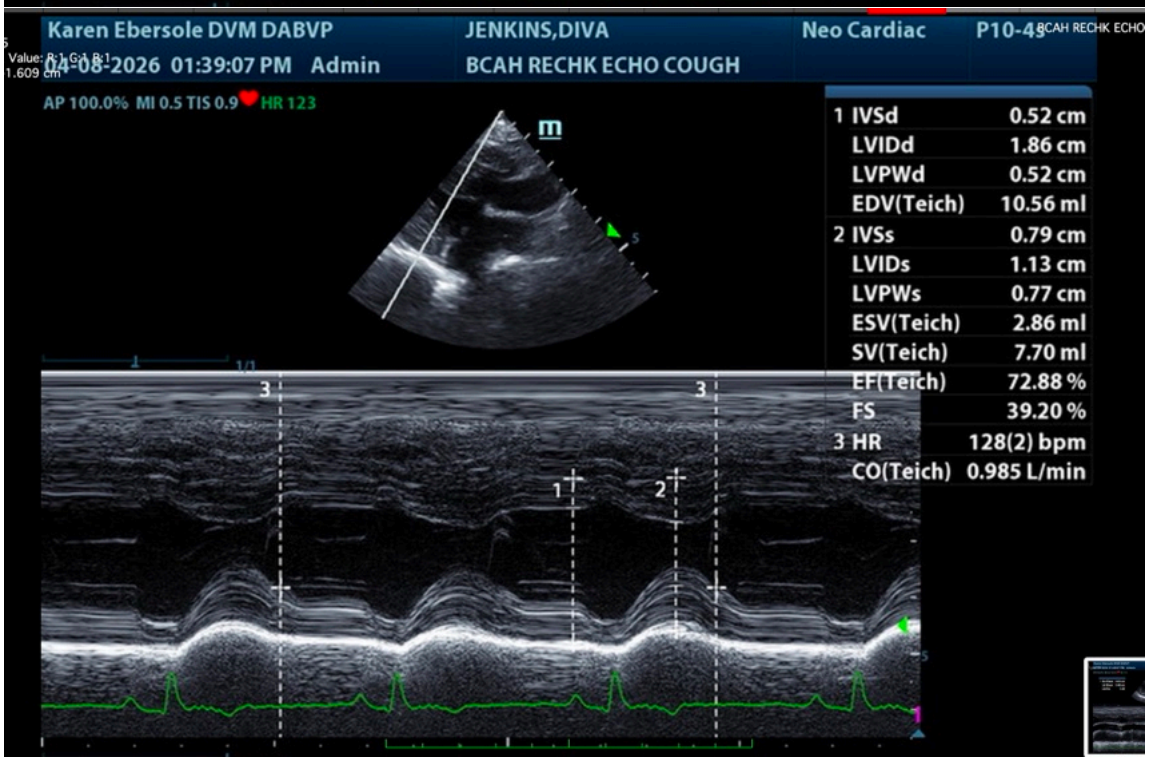

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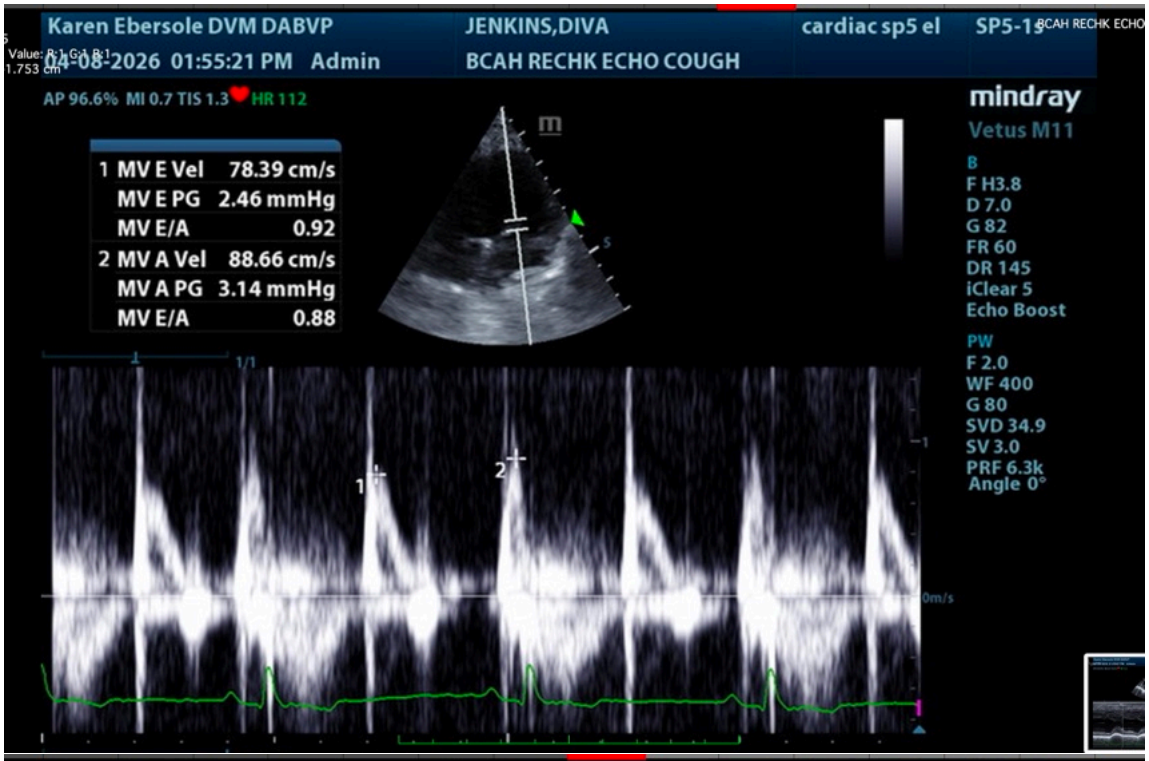

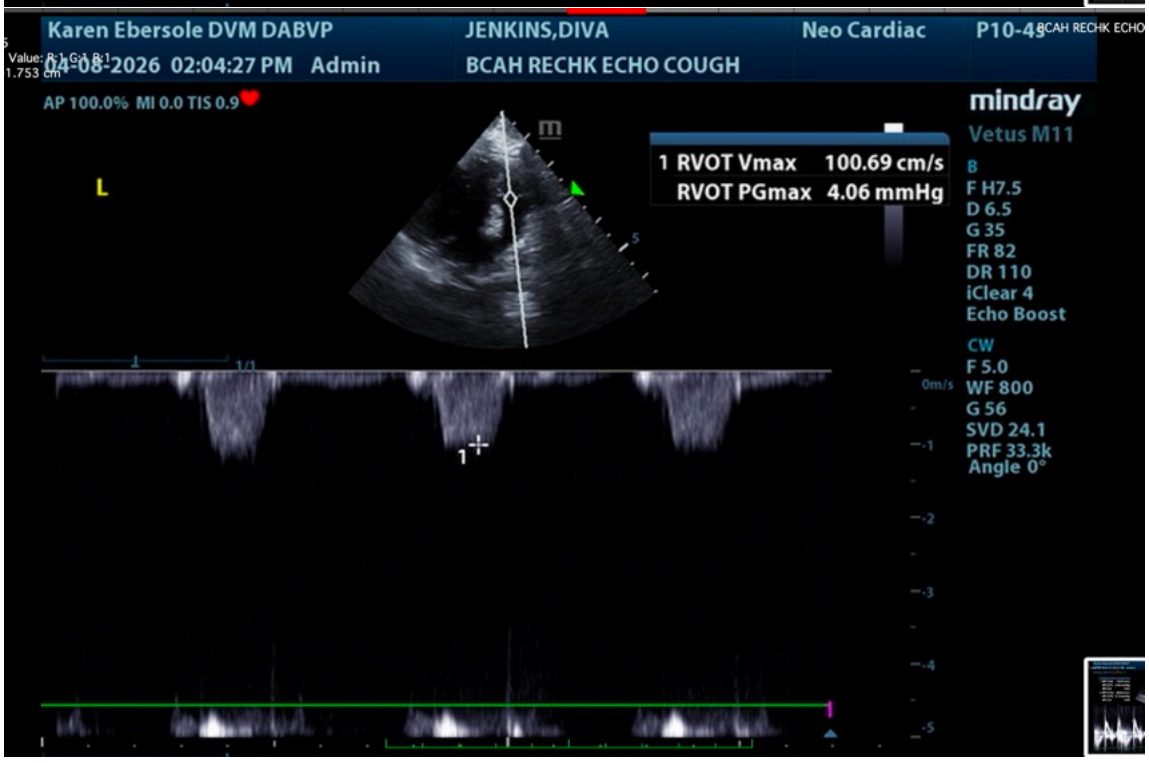

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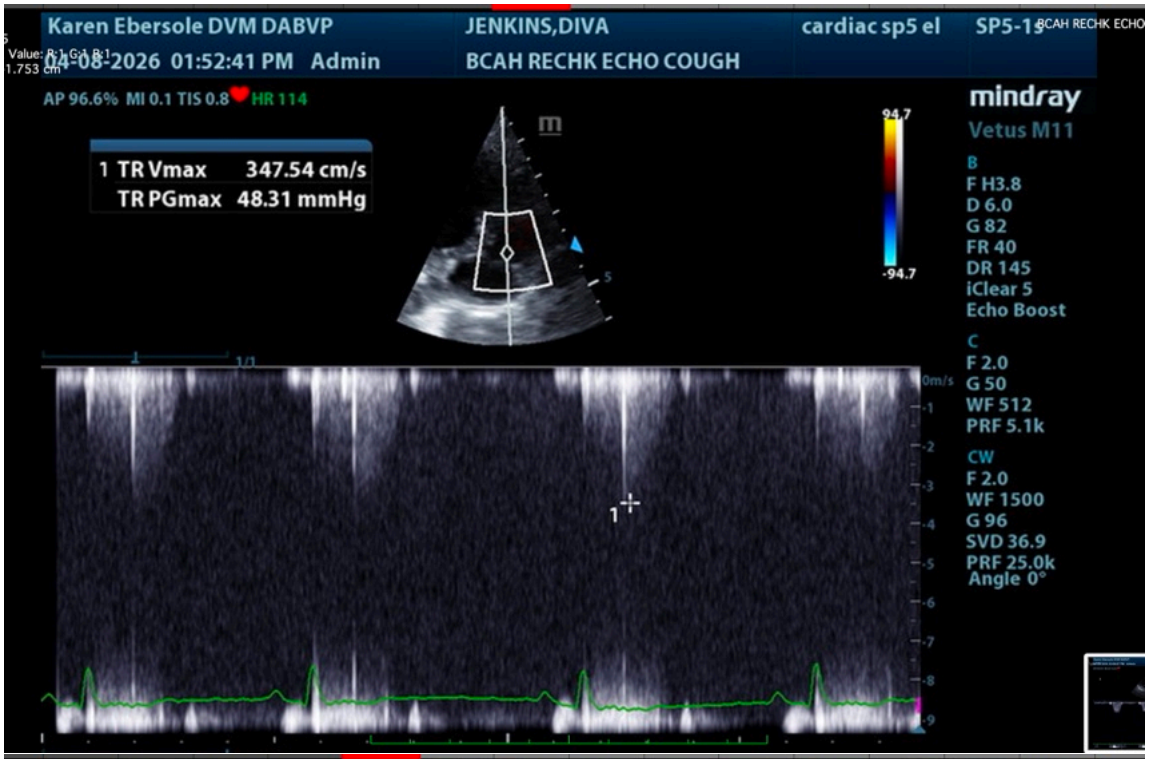

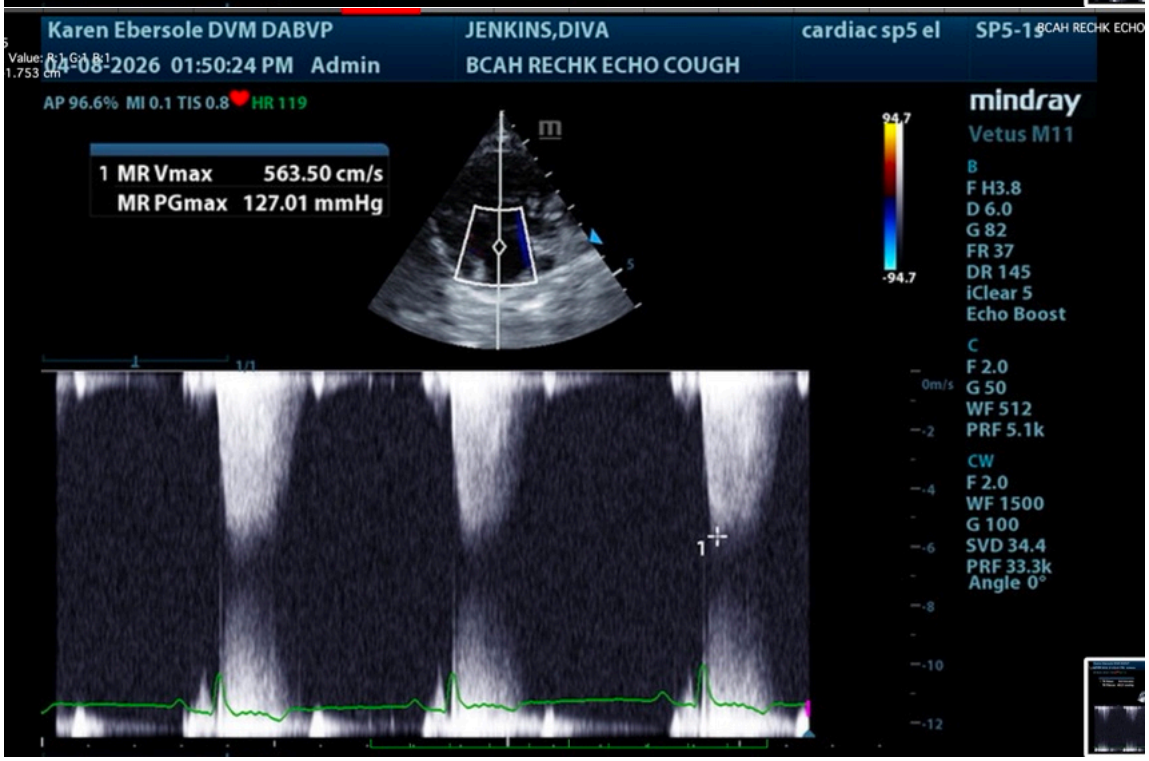

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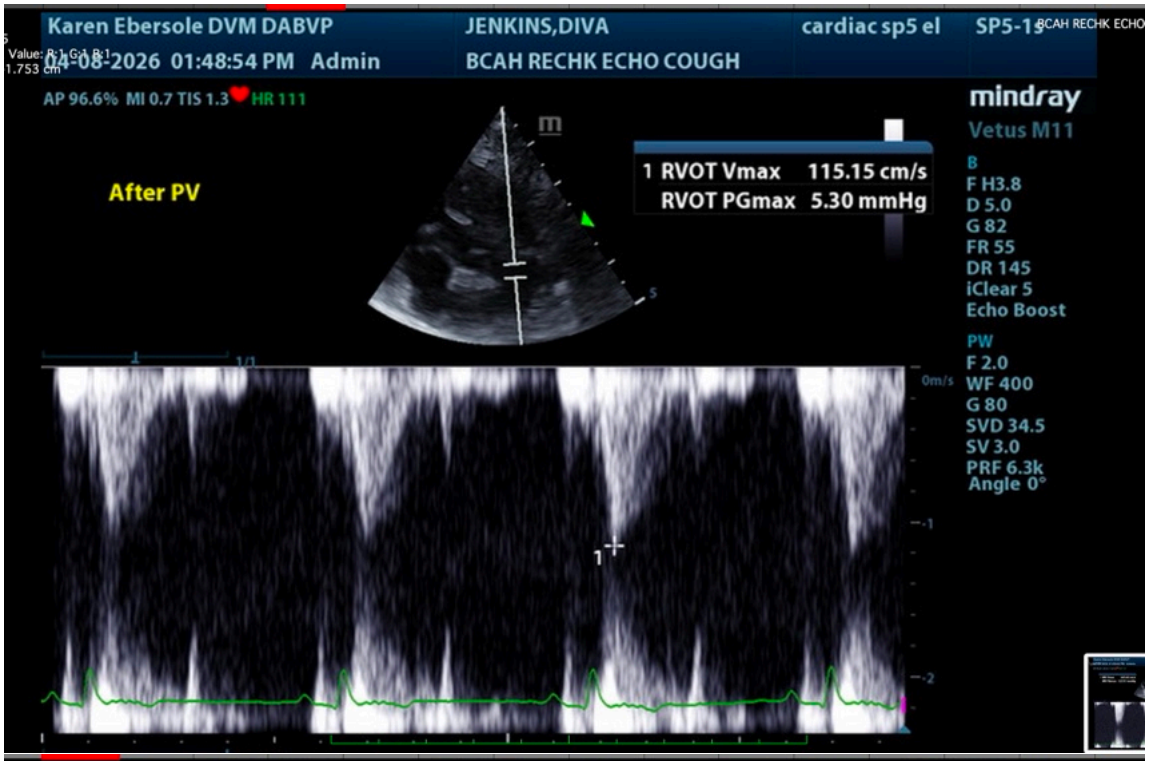

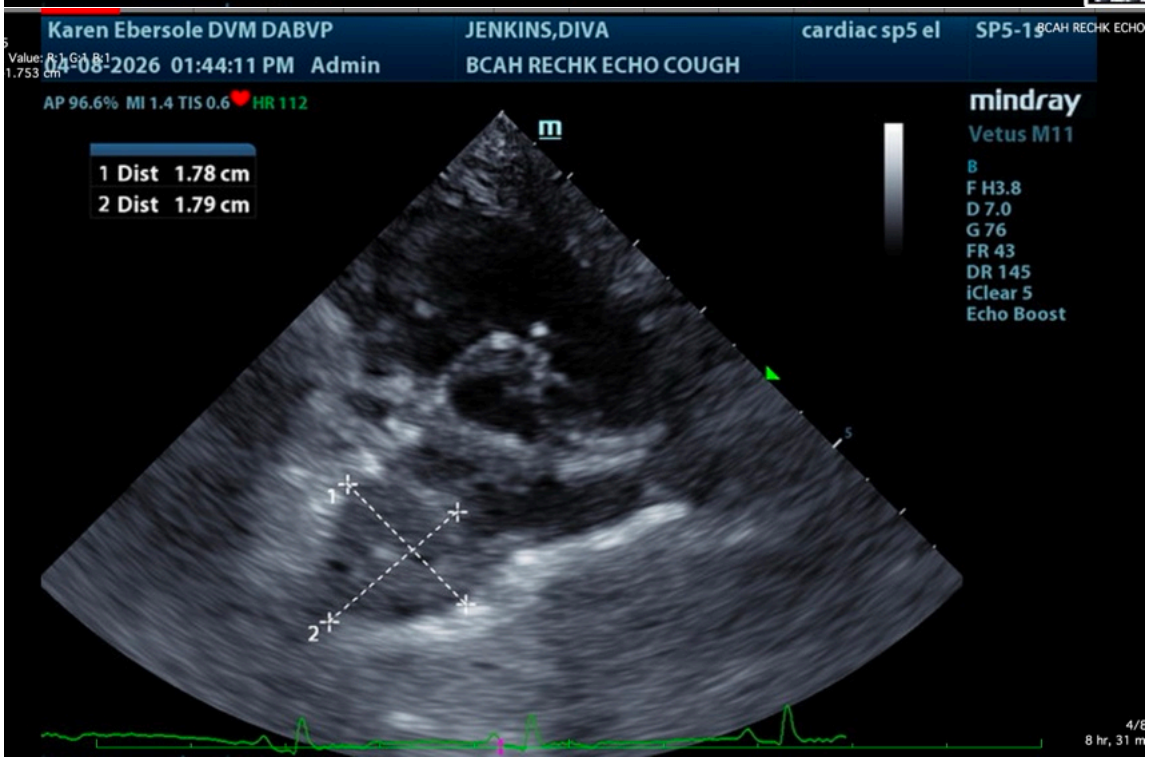

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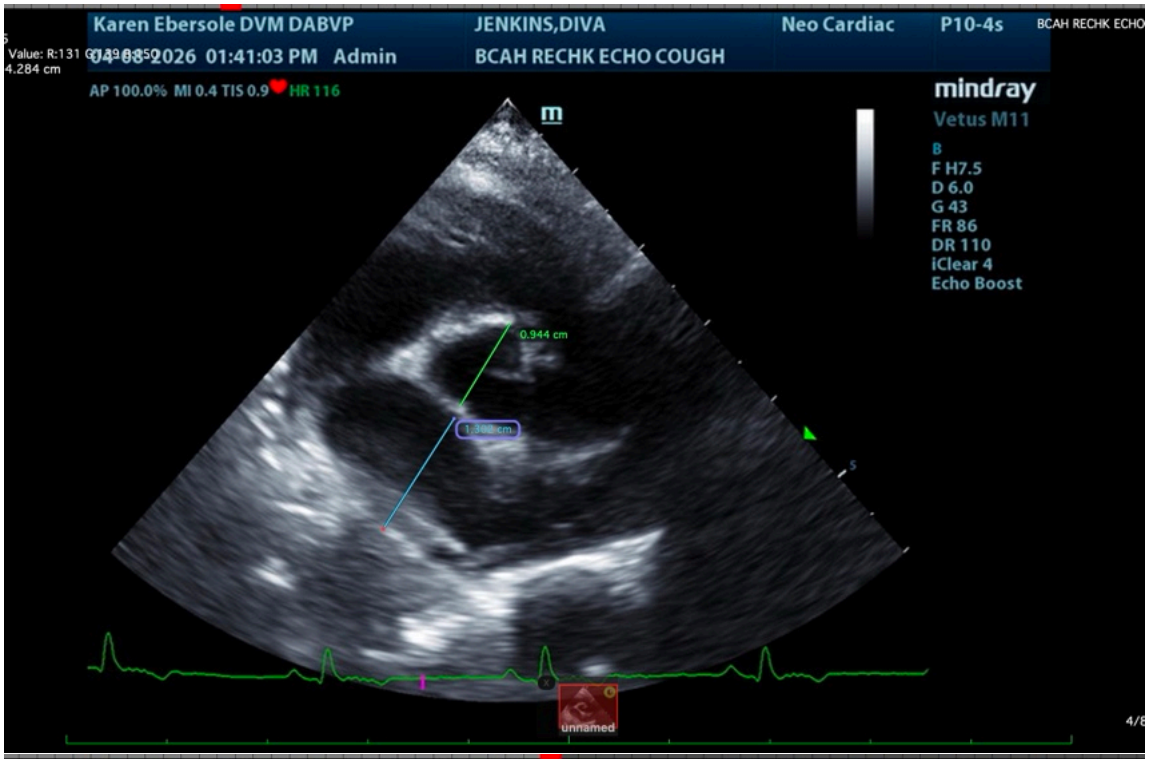

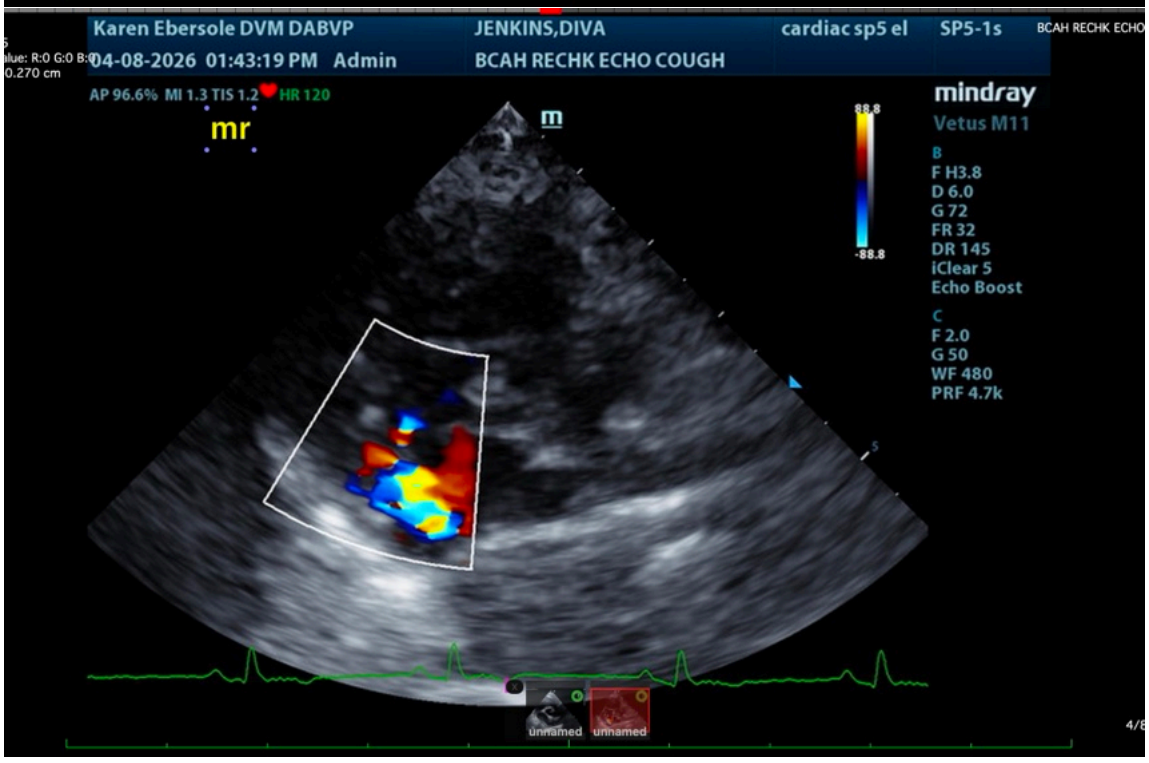

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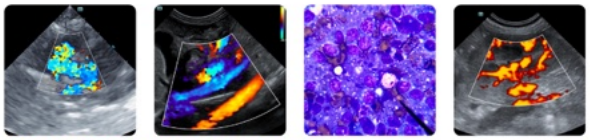

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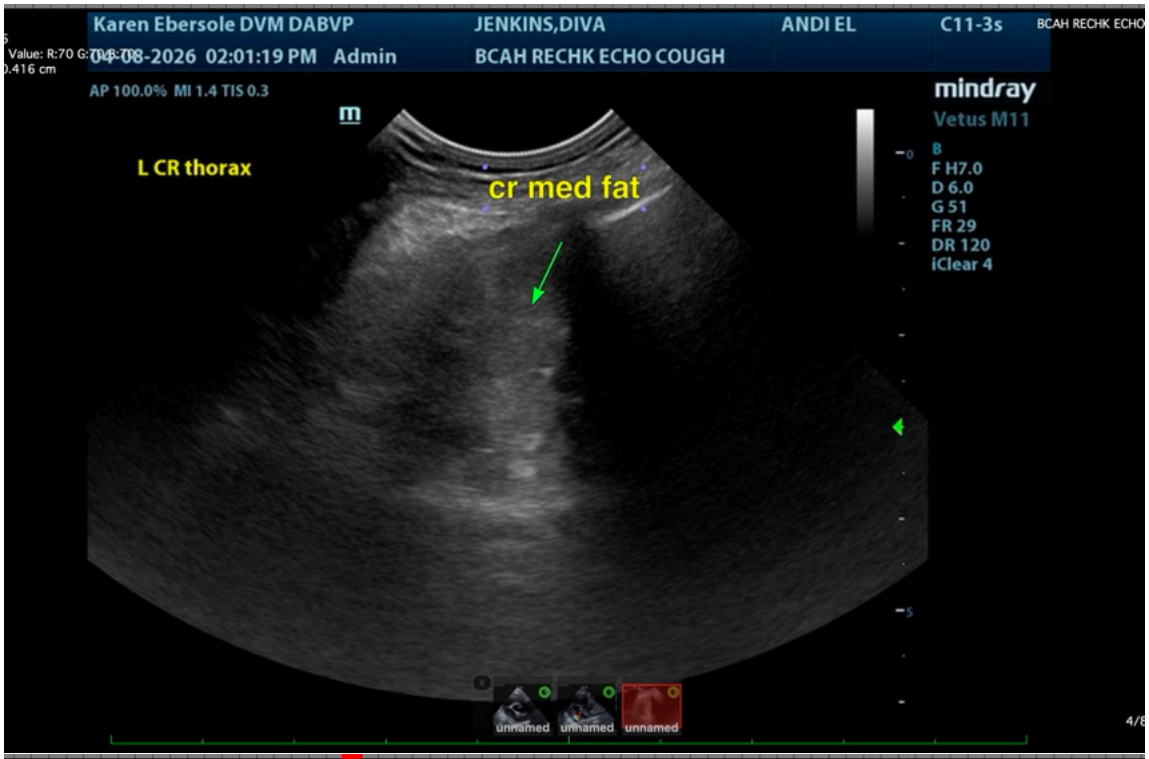

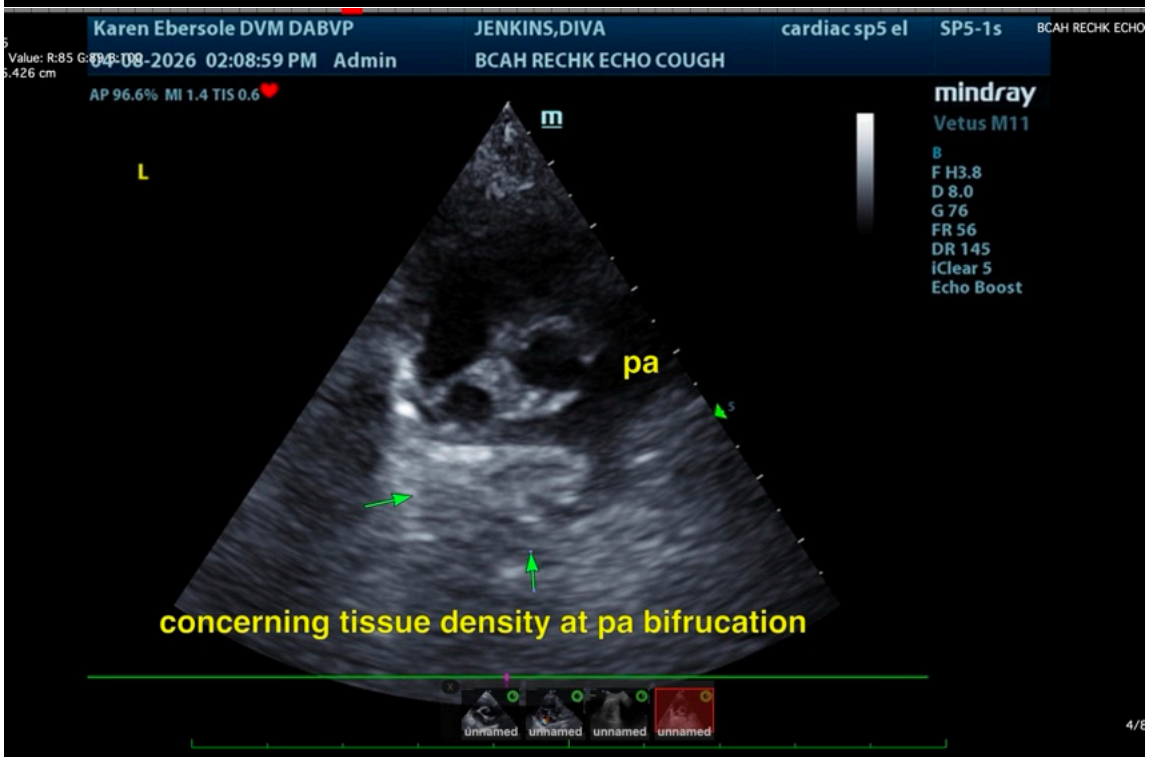

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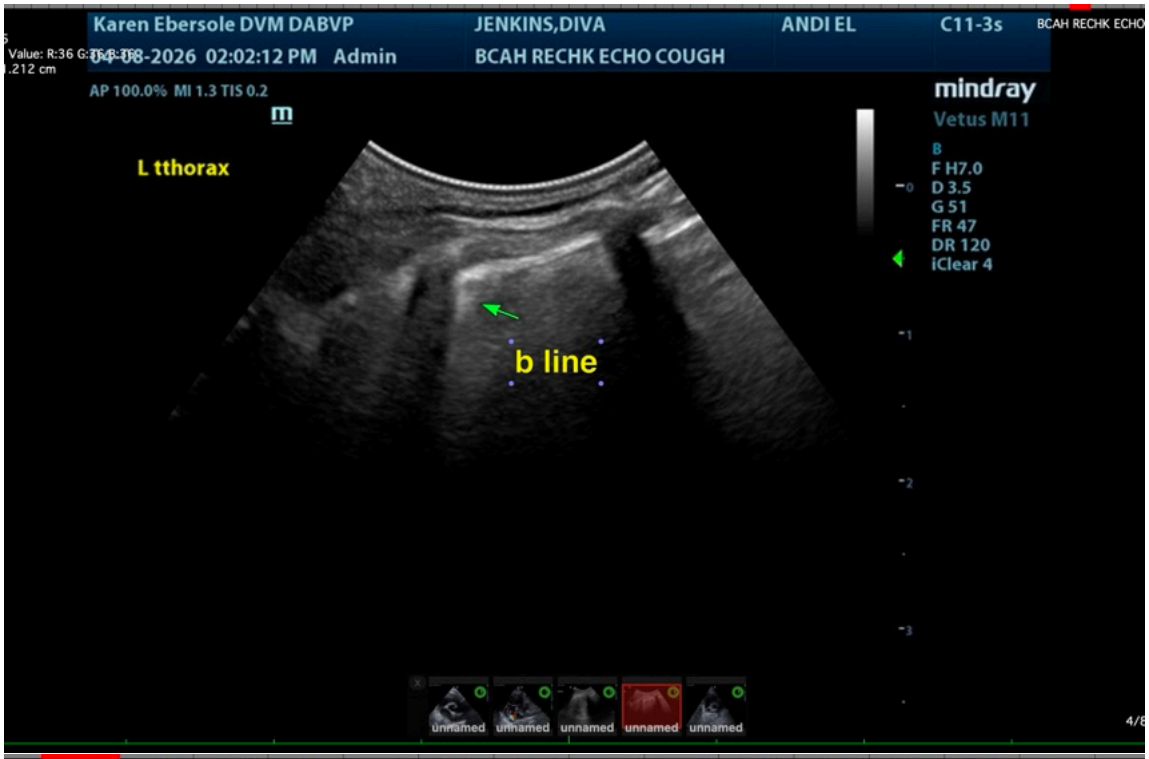
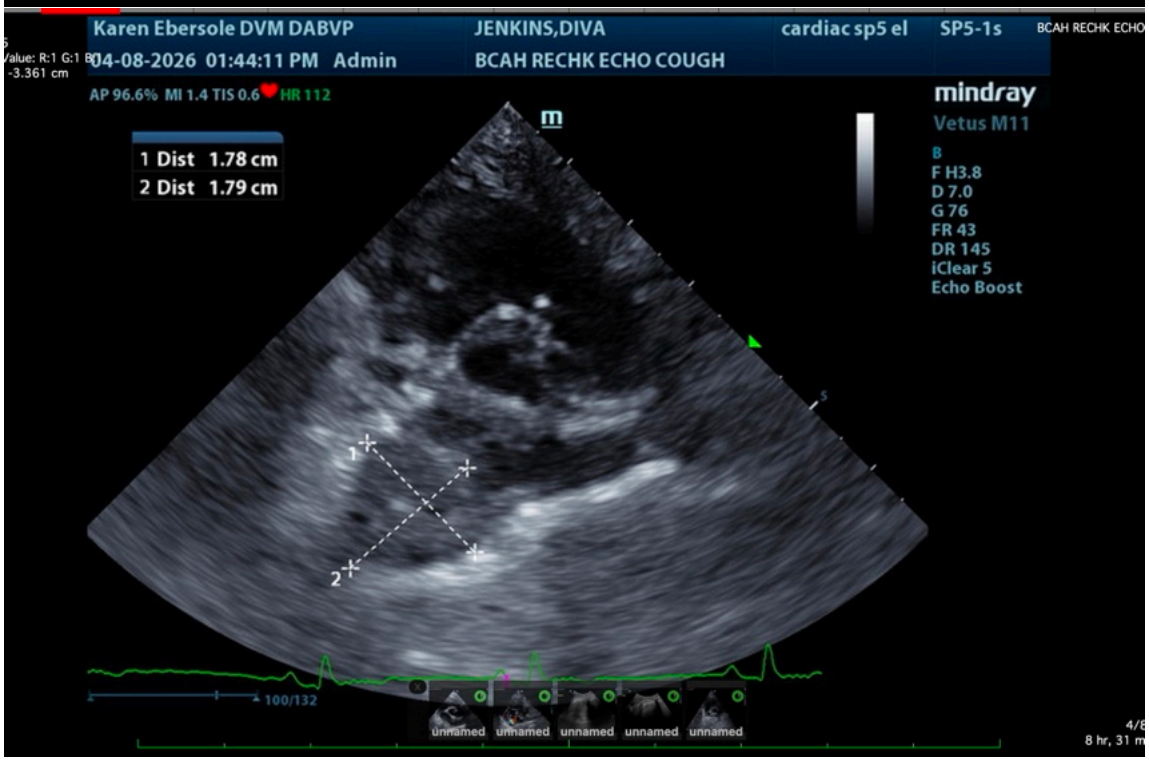
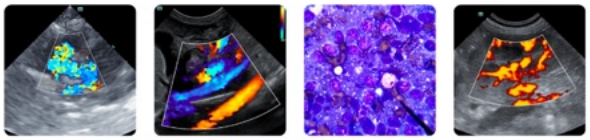




The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology



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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

info@SonoPath.com