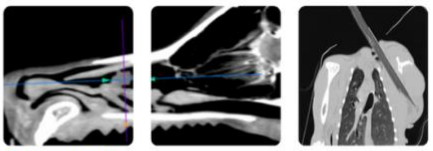

PATIENT

Johnny Dorich

SPECIES

Canine

BREED

Beagle X

SEX

Neutered Male

AGE

10 Years

WEIGHT

33.1 kg

INTERPRETED BY

James Wood, DVM, DACVIM (Cardiology)

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Preston AC

REFERRING VET

Rosenfeld

INVOICE

37156

DATE

5/20/26

PRESENTING CLINICAL SIGNS

History: Grade 3/6 Heart murmur discovered Jan 9, 2026, during annual exam. Still present as of May 15, 2026, at recheck exam. BCS 7/9.

Current Medications: Bravecto Quantum

Primary Question to Be Answered in This Exam: Want the significance of this heart murmur, as it is a relatively new finding.

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

CANINE CARDIAC PARAMETERS	LA long axis	LAmaxN	Ao long axis	LA/AO (Heart Base; Swe, short axis)	LA/AO long axis	LVIDd	LVIDdN
NORMAL PARAMETER		<1.57		<1.6	<2.5		<1.7
PATIENT	5.15	1.75	1.89	1.37	2.72	4.56	1.51
CARDIAC PARAMETERS	**Body Weight (kg)**	**AV VMAX (m/s)**	**PV MAX (m/s)**	**MR VMAX (m/s)**	**TR VMAX (m/s)**	**FS (%)**	**LVIDsN**
NORMAL PARAMETER		0.7-1.7	0.7-1.6			22 - 49%	<0.9
PATIENT	33.1	0.72	0.69	5.7	1.13	31.3	0.79
CARDIAC PARAMETERS	**HR (bpm)**	**MV E (m/s)**	**MV A (m/s)**	**MV E/A (m/s)**	**EF (%)**	**IVSdN**	**LVFWdN**
NORMAL PARAMETER						<0.6	<0.6
PATIENT	147	NM	NM	NM	59.2	0.44	0.44

ECG Interpretation

Six lead ECG revealed a sinus arrhythmia with an average rate of 114bpm. No ectopy or AV block is identified.

Cardiac Presentation

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Teleradiology
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The mitral valve leaflets are mildly thickened with mild eccentric and posteriorly directed mitral valve insufficiency. There is mild prolapse of the anterior mitral valve leaflet. The left atrium is equivocally dilated on long axis imaging and high/normal on short axis La/Ao. The left ventricular diastolic function was not assessed. The global left ventricular systolic function is normal. There is normal right atrial size with mild to moderate tricuspid regurgitation. There is no prolapse of the tricuspid valve leaflets and no evidence of pulmonary hypertension based upon tricuspid regurgitant velocities. The right ventricle subjectively appears normal in structure and function. The aortic and pulmonary valves have normal appearance and motion, and the corresponding outflow velocities are within normal limits. There is no evidence of pulmonary or aortic valve insufficiency. The aorta appears normal. The pulmonary artery and associated branches appear normal. There is no evidence of pleural effusion, pericardial effusion, or intracardiac masses.

ULTRASONOGRAPHIC FINDINGS

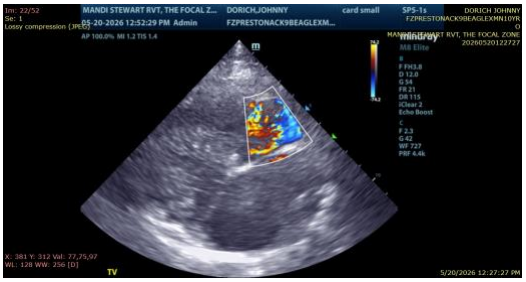
- Myxomatous mitral valve disease, ACVIM stage B1 (mild left atrial enlargement, normal LV dimension)

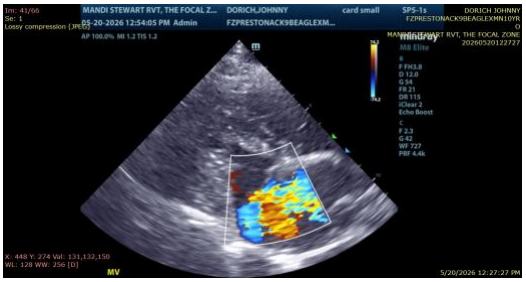
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The echocardiogram showed evidence of myxomatous mitral valve disease. Based on this echocardiogram, there is mild left atrial dilation with normal left ventricular chamber sizes.
No medications are recommended at this time. The overall risk of adverse cardiovascular outcomes is considered very low in the near future. This is, however, a progressive disease, and as such repeat echocardiogram in 6-9 months is recommended to screen for progression. Recheck sooner if there is a new cough, increase in the resting RR, or other concern for progressive cardiac disease. Recheck for an echocardiogram in 6-9 months or sooner if concerns arise.

Monitoring

It is very important to catch any clinical signs concerning for emerging CHF as early as possible. The client should be closely monitoring and ideally tracking the sleeping respiratory rate. The sleeping RR should be between 10-30 breaths per minute or less (ideally in the teens or low 20s). **If the resting RR is trending upward**, consistently>35/min while resting/sleeping AND/OR there is a new or progressive cough, the patient should be seen urgent for evaluation to determine if CHF is developing. *RECHECK ASAP for thoracic radiographs if there is a new cough or increase in RR to detect early CHF and avoid ER presentation**





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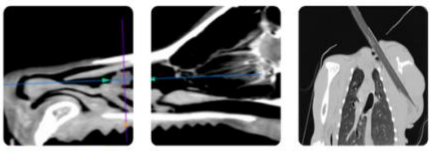

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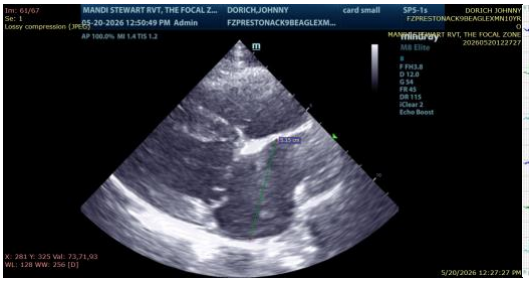

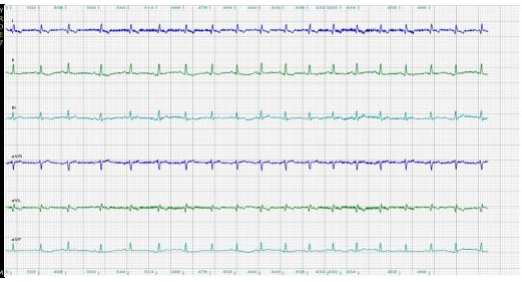

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

James Wood, DVM, DACVIM (Cardiology)

info@SonoPath.com