



PATIENT

Buddy Losten

SPECIES

Canine

BREED

Mix

SEX

Neutered Male

AGE

15 Years 6 Months

WEIGHT

29 Pounds

INTERPRETED BY

James Wood, DVM,
 DACVIM (Cardiology)

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

North Jersey AH

REFERRING VET

Dr. Chiu

INVOICE

35983

DATE

5/7/26

PRESENTING CLINICAL SIGNS

History: HM 5/6, Oral lesions. Meds: Pimobendan 2.5 mg PO q 12, Clindamycin 150 mg PO BID

Abnormal PE/Chem/CBC/UA Results: TP 8.1, Glob 4.5, ALKP 223, Chol 350

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

CANINE CARDIAC PARAMETERS	LA long axis	LMaxN	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	4.15	1.59	1.27	1.63	3.27	3.91	1.73
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	13.2	1.55	0.84	6.4	--	38.6	0.87
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	93	--	--	--	69.6	0.39	0.39

LA short: 2.6 Aorta short: 1.6

Cardiac Presentation

The mitral valve leaflets are mildly thickened with mild eccentric and posteriorly directed mitral valve insufficiency. Leaflet prolapse is not identified. The left atrium is mildly dilated. The left ventricle is mildly dilated. Normal global left ventricular systolic function. There is normal right atrial size with mild 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 valve is normal in appearance and motion. There is mild aortic valve insufficiency, subjectively, based on color doppler. The pulmonary valve is normal in appearance and the corresponding outflow velocities are within normal limits. There is no evidence of pulmonary 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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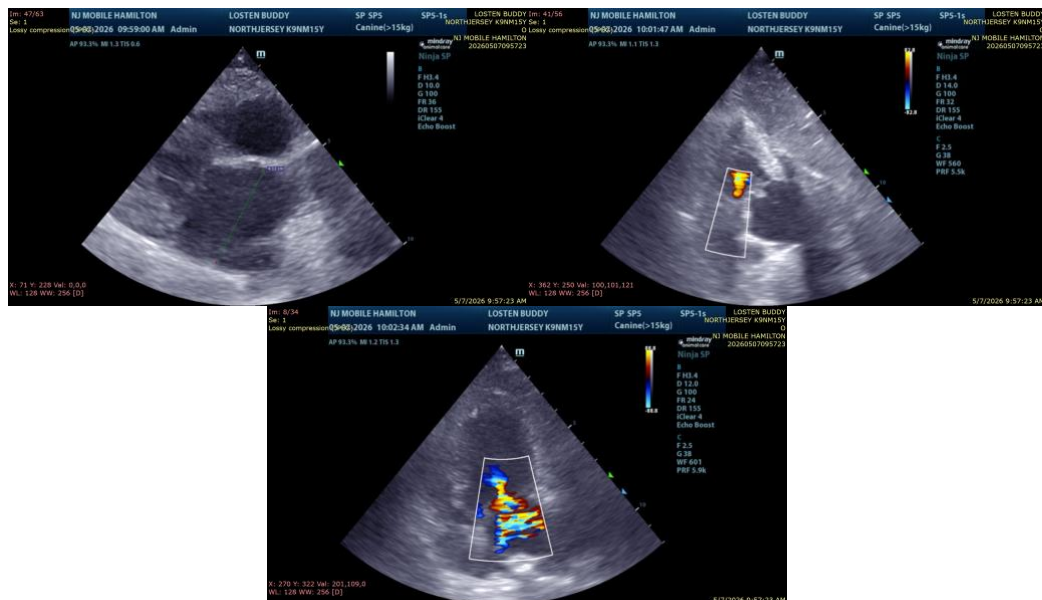
5/7/26

ULTRASONOGRAPHIC FINDINGS

- Myxomatous mitral valve disease- ACVIM stage B2
- Aortic valve insufficiency-mild: Rule out mild endocardiosis.
- Mild tricuspid insufficiency

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The echocardiogram showed evidence of myxomatous mitral valve disease. Based on this echocardiogram, there is significant enough chamber enlargement that the patient would benefit from starting pimobendan (if not already started) at 0.25-0.3mg/kg PO q12hr (for this patient, a slight dose increase for the body weight is recommended, give 1.5 of the 2.5 mg tablet, twice daily) to slow the progression of this disease and delay the onset of CHF. CHF at this time is unlikely based on the reported history and examination, however baseline chest X-rays (within the last ~6 months- 1 year) are reasonable to fully rule out CHF, and obtain a baseline of the patient's pulmonary parenchyma for comparison should clinical signs develop in the future. A blood pressure is also recommended. If the systolic BP >160mmHg while calm, an ACEi at 0.3-0.5 mg/kg PO q12 is recommended provided normal renal function. If so, recheck BP and renal panel with electrolytes in 1-2 weeks. Amlodipine should be considered if persistently hypertensive. If not hypertensive, the benefit of an ACEi or other RAAS blockade is not well established in this population of patients, and is typically reserved for once CHF develops, or if the left atrial and ventricular dimensions are severely increased. Monitoring of renal function is necessary when on these medications. Recheck in 6 months or sooner if concerns arise. At that time, a recheck echocardiogram to monitor for progression +/- thoracic radiographs (i.e. recommended if there is a new cough or increase in the RR).



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.



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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)

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