



**PATIENT**

Chloe Plenzik

**SPECIES**

Canine

**BREED**

Cavalier

**SEX**

Neutered Male

**AGE**

9 Years

**WEIGHT**

14 kg

**INTERPRETED BY**

James Wood, DVM,  
DACVIM (Cardiology)

**IMAGING PERFORMED BY**

Dr. Caroline Tan

**HOSPITAL NAME**

Cornerstone Square  
VH

**REFERRING VET**

Dr. Plenzik

**INVOICE**

37207

**DATE**

5/25/26

**PRESENTING CLINICAL SIGNS**

History: Attending reports that p is still asymptomatic and BAR. Eating drinking well. No VDCS. Not on medication. Reports gr 2 /6 right murmur. No change mentioned.

**ULTRASONOGRAPHIC EXAMINATION OF THE HEART**

CANINE CARDIAC PARAMETERS	LA long axis	LAmxN	Ao long axis	LA/AO (Heart Base; Swe, short axis)	LA/AO long axis	LVIDd	LVIDdN
<b>NORMAL PARAMETER</b>		<1.57		<1.6	<2.5		<1.7
<b>PATIENT</b>	2.64	1.17	0.98	1.22	2.69	2.63	1.14
CARDIAC PARAMETERS	Body Weight (kg)	AV VMAX (m/s)	PV MAX (m/s)	MR VMAX (m/s)	TR VMAX (m/s)	FS (%)	LVIDsN
<b>NORMAL PARAMETER</b>		0.7-1.7	0.7-1.6			22 - 49%	<0.9
<b>PATIENT</b>	14	0.44	0.71	--	1.3	42.6	0.54
CARDIAC PARAMETERS	HR (bpm)	MV E (m/s)	MV A (m/s)	MV E/A (m/s)	EF (%)	IVSdN	LVFWdN
<b>NORMAL PARAMETER</b>						<0.6	<0.6
<b>PATIENT</b>	125	0.3	0.34	0.91	33.9	0.26	0.43

**Cardiac Presentation**

The mitral valve remains mildly thickened. Mitral regurgitation remains trivial to mild. There is no prolapse of the mitral valve leaflets. The left atrial size is normal. Left ventricular internal dimensions during diastole are within normal limits and the global left ventricular systolic function is normal. The right atrium is subjectively normal in size. The septal leaflet of the tricuspid valve is moderately thickened. There is mild central tricuspid valve insufficiency. 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.



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## ULTRASONOGRAPHIC FINDINGS

- Myxomatous mitral valve disease, ACVIM stage B1
- Mild tricuspid valve insufficiency – suspect endocardiosis

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The echo shows static mild tricuspid valve insufficiency secondary to what is suspected to be degenerative valve disease. There remains very mild mitral valve regurgitation. Given the normal left-sided chamber dimensions with no progression, no medications are recommended at this time. An annual echocardiogram is reasonable unless concerns for progression arise sooner.

### 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\*\*

### Anesthesia

There is only a mildly increased risk to anesthesia given the underlying cardiac disease. On top of the increased intraoperative risks (hypotension, hypoventilation, hypothermia) with cardiac disease, there is an increased risk of precipitating CHF. With this understanding, anesthesia can be pursued pending normal labwork, with appropriate precautions. Recommendations for pre-operative sedation include an opiate (such as butorphanol) combined with a benzodiazepine (such as midazolam or diazepam). It is recommended to avoid alpha 2 agonists, as these agents can cause vasoconstriction and worsen MR, exacerbating left atrial hypertension. These effects persist for hours even after reversal. Etomidate or alfaxalone are preferred induction agents. Propofol can be considered for induction; however, is less preferred to alfaxalone or etomidate. Ketamine should ideally be avoided. Atropine should be used as needed for blood pressure support when bradycardia is present during periods of hypotension.

Full cardiac precautions should be taken with regards to monitoring (ideally CO<sub>2</sub>, SpO<sub>2</sub>, ECG, and BP monitoring) and judicious IV fluid administration (avoid volume overload or underload/hypotension - 4-5 mL/kg/hr surgical fluid rate is recommended).



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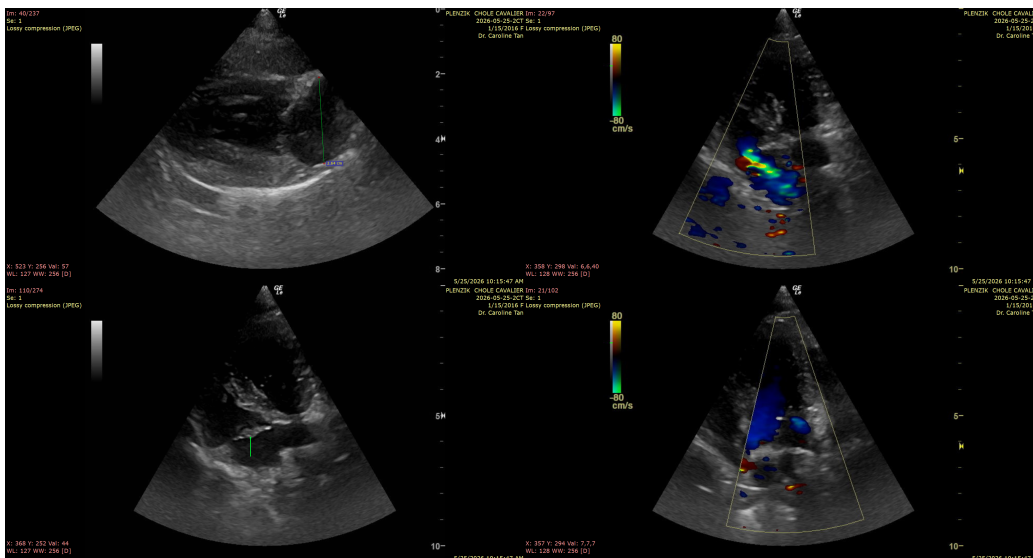
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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](mailto:info@SonoPath.com)