



## PATIENT

Wocket Munson

## SPECIES

Canine

## BREED

Chihuahua Mix

## SEX

Neutered Male

## AGE

13

## WEIGHT

13.6 Pounds

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Dr. Naaman Dyer

## HOSPITAL NAME

Proctorville AC

## REFERRING VET

Dr. Naaman Dyer

## INVOICE

35963

## DATE

5/5/26

## PRESENTING CLINICAL SIGNS

Historical data is significantly limited due to the lack of RDVM notes. A new murmur was auscultated recently during pre-operative examination for COHAT. Only pertinent symptom noted by the owner is a recent lack of energy/decreased activity level.

Abnormal PE/Chem/CBC/UA Results: Grade IV/VI left apical systolic murmur. Normal rate and rhythm. Lungs auscultate normally. Vitals are WNL. Patient was recently presumptively diagnosed with Stage B1 MMVD based on rads and ECG, but an echo was recommended by the cardiologist. 4Dx negative, CBC normal, comprehensive chemistry revealed SDMA of 16 and BG of 55. TT4 was 1.9, cystatin B was 68, USG was 1.026, UA was WNL otherwise. These diagnostics were all done as a pre-operative workup. The patient has a COHAT scheduled on 5/10/26, but whether we proceed depends on echo findings.

## 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	--	~1.5	NM	1.1	--	--	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	--	Undest 0.7	.40	13.6	2.3	--	--

## 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. 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 **right atrium** and auricle



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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. Mild pulmonic insufficiency (0.5 m/s) was noted. 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. Arrhythmogenic activity was noted. The hepatic veins were not dilated.

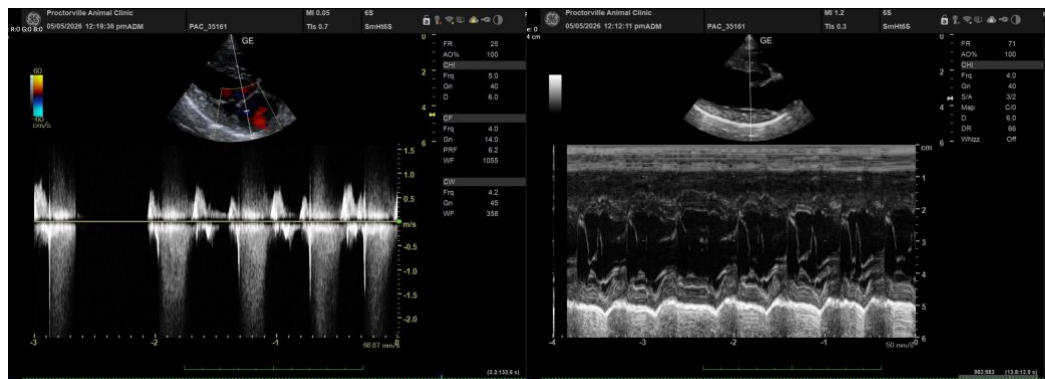
## ULTRASONOGRAPHIC FINDINGS

- Stage B-1 valvular disease
- No evidence of volume overload
- Mild pulmonic insufficiency
- Arrhythmogenic activity

## 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, Isoflor 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.

Some velocities may be underestimated owing to weak signal or a necessity for lower frequency; however, no significant disease is present at this time. The valvular disease appears to be compensated.





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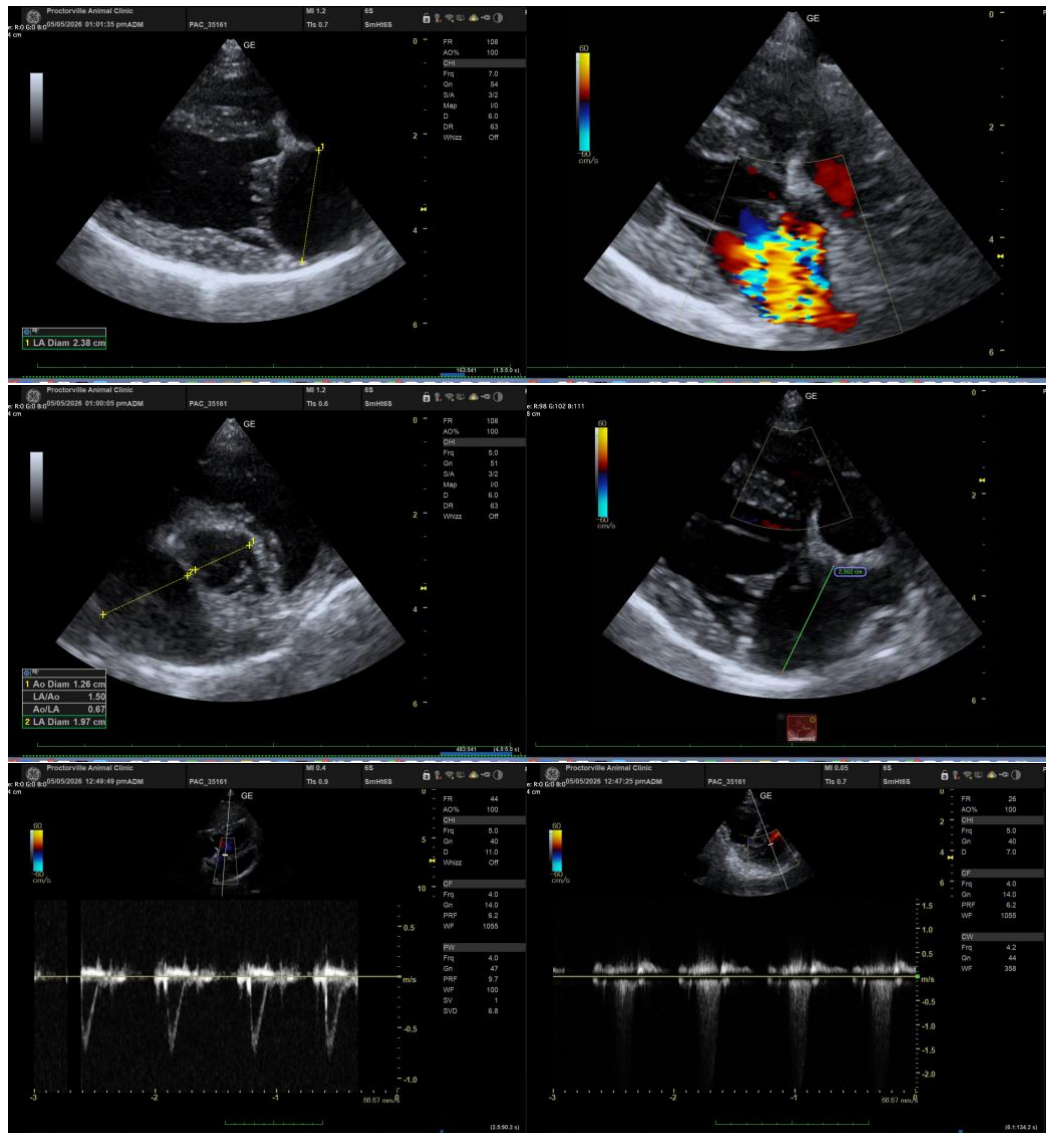
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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[info@SonoPath.com](mailto:info@SonoPath.com)