



PATIENT

Vivian Brett

SPECIES

Canine

BREED

Vizsla

SEX

Spayed female

AGE

11 years

WEIGHT

50 lbs

INTERPRETED BY

Eric Lindquist, DMV,
 DABVP, Cert. IVUSS,
 CEO of SonoPath.com

IMAGING PERFORMED BY

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2/24/26

PRESENTING CLINICAL SIGNS

Grade IV/VI heart murmur

Amylase 2343, lipase > 1800

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

The echocardiogram presented moderate volume overload of the **left atrium** without evidence of clots or masses. Prolapse of the anterior **mitral valve** leaflet was noted with complete filling of the left atrium noted on color flow assessment. The **left ventricle** revealed volume overload without adequate contractility. 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 right ventricle were unremarkable. Trivial **tricuspid** insufficiency was noted and not clinically significant. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. **Pulmonary outflow** tract assessment revealed normal valve structure, laminar flow, and diameter (approx.1:1 pa/ao ratio). No **pericardial** or pleural effusion was noted. The cranial **mediastinum and pericardial and extra-cardiac regions** were free of masses in the visible window. Occasional ectopic beat was noted.

E Wave Velocity 1.4

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	6.4	-	1.7	1.8	53	84	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	110	1.17	0.8	50 lbs	6.34	5.25	



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ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The pelvic urethra was imaged 3.0 cm beyond the cystourethral junction and appeared normal. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 5.7 cm. The right kidney measured 5.88 cm.

The iliac trifurcation was unremarkable.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 3.0 x 0.8 cm at the cranial pole and 0.72 cm at the caudal pole. The right adrenal gland measured 2.54 x 0.84 cm at the caudal pole and 0.94 cm at the cranial pole.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. Occasional, hypoechoic nodule was noted and was non-disruptive. The liver nodule measured 1.24 cm and the left liver nodule measured 2.0 x 1.87 cm. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder and common bile duct were unremarkable.



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Gastrointestinal

The **stomach** revealed a minor amount of fluid accumulation, structurally consistent with gastritis or gastric stasis/ileus. The pylorus was patent. The intestines were free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

ULTRASONOGRAPHIC FINDINGS

- Consistent with stage B2+ valvular disease.
- Occasional ectopic beat.
- Nodular hyperplasia liver pattern, subjectively benign.
- Possible, mild low-grade gastritis or gastric ileus.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Pimobendan is indicated at 0.3 mg/kg b.i.d., ace inhibitor at 0.5 mg/kg s.i.d. progressing to b.i.d. and Spironolactone at 1-2 mg/kg s.i.d. I recommend monitoring this patient for any evidence of left-sided congestive heart failure such as pulmonary edema given the significant volume overload in the left atrium, left ventricle and the elevated E wave velocity. Cardiologist referral may be appropriate depending upon progression or response to clinical signs. Holter monitor would be ideal.

Given the patient's history periodic hypoxia could theoretically be inducing a seizure activity; however, primary CNS disease and hypertension should be ruled out. If any CNS signs are noted then skull CT may be appropriate.

If anorexia or any GI signs are present then gastroprotectant protocol is indicated.

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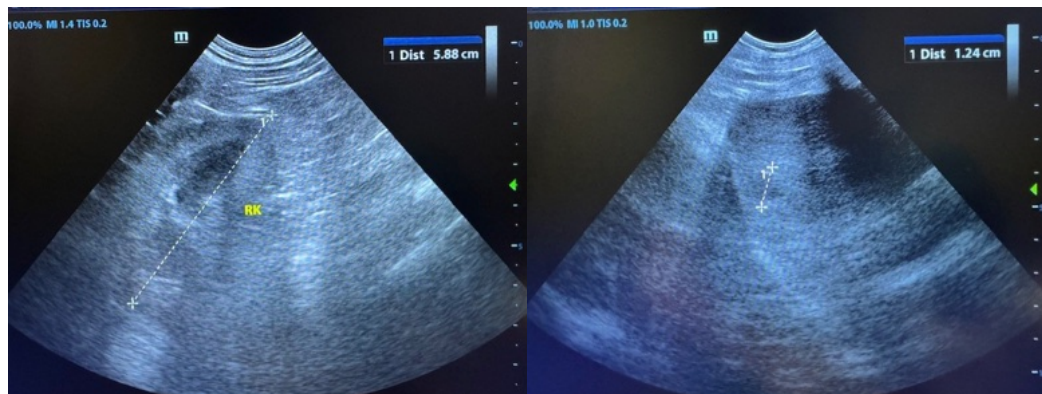
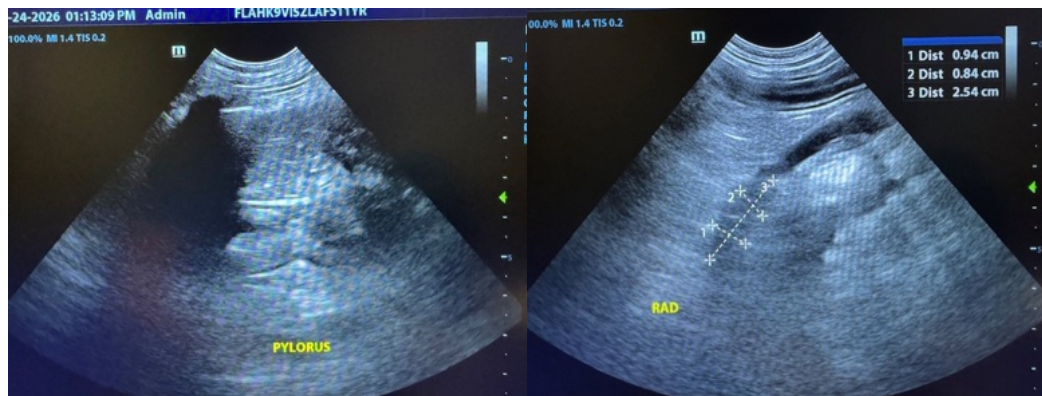
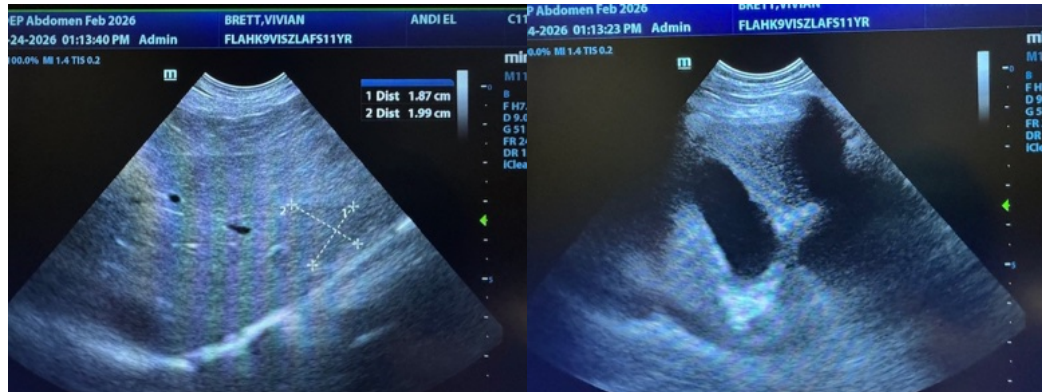
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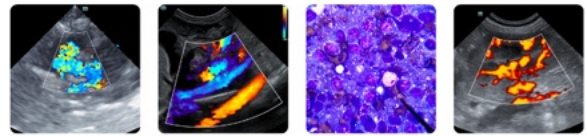
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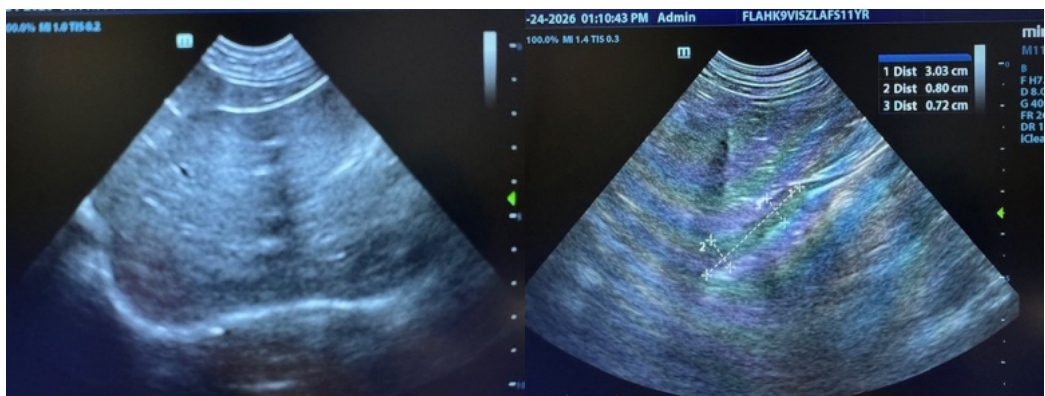
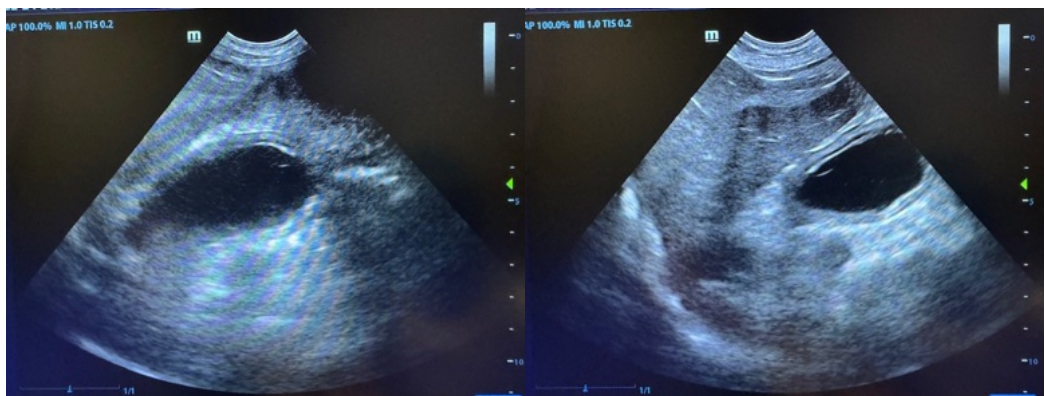
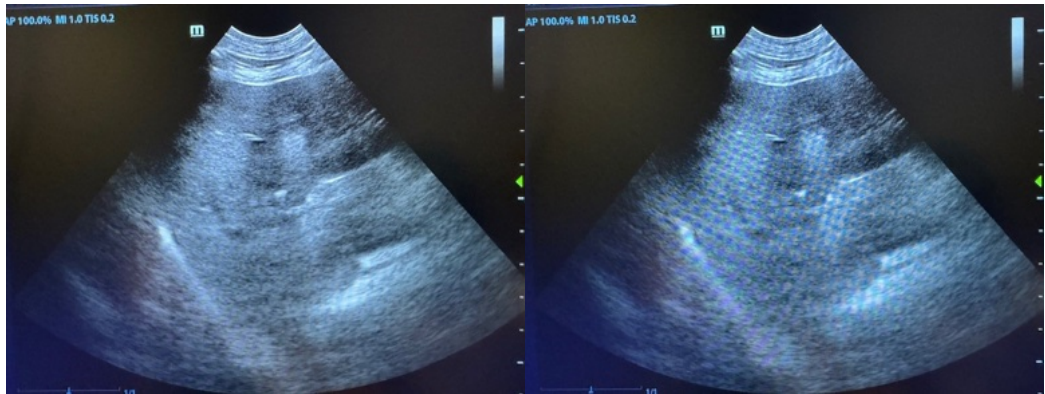
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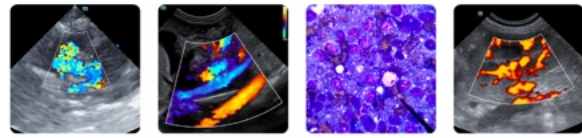
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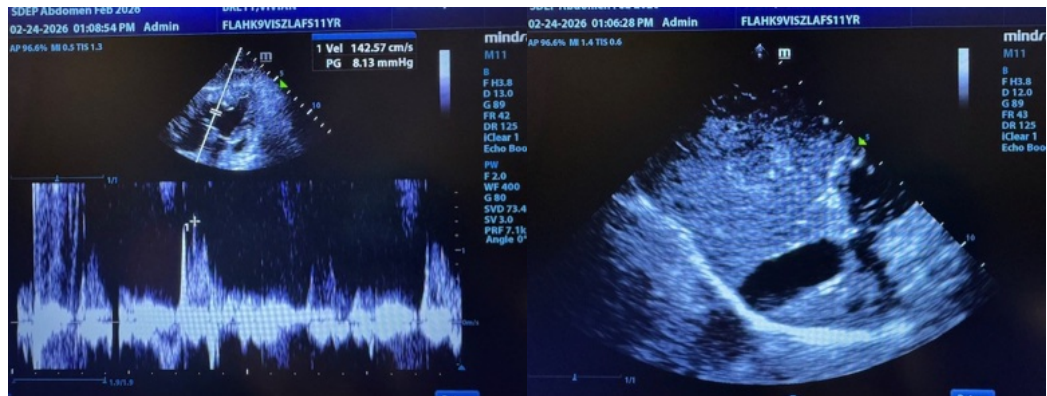
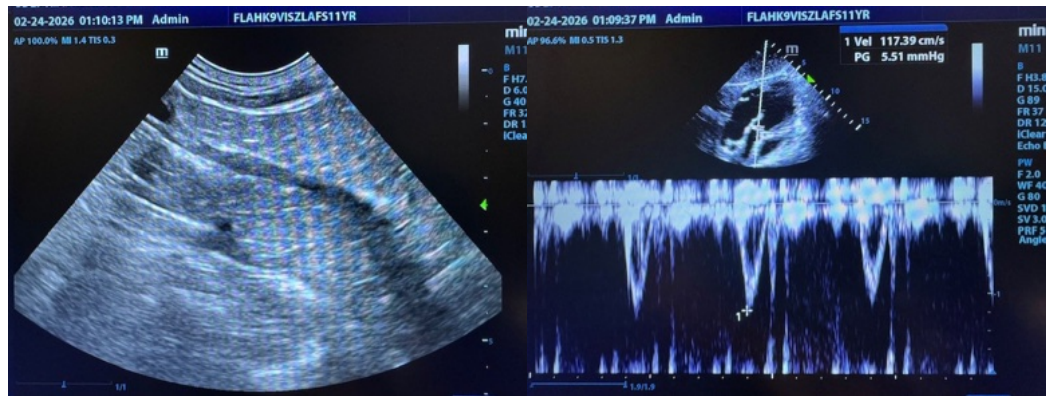
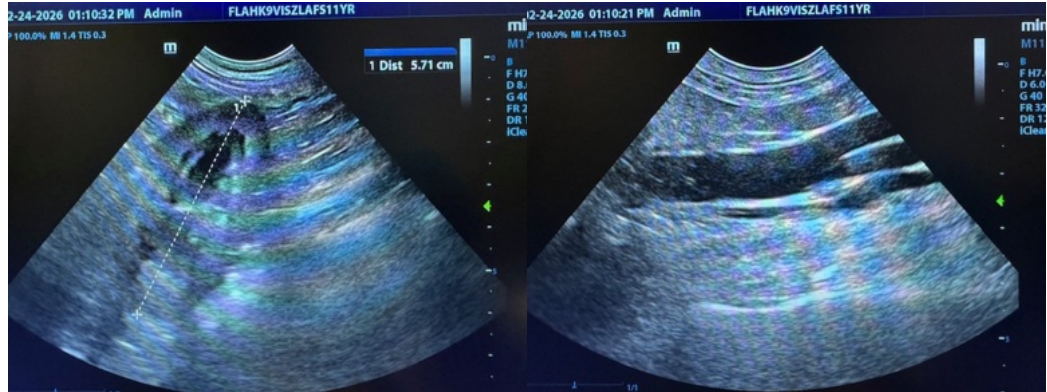
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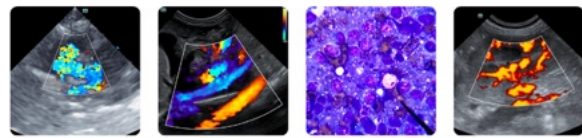
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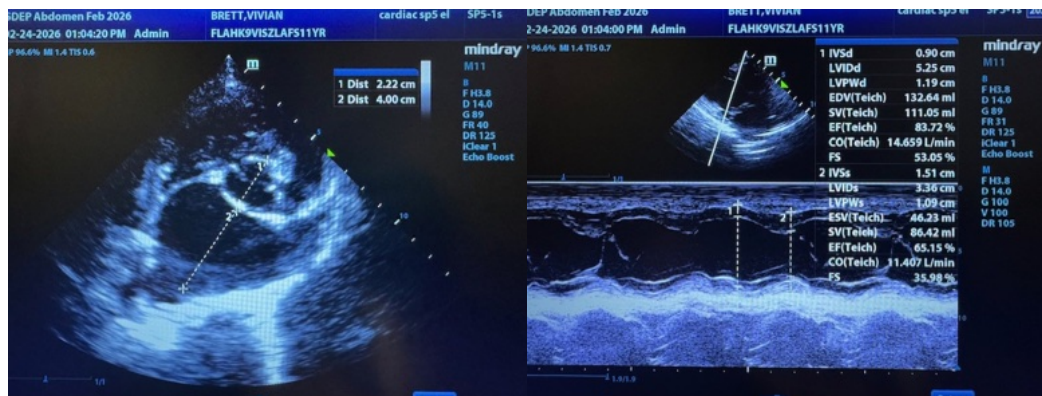
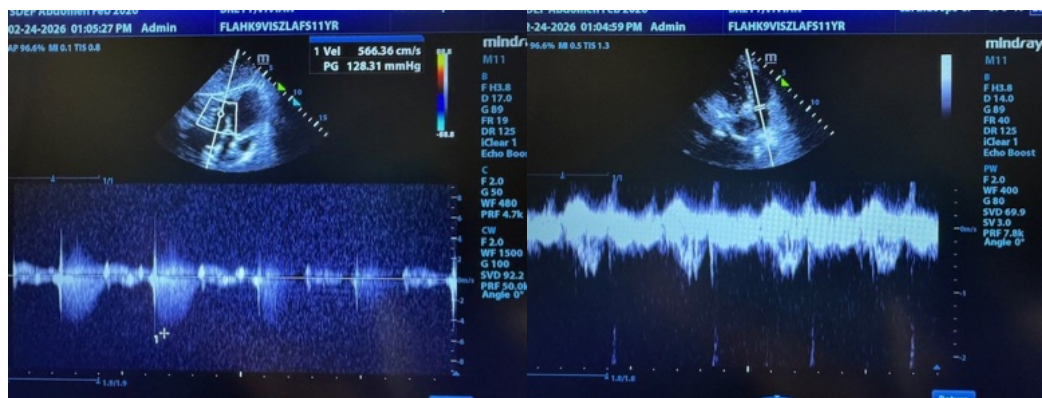
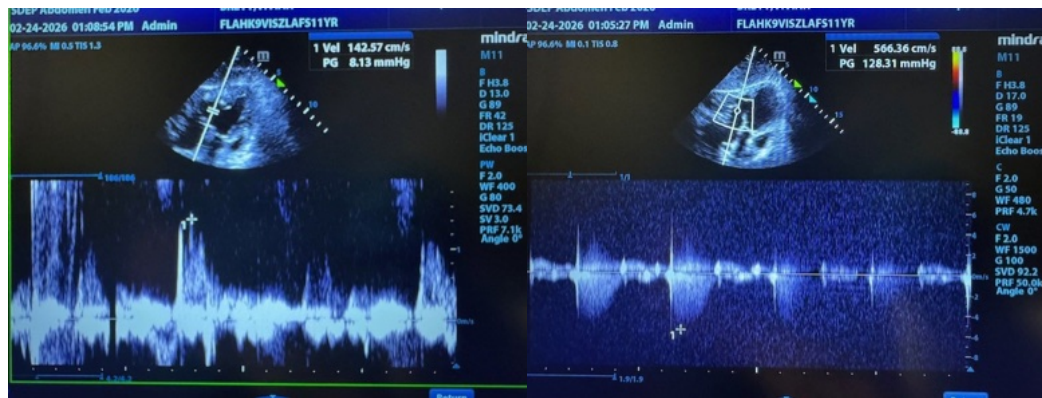
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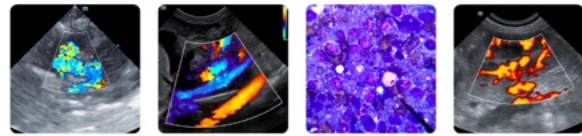
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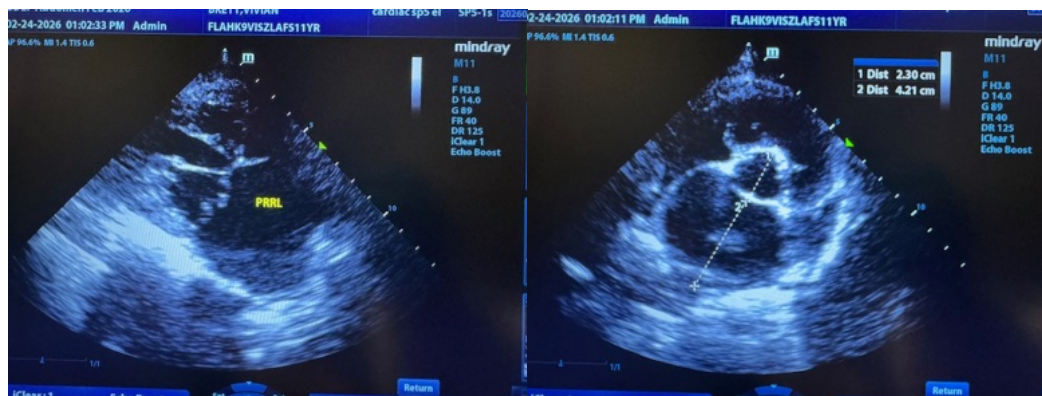
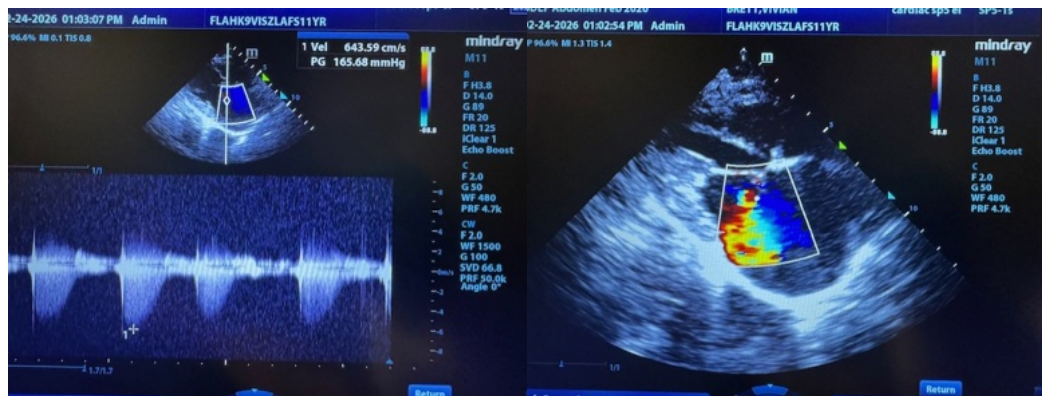
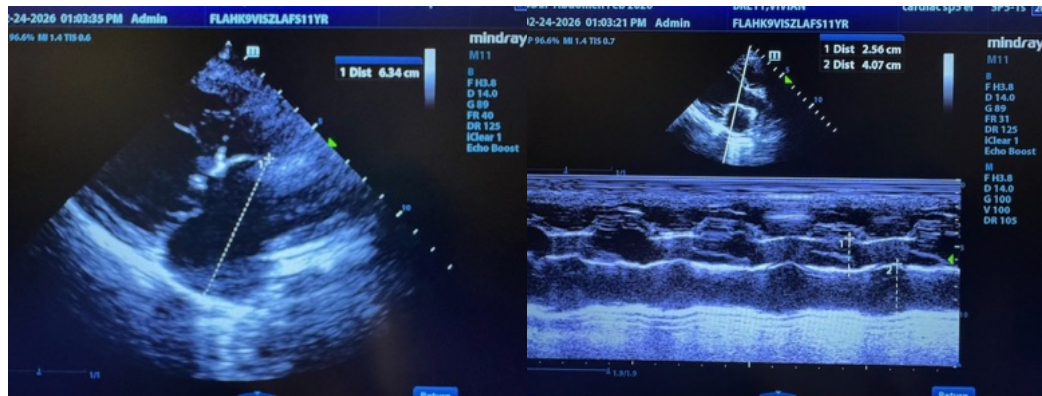
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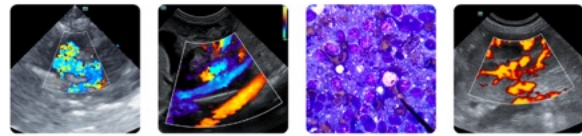
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, Cert. IVUSS, CEO of SonoPath.com

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