



PATIENT PRESENTING CLINICAL SIGNS

Jasper Rojas Coughing, fainting/collapse HM
Abnormal PE/Chem/CBC/UA Results: HCT 37% BUN 32 Creat 1.0 remainder WNL 4dx neg all 4

SPECIES ULTRASONOGRAPHIC EXAMINATION OF THE HEART

Canine

BREED

Pom X

SEX

Neutered Male

AGE

12

WEIGHT

9.4

INTERPRETED BY

Eric Lindquist, DMV

DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Jenn

HOSPITAL NAME

Rockaway AH

REFERRING VET

Dr. Ascot

INVOICE

44634

DATE

8/14/23

CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (Boon method)	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			2.0	2.0	63	93	NM
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	125	1.0	0.56		3.0	2.78	

Cardiac Presentation

The echocardiogram for this patient presented excessive **left atrial size** expressed both in the LA/AO and LA max measurements. Complete filling of the left atrium noted on color flow assessment. The cranial and caudal **mitral** valve leaflets presented vegetative thickening consistent with endocardiosis. Doppler indicated measurable insufficiency. Prolapse of the anterior mitral valve leaflet noted. 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. Pulmonary edema lines noted in the lung fields adjacent to the heart. Hepatic veins were dilated. There is a possibility of emerging pulmonary hypertension.

ULTRASONOGRAPHIC FINDINGS

- Mitral insufficiency with mitral valve prolapse
- Left atrial enlargement



PATIENT

- Tricuspid insufficiency
- Likely pulmonary hypertension

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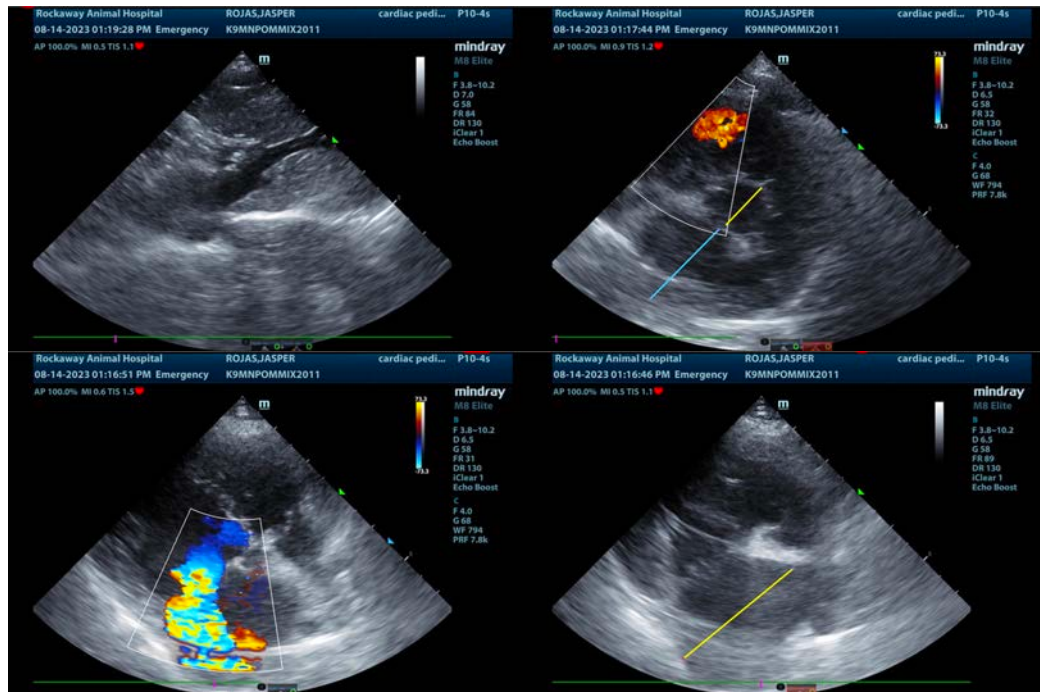
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommend triple therapy in this patient and treatment for stage C1 valvular disease, given the patient history. Pimobendan 0.3 mg/kg BID, ACE inhibitor 0.5 mg/kg SID progressing to BID as long as azotemia is not an issue, Lasix at 1-2 mg/kg BID. Recheck echo in one month. Cough suppressant such as hycodan or similar can be utilized.

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. There is severe anesthetic risk for this patient. Light dose opioids may be used to calm but I do not recommend anesthesia.





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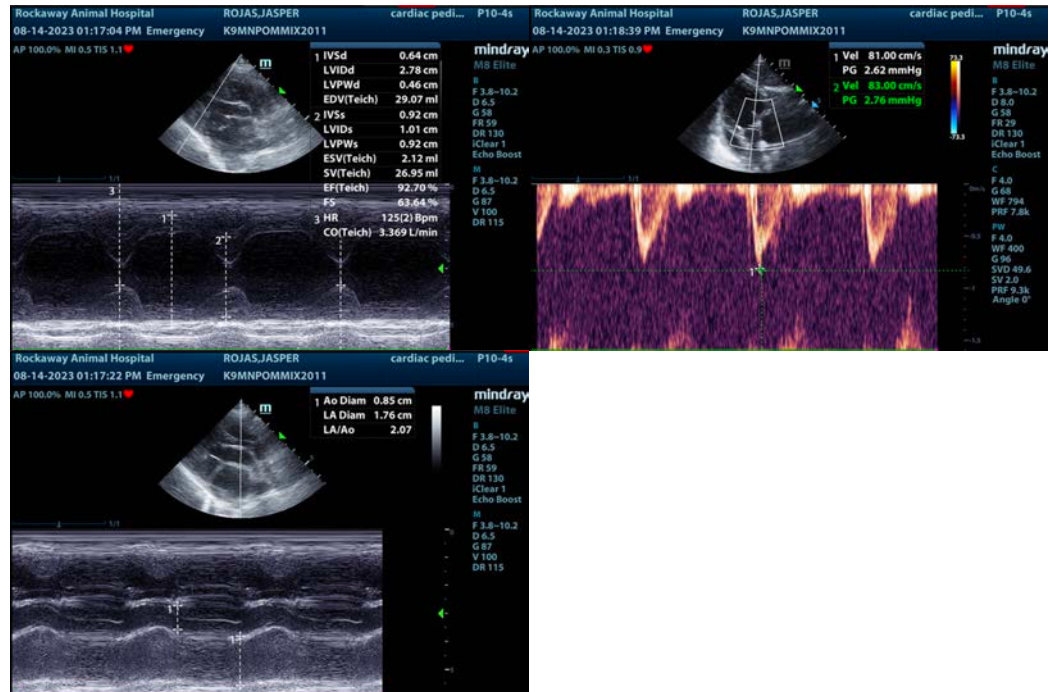
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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