



**PATIENT**

Stella Santos

**SPECIES**

Canine

**BREED**

French Bulldog

**SEX**

Spayed Female

**AGE**

8 Years 11 Months

**WEIGHT**

26 pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Kerri Becker

**HOSPITAL NAME**

Oakland Animal  
Hospital

**REFERRING VET**

Dr. Pellicano

**INVOICE**

12859

**DATE**

12/30/25

**PRESENTING CLINICAL SIGNS**

Declining health, concern for heart dz. Enlarged LN (cytology pending) Enlarged heart on rads

Abnormal PE/Chem/CBC/UA Results: ALT-191 ALP-1937 Tbili-0.7 Alb-1.4 HCT-38.3

**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	NM	44	76	0.1
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	1.0	--	2.4	2.5	--

**Cardiac Presentation**

The echocardiogram in this patient demonstrated normal **left atrial** dimension based on LA2D measurement. The cranial and caudal **mitral** valve leaflets presented normal linear structure, extension in systole, and union in diastole with normal kinesis. No obvious significant 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. The **right atrium** and auricle revealed subjective mild increased dimension, normal structure and content. No evidence of right atrium/auricle masses were noted. **Tricuspid** valve was indistinctly visualized exhibiting mild to moderate TR on doppler. The **right ventricle** was of subjective normal size (compared to the LV) with normal chordae structure, myocardial echogenicity and subjective free wall thickness. **Pulmonary outflow** tract assessment revealed normal valve structure, laminar flow on doppler with increased pulmonary artery (~1.8 cm) diameter compared to the aorta. 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. A small nonhomogenous mass in the area of the heart base and left atrium was visualized measuring approximately 2.0 cm in diameter. No evidence of hepatic congestion or cranial abdomen ascites. Mild transdiaphragmatic comet tail artifact was present.



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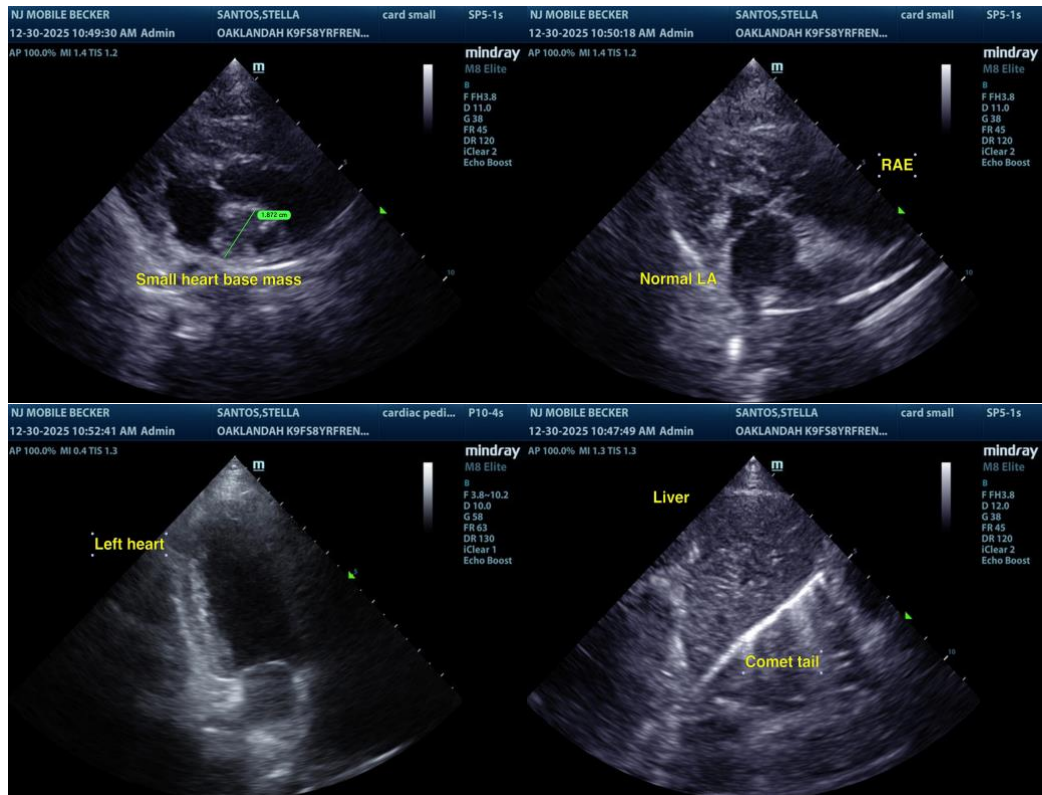
12/30/25

**ULTRASONOGRAPHIC FINDINGS**

- Normal LA/LV.
- Mild enlarged right atrium with TV insufficiency.
- Mildly dilated pulmonary artery.
- Small heart-based mass adjacent to the left atrium- sarcoma, chemodectoma, or other.
- Noncongested liver with mild transdiaphragmatic comet tail artifact.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Although definitive tricuspid valve regurgitation measurement was not obvious, the dilated pulmonary artery, mild right atrium enlargement and tricuspid insufficiency may suggest some degree of pulmonary hypertension if concurrent clinical signs are present. No evidence of left heart volume overload. Correlation with thoracic radiographs to assess for evidence of primary pulmonary pathology is recommended. If present, potential pulmonary hypertension appears to be compensated given no evidence of hepatic congestion. A referral for further diagnostic imaging may be considered given small heart-based/peri-atrial mass.





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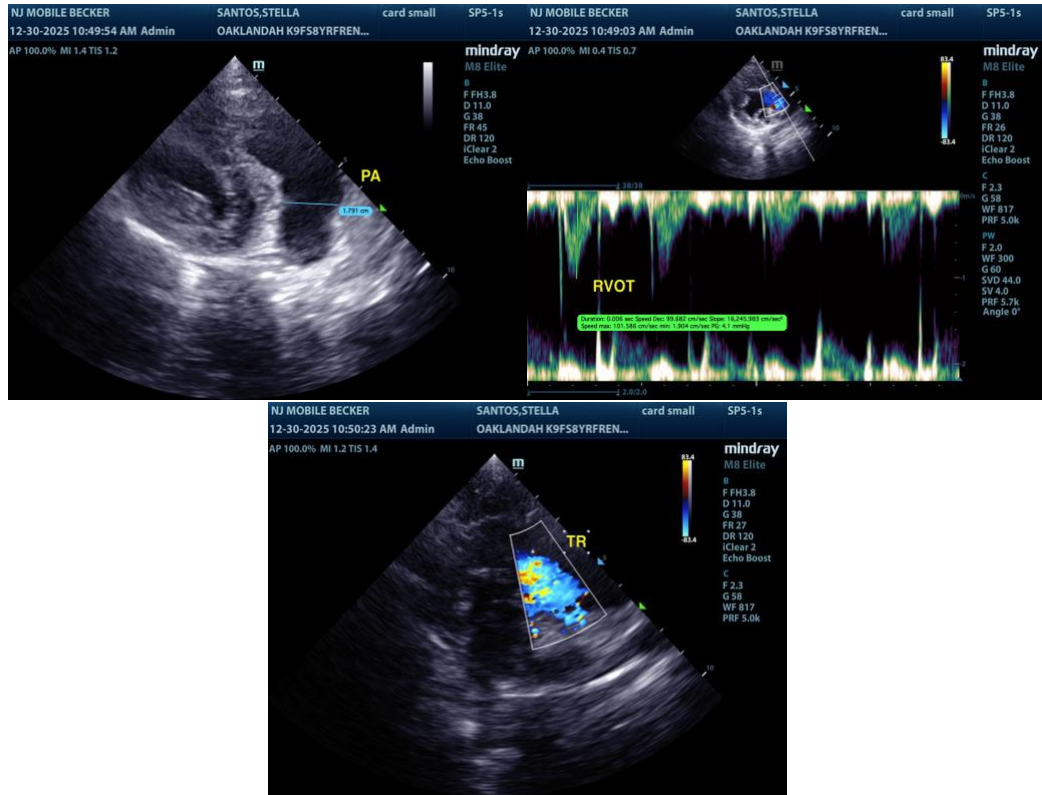
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)