



PATIENT

Roxy Acquaviva

SPECIES

Canine

BREED

Pomeranian

SEX

Spayed Female

AGE

16 Years 4 Months

WEIGHT

8.9 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Kerri Becker

HOSPITAL NAME

Legacy Animal Hospital

REFERRING VET

Dr. Potenzzone

INVOICE

13601

DATE

02/04/26

PRESENTING CLINICAL SIGNS

- CHF-recheck- syncope events-med change?
- Vetmedin, gaba, denamarin, hydro, benaz, furos

Abnormal PE/Chem/CBC/UA Results: Borderline anemia non regen hct-35 neut-15 mono-2.19

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	--	3.0	NM	1.3	40	74	0.2
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT (lbs)	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	0.85	8.9	2.0	2.0	--

Cardiac Presentation

The echocardiogram in this patient demonstrated normal **left atrial** size based on 2 different LA measurement methods. The cranial and caudal **mitral** valve leaflets presented mild thickening consistent with mild endocardiosis. Doppler revealed eccentric insufficiency. The **left ventricle** presented thicknesses with linear contour and was not dilated nor restricted. Flattened appearance to the IVS. The **myocardium** presented normal echogenicity without subjective evidence of significant fibrotic or ischemic disease with mild myocardial remodeling. **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 mild increased size with normal structure and content. No evidence of masses was noted or chamber overload. **Tricuspid** valvular assessment demonstrated thickening with moderate tricuspid regurgitation on doppler. The **right ventricle** demonstrated increased size compared to the LV with normal chordae structure, myocardial echogenicity and free wall thickness. **Pulmonic** tract assessment revealed overtly normal valve structure, laminar flow and subjective diameter compared to the aorta. Normal to mildly decreased measured LV outflow velocity. No visible **pericardial** or free pleura fluid was noted. No echographically detectable evidence of cardiac / pericardial tumors was visible. No current evidence of hepatic congestion.



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Transdiaphragmatic view revealed mild comet tail lung pattern, which is echogenic sound wave interface with microconsolidations within the caudal lung field. The lung field should not be visualized by sonogram unless pathology is present. Chest radiographs are recommended to rule out alveolar/lung disease such as neoplasia, thromboembolic disease, chronic inflammatory disease with microconsolidation.

ULTRASONOGRAPHIC FINDINGS

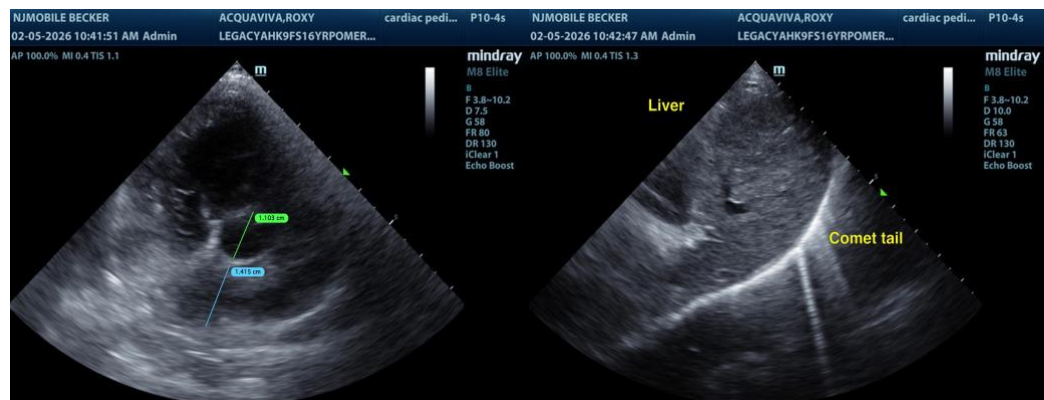
- Compensated mitral valve insufficiency (B1).
- Pulmonary hypertension with mild RA/RV enlargement- possible cor pulmonaly.
- Noncongested liver with mild transdiaphragmatic comet tail artifact.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The measured TR velocity indicates mild pulmonary hypertension yet given evidence of right atrium/ventricle enlargement and clinical signs, underestimation of TR velocity is probable indicating at least moderate pulmonary hypertension without current evidence of right heart failure. Except in cases of known heartworm disease, the underlying etiology for pulmonary hypertension may not be obvious yet may be associated with chronic lower airway disease.

Correlation with three view chest radiographs is recommended. Continued Pimobendan 0.3 mg/kg PO BID is warranted. Sildenafil 1 to 3 mg/kg BID is recommended with concurrent as needed respiratory support. Given current lack of left or right heart congestive criteria, no overt indication for diuretic therapy at this stage, however, this patient will remain at significantly increased risk for progressive pulmonary hypertension or congestive right heart failure.

Elective anesthesia is not advised with concurrent exercise restriction. Sonographic monitoring is indicated for further prognosis. Recheck echo is suggested in four to six months if patient is stabilized or sooner if progressive clinical signs.





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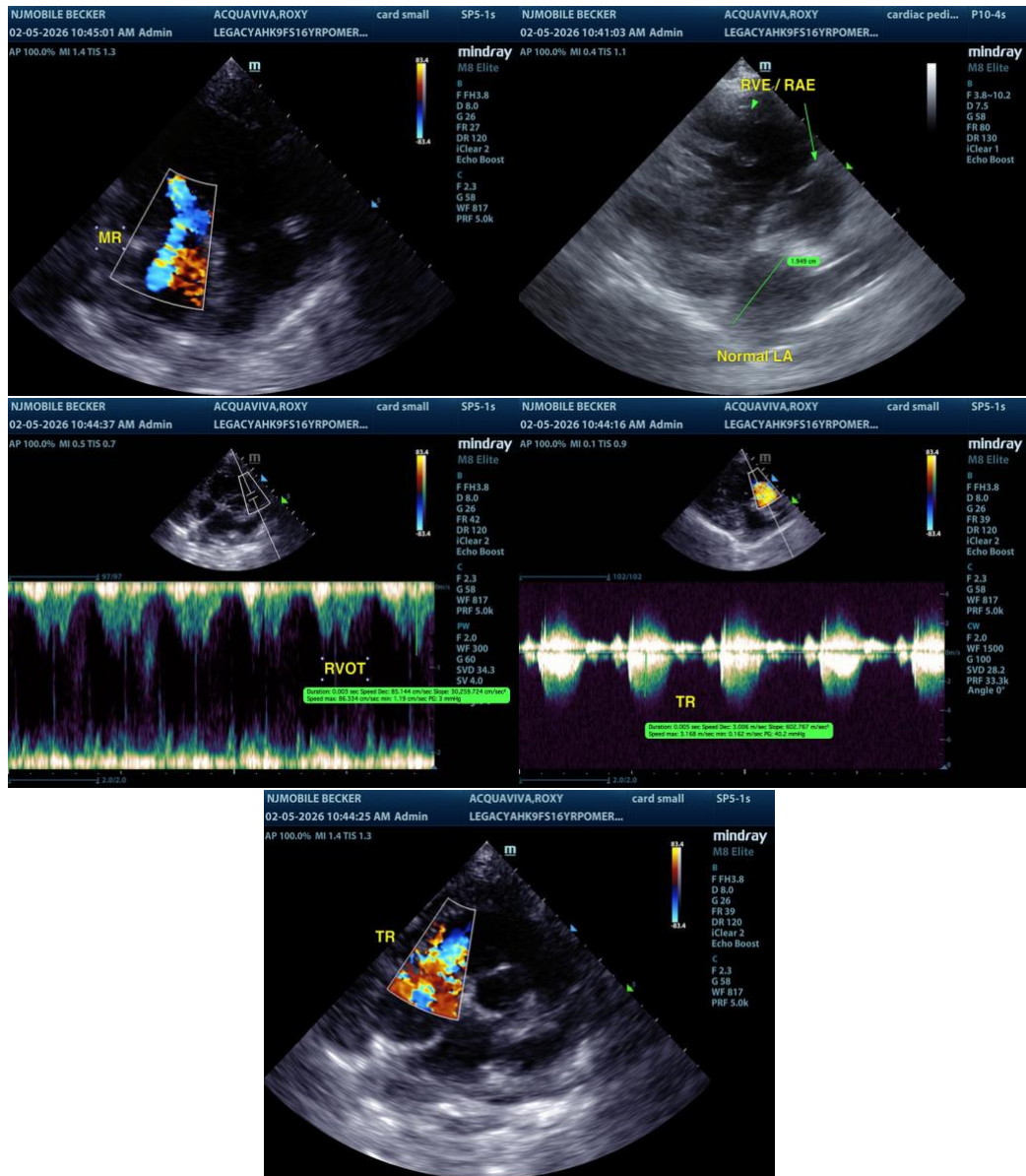
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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