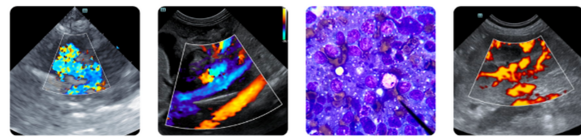




**PATIENT**

Jake Beesimer

**SPECIES**

Canine

**BREED**

Dachshund

**SEX**

Male Neutered

**AGE**

11 years

**WEIGHT**

16.5 lbs

**INTERPRETED BY**

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

**IMAGING PERFORMED BY**

Meghan Morse, LVT, CVT

**HOSPITAL NAME**

Rondout Valley Veterinary Associates

**REFERRING VET**

Dr. Laux

**INVOICE**

12840

**DATE**

11/19/25

## PRESENTING CLINICAL SIGNS

History: CHF, presented today with dyspnea and severe cackles in all fields, Grade 3/6 L systolic murmur

Current meds: Denamarin

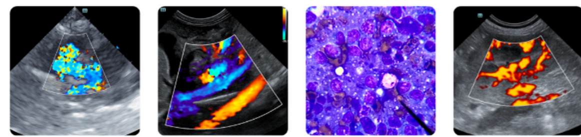
Abnormal PE/Chem/CBC/UA Results: Hx of elevated ALT from another vet

## 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 | -- | -- | -- | 2.6 | 55 | 86 | 0.2 |
| **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 | 1.2 | 0.6 | -- | 4.3 | 3.6 | -- |

### *Cardiac Presentation*

The echocardiogram in this patient demonstrated severe increased **left atrial** size with intra atrial septal deviation based on 2 different LA measurement methods. The cranial and caudal **mitral** valve leaflets presented thickening consistent with endocardiosis, mild valve prolapse and lack of coaptation owing to LA enlargement. Doppler indicated significant eccentric insufficiency. The **left ventricle** presented normal thicknesses with linear contour, moderate to severe increased LV dimension and sphericity. 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 TR noted on doppler. TR velocity measured 3.1 m/s max. 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 free pleura fluid was noted. No echographically detectable evidence of cardiac / pericardial tumors was visible. Pericardial to transdiaphragmatic comet tail artifact noted. No evidence of current hepatic congestion.





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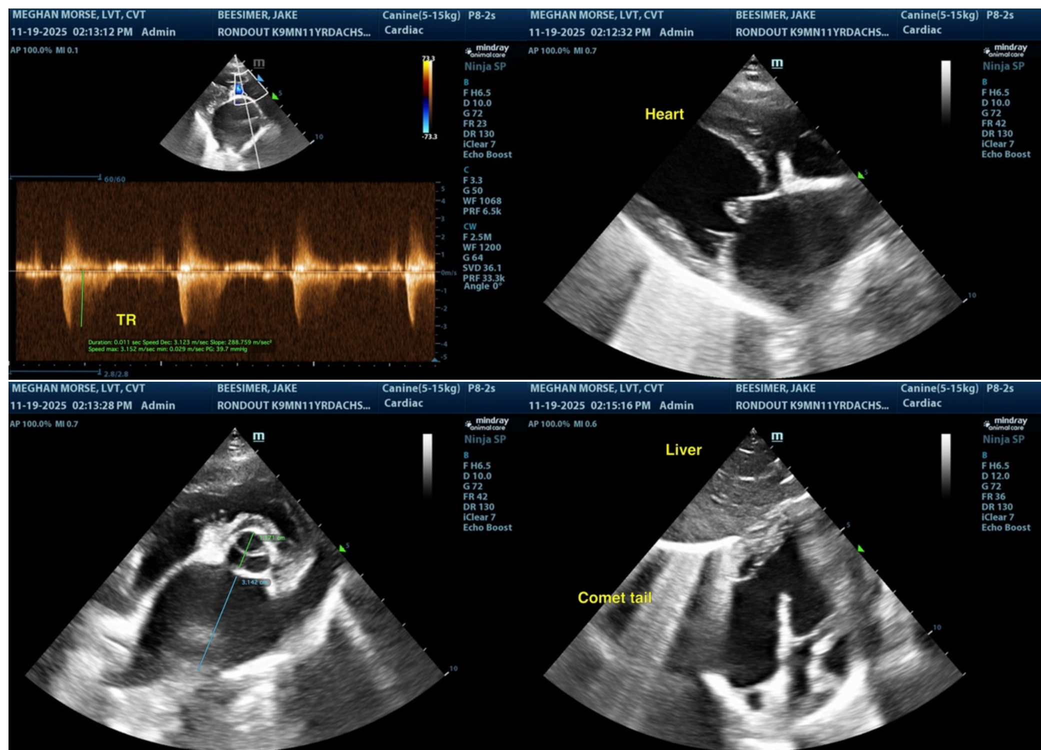
## ULTRASONOGRAPHIC FINDINGS

- Chronic mitral valve disease with eft heart volume overload, mitral valve prolapse, and lack of valve coaptation
- TV insufficiency – estimated pulmonary pressure gradient consistent with mild pulmonary hypertension

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of the murmur is chronic degenerative valvular changes with secondary eccentric mitral valve insufficiency. The left atrial enlargement implies that the risk of complication secondary to mitral valve insufficiency is significantly elevated with possible clinical signs secondary to volume overload. Initiate **Furosemide** / **Spinolactone** 1-2 mg/kg BID, **Pimobendan** 0.3 mg/kg BID. **ACEI** is suggested if systemic BP >130 (not indicated if <130). Monitoring of renal parameters, systemic BP and ECG is recommended as this patient will remain at significant increased risk for progressive CHF development of malignant arrythmia and progressive pulmonary hypertension. Antitussive medication if coughing is suggested. Elective anesthesia is not advised. Prognosis severely guarded to potentially poor, long-term and sonographic monitoring is indicated. Recheck echo suggested in 4-6 months, sooner if clinically indicated.



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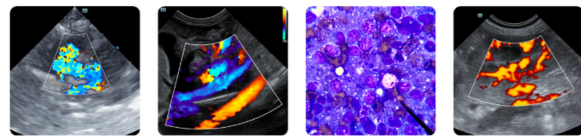

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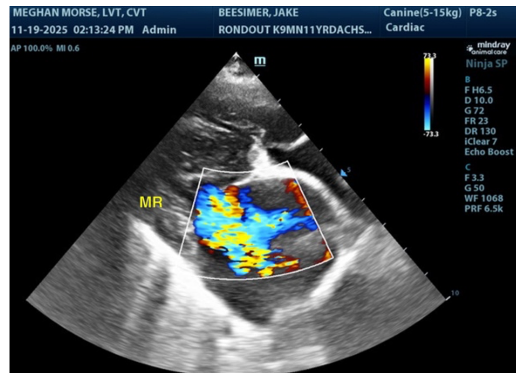


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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