



PATIENT

Tug Cioffi

SPECIES

Canine

BREED

Maltese/Pom Mix

SEX

Male

AGE

13 Years 8 Months

WEIGHT

5.96 pounds

INTERPRETED BY

R. McKenzie Daniel,
 DVM, DABVP (Canine / Feline Practice)

IMAGING PERFORMED BY

Shari Reffi CVT

HOSPITAL NAME

Smithfield Animal Hospital

REFERRING VET

Dr. Hull

INVOICE

13323

DATE

01/22/26

PRESENTING CLINICAL SIGNS

- Dx w/B2 in 5/2025 (report attached) Seen today for acute coughing, Dyspneic, increased RR
- Current Meds: Pimobendan 5mg (1/4-tab po bid)
- BW pending

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (M-Mode)	LA/AO (Heart Base; Swe)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	Up to 1.6	28-40	40-100	<0.6
PATIENT	6.2	2.2	NM	1.6	45	78	0.3
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT (lbs)	LAD LA MAX 4 Chamber	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				
PATIENT	155	1.1	0.94	5.96	3.0	2.55	--

Cardiac Presentation

The echocardiogram in this patient demonstrated moderate increased **left atrial** size with mild intra-atrial septal deviation based on 2 different LA measurement methods. The cranial and caudal **mitral** valve leaflets presented thickening consistent with endocardiosis with mild valvular prolapse. No evidence of chordate tendon rupture. Doppler revealed significant eccentric MR with mild elevated measured MR velocity. The **left ventricle** presented thicknesses with linear contour and moderate increased LV internal dimension. 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 auricle revealed normal size, structure and content. No evidence of masses was noted or chamber overload. **Tricuspid** valvular assessment demonstrated mild thickening with mild TR on doppler. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. **Pulmonic** tract assessment revealed normal valve structure, laminar flow, and diameter (approx.1:1 pa/ao ratio). No visible **pericardial** or free pleura fluid was noted. No echographically detectable evidence of cardiac / pericardial tumors was visible. No evidence of arrhythmia or hepatic congestion.

ULTRASONOGRAPHIC FINDINGS



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- Chronic mitral valve disease with mild valve prolapse (B2).
- Mild TV insufficiency- no overt current evidence of clinical pulmonary hypertension.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Similar cardiac presentation compared to the previous study with static chamber dimension and without overt progression. The degree of LA/LV enlargement indicates the current and future risk of complication, secondary to MR, is moderately elevated. The potential for emerging cardiogenic pulmonary congestion cannot be definitively excluded with potential concurrent lower airway disease possible. In conjunction with current Pimobendan, a LASIX trial 1.0 to 2.0 mg/kg PO BID with assessment of clinical response is recommended. If positive response, continued low effective dose of diuretic would be indicated. Assessment of systemic BP for evidence of hypertension given mild elevated MR velocity is recommended.

Concurrent as needed respiratory support is recommended. Baseline monitoring of resting respiration rate going forward is advised. Mild salt restriction and omega fatty acid supplementation may prove beneficial. Sonographic and clinical monitoring is recommended for further prognosis. Recheck echo is recommended in four to six months or sooner if continued or progressive clinical signs. If anesthesia is required, the following protocol is recommended with close clinical monitoring and judicious IV fluid use. Suggested anesthetic protocol may include opioid or Benzodiazepine pre-med, induction with Propofol or Alfaxalone, and appropriate gas anesthesia with avoidance of alpha 2 agonists.

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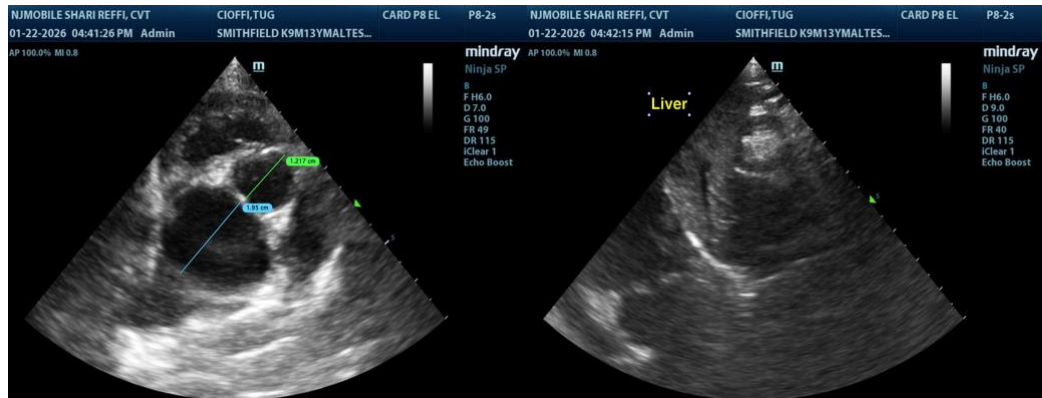
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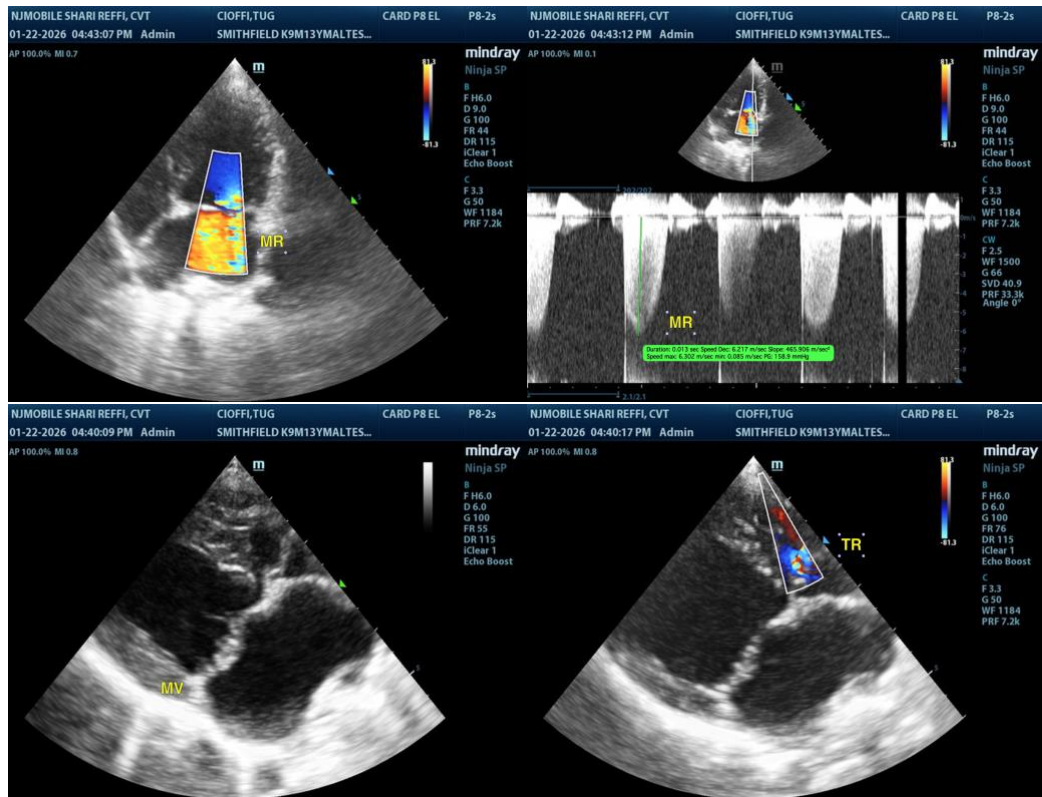
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com