



**PATIENT**

Chloe Mason

**SPECIES**

Canine

**BREED**

Terrier Mix

**SEX**

Spayed female

**AGE**

13 years

**WEIGHT**

17.8 lbs

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Jessica Miller, RDMS

**HOSPITAL NAME**

Advanced VC

**REFERRING VET**

Dr. Gas

**PRESENTING CLINICAL SIGNS**

History: 1. Left-sided cardiomegaly 2. Mitral valve disease 3. Bronchial Pattern lungs  
Abnormal PE/Chem/CBC/UA Results: BUN 34, Amylase 1513, T4 1.0

**ULTRASONOGRAPHIC EXAMINATION OF THE HEART**

The **echocardiogram** presented a prominent **right heart** with mild **right ventricular** hypertrophy, with minor **tricuspid** regurgitation, yet normal **right atrial** size. No evidence of neoplasia was noted in the right auricle, or elsewhere in the heart. The **pulmonary artery** was uniformly prominent with mildly depressed pulmonic velocity measured on PW Doppler. No overt heartworms were noted in the main or visible deep pulmonary arteries. Yet, theoretically heartworms could be present in the deep pulmonary vasculature out of visible sonographic range. More likely, however, this prominent right heart is due to excessive intra-thoracic pressures caused by chronic respiratory disease or potentially excessive intra-thoracic fat (Pickwickian syndrome). The **left heart** demonstrated a linear **ventricular septum**. Contractility was functionally adequate demonstrated by the FS% measurement. The **mitral valve** revealed insufficiency and the **left atrial** was enlarged. The **left ventricular outflow** demonstrated normal flow patterns and velocities through the aortic valve. No evidence of tumor, pericardial or pleural effusion was noted. The visible **extra-cardiac** tissues were uniformly linear without evidence of masses, infiltrative or inflammatory mediastinal tissue. No evident arrhythmic activity was noted during the exam. The hepatic veins were not dilated and there was no evidence of pulmonary hypertension.

CANINE	MR	TR	LA/AO	LA/AO	FS	EF	EPSS
<b>CARDIAC PARAMETERS</b>	<b>VMAX</b> (m/s)	<b>VMAX</b> (m/s)	(Boon method)	(Heart Base; Swe)	(%)	(%)	(cm)
<b>NORMAL PARAMETER</b>	4.5-5.5	<2.7	1.3	<1.6	28-40	40-100	<0.6
<b>PATIENT</b>	6.5	1.85	1.4	1.9	48	81	0.2
CANINE	HR	AV	PV	BODY WEIGHT	LA	LVIDd	LVIDs
<b>CARDIAC PARAMETERS</b>	(BPM)	<b>VMAX</b> (m/s)	<b>MAX</b> (m/s)		2D short axis Base view (cm)	Avg; 2D and m-mode short axis (cm)	Avg; 2D and m-mode short axis (cm)
<b>NORMAL PARAMETER</b>	50-100	0.7-1.7	0.7-1.6	BELOW	BELOW	BELOW	BELOW
<b>PATIENT</b>	132	1.3	0.84	17.8 lbs	3.95 max	3.51	

**ULTRASONOGRAPHIC FINDINGS**

Stage B2 valvular disease with cor pulmonale component.

**INVOICE**

42285

**DATE**

12/21/22



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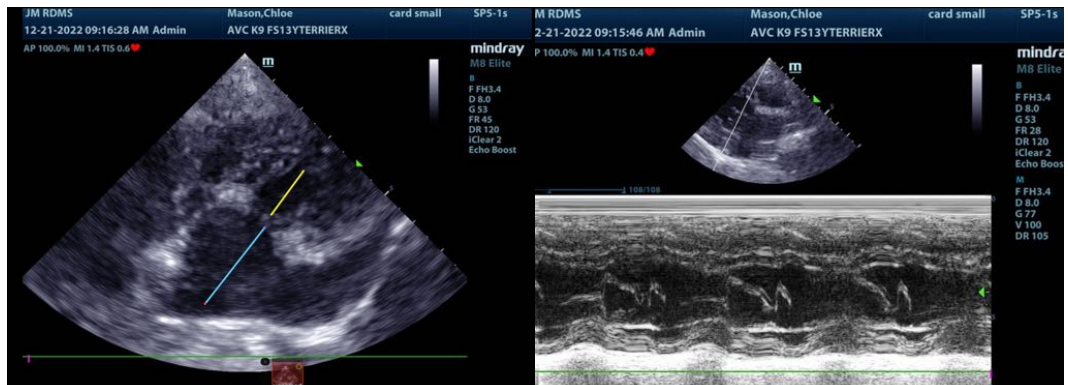
**DATE**

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The patient should not have any overt clinical signs at this point; however, preventative measures with Pimobendan at 0.3 mg/kg b.i.d. would be indicated. If systolic blood pressure is > 160 then ace inhibitor therapy can be considered. Primary respiratory component is likely playing a role given the patient's history.

The heart has some volume overload and 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 3-6 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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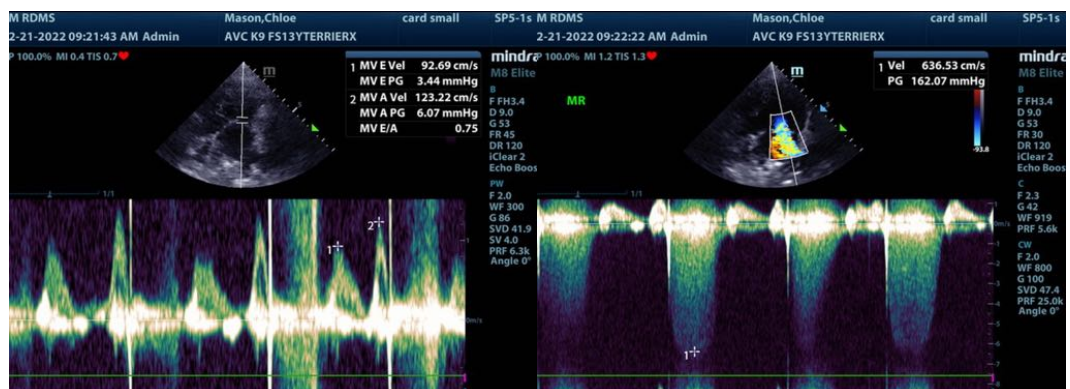
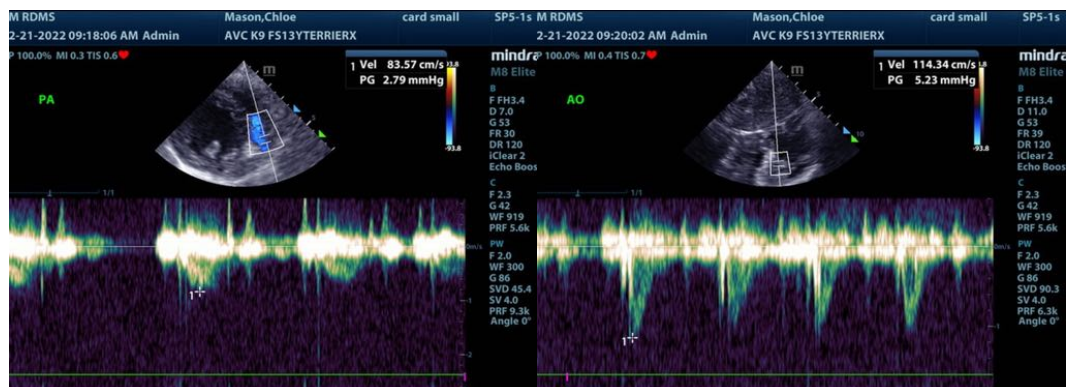
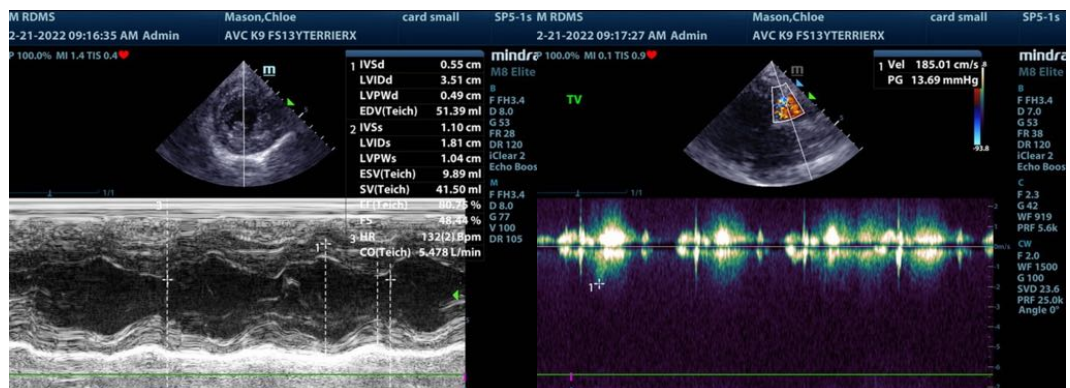
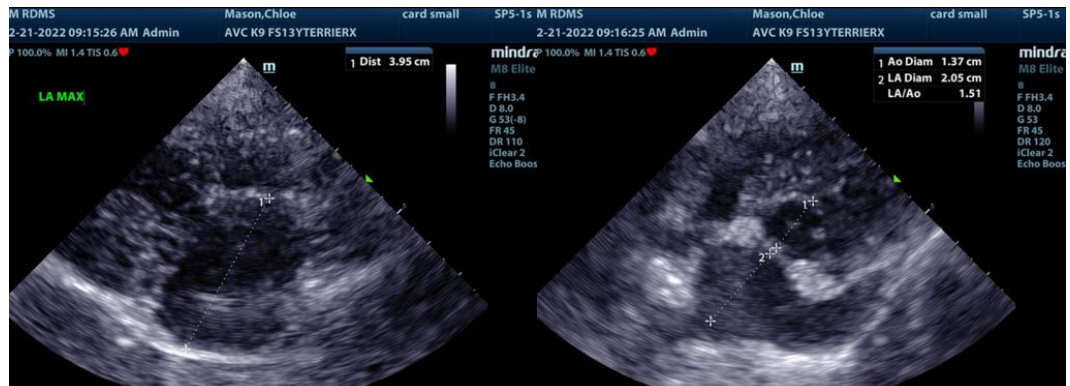
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

**SPECIES**

Canine

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  
info@SonoPath.com

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