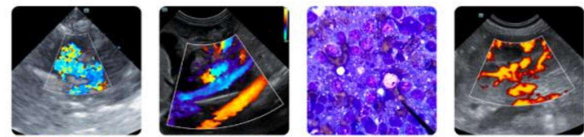


PATIENT

Chuqui Molina

SPECIES

Canine

BREED

Mini Poodle

SEX

Neutered Male

AGE

12 Years 3 Months

WEIGHT

Not Provided

INTERPRETED BY

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

IMAGING PERFORMED BY

Shari Reffi CVT

HOSPITAL NAME

Fredon Animal Hospital

REFERRING VET

Dr. Bednar

INVOICE

13445

DATE

01/29/26

PRESENTING CLINICAL SIGNS

- grade 4-5/6 systolic murmur.
- no crackles
- Meds: prev vet placed on Enalapril - owner unsure of dose.
- pet seen once as pre-dental visit.

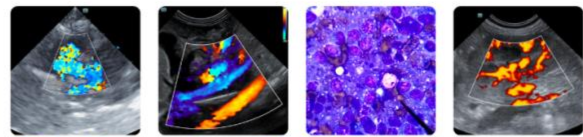
Abnormal PE/Chem/CBC/UA Results: Wnl

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	5.1	3.0	NM	1.1	38	70	0.25
CANINE CARDIAC PARAMETERS	**HR** (BPM)	**AV VMAX** (m/s)	**PV MAX** (m/s)	**BODY WEIGHT** (kg)	**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	NM	1.0	0.6	NM	3.0	2.9	--

Cardiac Presentation

The echocardiogram in this patient demonstrated normal **left atrial** dimension based on 2 different LA measurement methods. The cranial and caudal **mitral** valve leaflets presented thickening consistent with endocardiosis. Doppler indicated measurable moderate eccentric insufficiency. The **left ventricle** presented thicknesses with linear contour and was not dilated nor restricted. 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 auricle** revealed mild increased size, normal structure and content. Right atrial dimension measured 3.0 cm similar to the left atrial dimension. No evidence of masses was noted or chamber overload. **Tricuspid** valvular assessment demonstrated thickening with valvular prolapse and TV insufficiency. 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



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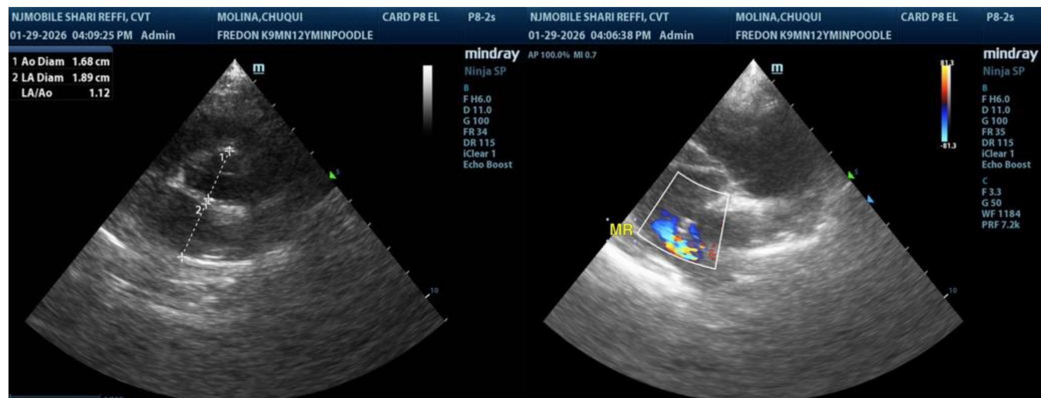
noted. No echographically detectable evidence of cardiac / pericardial tumors was visible. No evidence of arrhythmia.

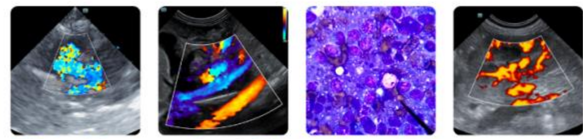
ULTRASONOGRAPHIC FINDINGS

- Chronic mitral valve disease (B1).
- Mild right atrial enlargement.
- Tricuspid valve prolapse with TV insufficiency- estimated pulmonary pressure gradient consistent with mild increased pulmonary pressure without overt clinical pulmonary hypertension.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of the murmur is chronic degenerative valvular changes with secondary eccentric mitral valve and tricuspid valve insufficiency. The lack of left atrial enlargement indicates that the risk of complication secondary to mitral valve insufficiency is low. The mild increased right atrial dimension likewise is currently nonclinical and without evidence of congestive right heart failure or overt pulmonary hypertension. This may suggest mild cor pulmonaly and monitoring for respiratory signs going forward is advised. No indication for medical therapy at this stage. Prognosis is considered variable and sonographic monitoring is recommended. Recheck echo cardiogram is suggested in 6-12 months, sooner if clinical signs are suggestive of left sided heart disease or pulmonary hypertension arise. Current cardiac anesthetic risk is considered mild. 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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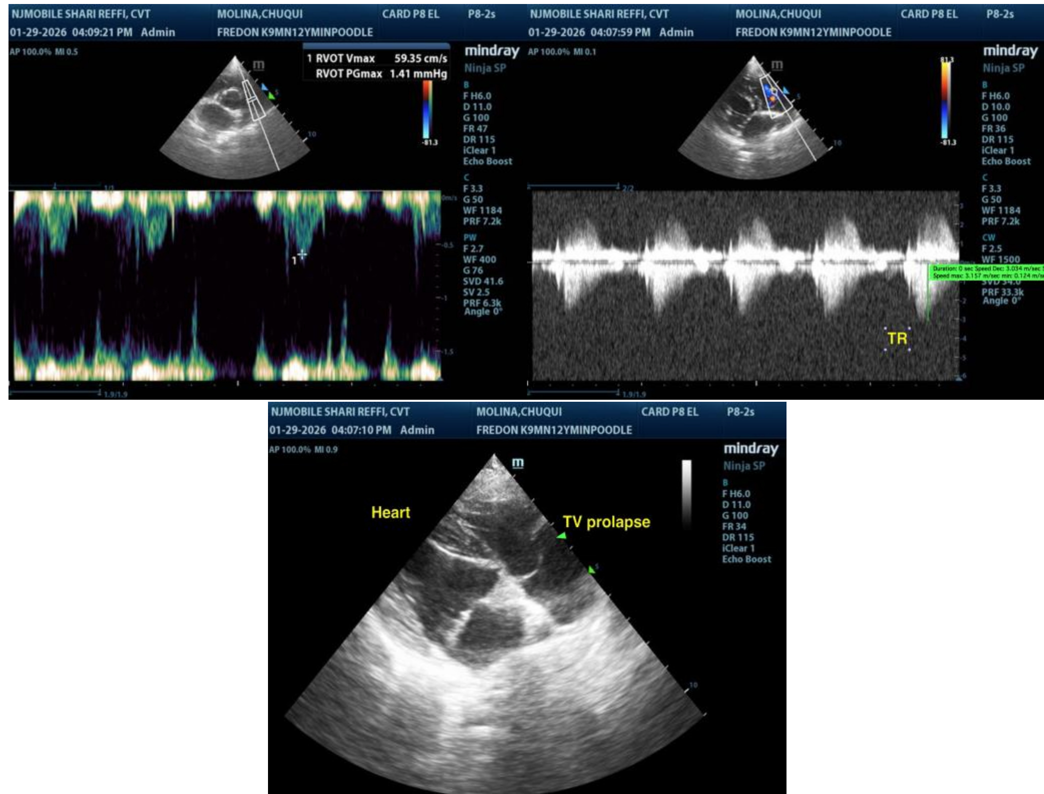

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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