



**PATIENT**

Charlie Woodell

**SPECIES**

Canine

**BREED**

Boxer

**SEX**

Female

**AGE**

4 Years 8 Months

**WEIGHT**

63 pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Rebecca Hamilton

**HOSPITAL NAME**

Black River Vet  
 Hospital

**REFERRING VET**

Dr. Gussman

**INVOICE**

12207

**DATE**

11/11/25

**PRESENTING CLINICAL SIGNS**

Grade 2/6 murmur, no arrhythmia, needs OVH.

**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	--	--	NM	1.3	39	70	0.45
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	128	2.1	1.3	--	3.4	3.8	--

**Cardiac Presentation**

The echocardiogram in this patient demonstrated normal **left atrial** dimension based on 2 separate methods of LA evaluation. The cranial and caudal **mitral** valve leaflets presented normal linear structure, extension in systole, and union in diastole with normal kinesis. No MR on doppler. 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. Mild dynamic LV outflow profile on doppler with mild increased measured LV outflow velocity and aortic valve insufficiency on doppler. The **right atrium** and auricle revealed normal size, structure and content. No evidence of masses was noted. **Tricuspid** valvular assessment demonstrated adequate linear morphology and kinesis. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. **Pulmonary outflow** 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. The cranial **mediastinum** and **pericardial and extra-cardiac regions** were free of masses in the visible window. No evidence of arrhythmia.

**ULTRASONOGRAPHIC FINDINGS**

- Overall, normal cardiac structure/function.
- Mild increased measured LV outflow velocity with mild dynamic outflow pattern.



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- Mild aortic valve insufficiency.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

**SPECIES**

No evidence of clinical issues such as left or right heart chamber enlargement, systolic dysfunction, DCM criteria, pulmonary hypertension or arrhythmia. The only source of the murmur is the mild elevated LV outflow velocity which without overt evidence of LV outflow structural or aortic valve pathology, essentially classifies it as a flow murmur. Mild aortic valve stenosis in conjunction with mild aortic valve insufficiency cannot be definitively excluded. Regardless, the hemodynamic effects of the murmur appear low. No indication for cardiac medication. Conservative monitoring of the murmur going forward is advised with recheck echo suggested in 6-12 months or sooner if clinical signs arise or if murmur intensity increases. Anesthetic risk is considered low. The following protocol is recommended. 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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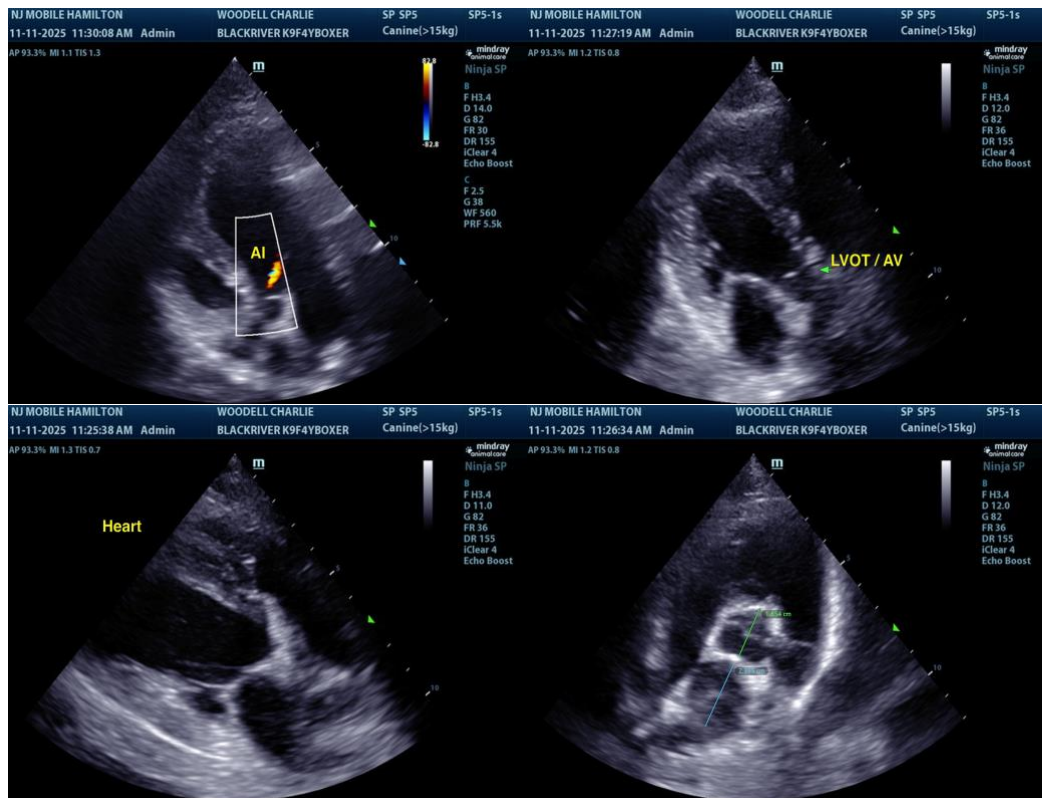
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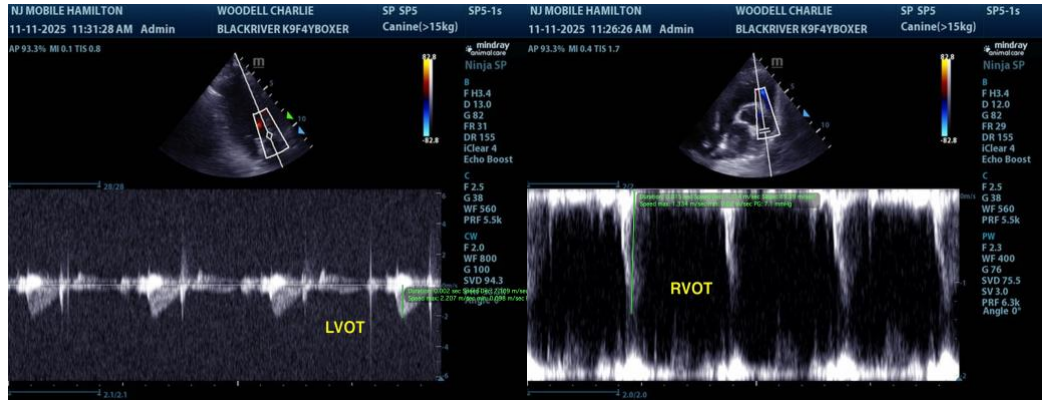
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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](mailto:info@SonoPath.com)