



PATIENT

Douglas Sudia

SPECIES

Canine

BREED

Mix

SEX

MN

AGE

9 years

WEIGHT

12.5 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Diane McFadden

HOSPITAL NAME

Advanced Veterinary
Care

REFERRING VET

Dr. Anderson

INVOICE

13520

DATE

3/22/22

PRESENTING CLINICAL SIGNS

3/6 murmur noted during well visit. On Heartgard plus
Abnormal PE/Chem/CBC/UA Results: n/a

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (Boon method)	LA/AO (Heart Base; Swe)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	<1.6	28-40	40-100	<0.6
PATIENT	5.7	3.2	1.33	1.33	43.5	78.1	0.25
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT (kg)	LA 2D short axis Base view (cm)	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	BELOW	BELOW	BELOW	BELOW
PATIENT	167	1.0	0.9		2.8	2.3	

Cardiac Presentation

The echocardiogram in this patient demonstrated normal **left atrial** size based on 3 different LA measurement methods. Chamber volumes and echogenicity were normal. The cranial and caudal **mitral** valve leaflets presented vegetative thickening consistent with endocardiosis. Doppler indicated measurable eccentric insufficiency. 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 normal size, structure and content. No evidence of masses was noted or chamber overload. **Tricuspid** valvular assessment demonstrated subjective adequate linear morphology with subjective mild thickening. Mild TR was present on doppler. 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 infiltrative disease was visible. The cranial **mediastinum and pericardial regions** were free of masses in the visible window.



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ULTRASONOGRAPHIC FINDINGS

- Chronic mitral valve disease (ACVIM B1)
- Mild TV insufficiency - estimated pulmonary pressure gradient consistent with mild elevated pulmonary pressures yet not suggestive of clinical pulmonary hypertension

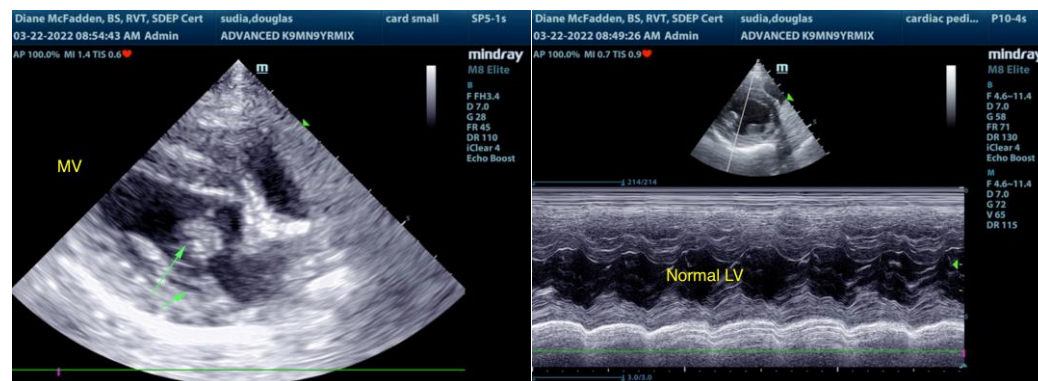
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of the murmur is secondary to chronic degenerative valvular changes with primary eccentric mitral valve insufficiency and concurrent mild tricuspid valve insufficiency. The lack of left atrium enlargement indicates that the current risk of complication secondary to mitral valve insufficiency is low, yet prognosis at this stage is highly variable. No other clinical issues such as systolic dysfunction were present.

In a nonclinical patient without significant chamber enlargement, cardiac medications are not specifically indicated. Conservative monitoring of the murmur at this time is recommended. Serial sonographic monitoring is recommended for further prognosis. Recheck echocardiogram is suggested in 6 months, sooner if clinical signs suggestive of left-sided heart disease or pulmonary hypertension arise.

The following anesthetic protocol is suggested if anesthesia is required.

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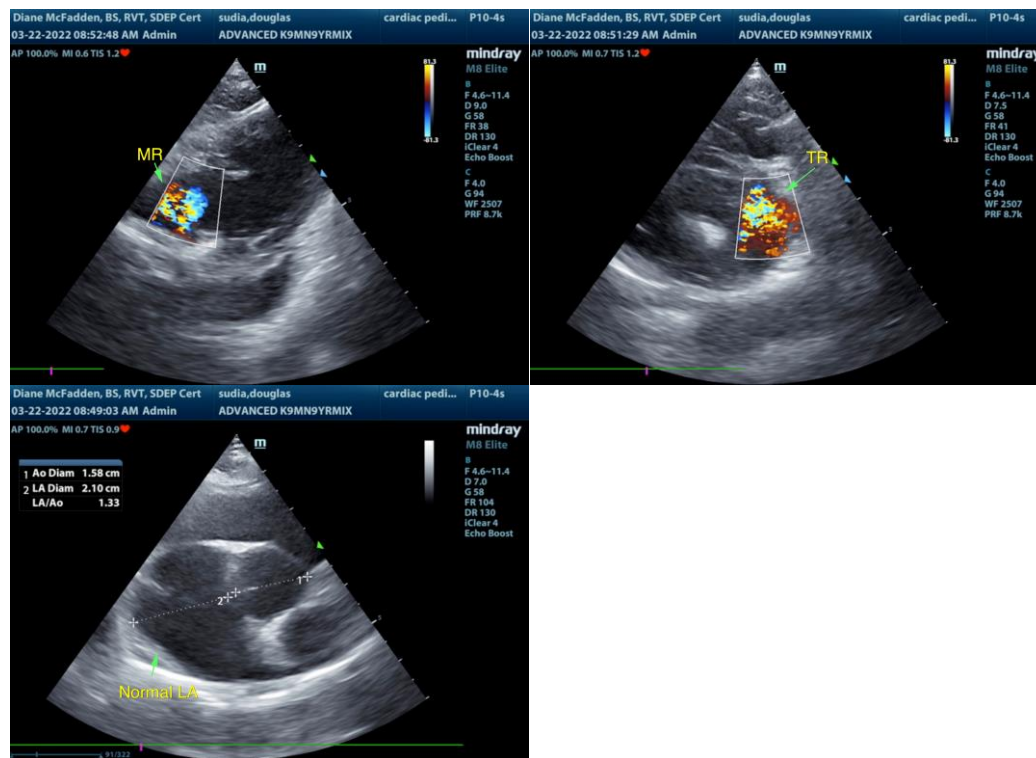
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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