



PATIENT

Spencer Dellorto

SPECIES

Canine

BREED

Maltese Mix

SEX

Spayed Female

AGE

11

WEIGHT

13.8

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenn

HOSPITAL NAME

Rockaway Animal
Hospital

REFERRING VET

Dr. Brooks

INVOICE

13981

DATE

02/27/26

PRESENTING CLINICAL SIGNS

- 1 week of coughing , not eating well for a week did eat chicken and rice. loose stool 2-3 days
5/6 L apical systolic murmur with bilateral mild crackles

Abnormal PE/Chem/CBC/UA Results: CBC Chem lytes normal 4 dx negative

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	5.3	--	NM	2.1	52	85	0.25
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT	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	--	13.8	3.7	3.5	--

Cardiac Presentation

The echocardiogram in this patient demonstrated severe increased **left atrial** dimension with 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. Doppler indicated measurable significant eccentric insufficiency. The **left ventricle** presented thicknesses with linear contour and increased LV 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 suspect mild TR with no overt clinical pulmonary hypertension. 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.

ULTRASONOGRAPHIC FINDINGS



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- Chronic mitral valve disease (ACVIM stage C).

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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The cause of the murmur is chronic degenerative valvular changes with secondary eccentric mitral valve insufficiency. The degree of LA enlargement and intra-atrial septal deviation indicates that the risk of complication secondary to mitral valve insufficiency is significantly elevated with suspect emerging congestion and clinical signs owing to volume overload. **Furosemide** 1-2 mg/kg BID, **Pimobendan** 0.3 mg/kg BID. **ACEI** is suggested if systemic BP >130. Antitussive medication if coughing is suggested. Omega fatty acid supplementation and mild salt restriction may be beneficial. Serial monitoring of resting respiration rate is recommended. Prognosis is considered guarded / variable and sonographic monitoring is recommended. Recheck echo cardiogram is suggested in 6 months, sooner if progressive clinical signs.

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Anesthetic risk is significant with elective anesthesia not advised unless absolutely necessary. If required, the following protocol is recommended with limited anesthetic time and judicious IV fluid administration. 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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Monitoring of renal parameters, systemic BP and ECG are recommended as this patient will remain at increased risk for progressive CHF or development of malignant arrhythmia, i.e. atrial fibrillation.

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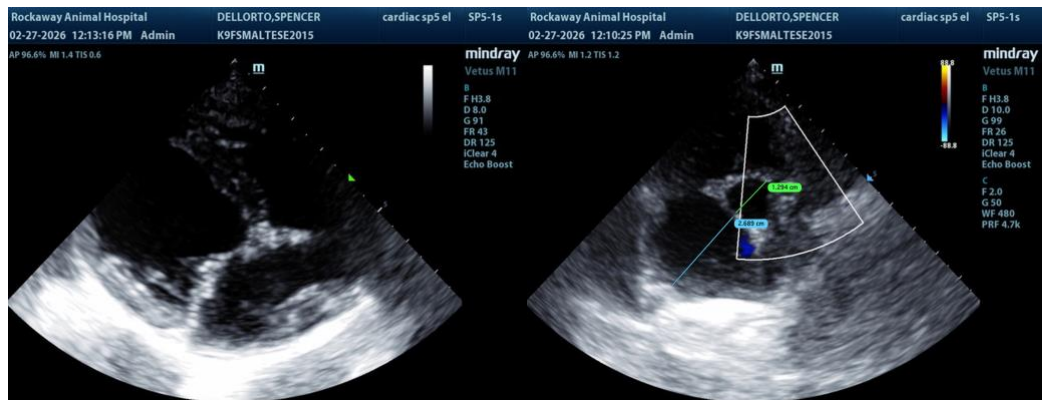
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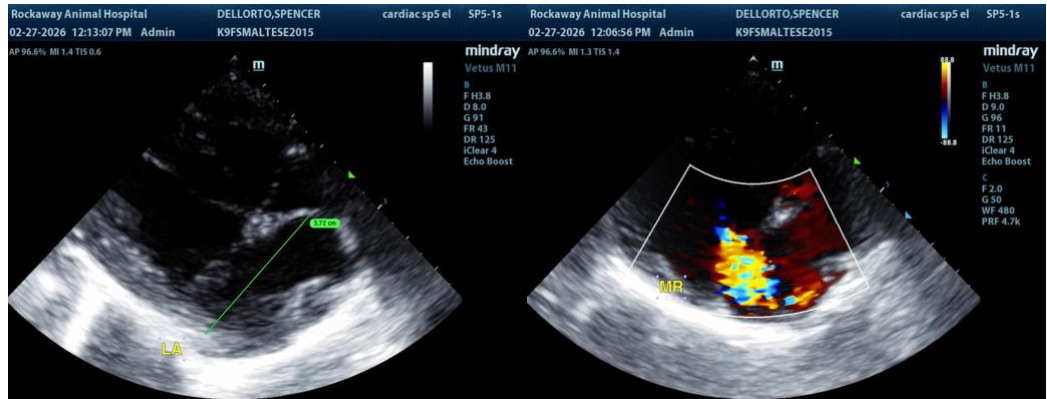
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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