



PATIENT

Riley McCarthy

SPECIES

Canine

BREED

Mix

SEX

MN

AGE

10 years

WEIGHT

57 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

VCA Blaristown AH

REFERRING VET

Dr. Clegg

INVOICE

13559

DATE

3/25/22

PRESENTING CLINICAL SIGNS

Pre-anesthetic evaluation for surgery. Grade III/VI murmur. Current meds: Clonidine, Fluoxetine, Torbutrol for the u/s.

Abnormal PE/Chem/CBC/UA Results: wnl

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	5.1		1.4	1.59	38.7	69.1	0.4
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	NM	1.0	0.83		5.0	4.6	

Cardiac Presentation

The echocardiogram in this patient demonstrated mildly enlarged **left atrial** size based on 3 different LA measurement methods. The left atrium exhibited subtle deviation of the interatrial septum towards the right atrium suggestive of mild increased left atrial pressure. Chamber volumes and echogenicity were normal. The cranial and caudal **mitral** valve leaflets presented vegetative thickening consistent with endocardiosis. Doppler indicated measurable eccentric insufficiency. No evidence of mitral valve prolapse was evident. The **left ventricle** presented normal thicknesses with maintained linear contour with subtle subjective increased left ventricle volume. 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 adequate linear morphology. 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 early B2)

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of the murmur is secondary to chronic degenerative valvular changes with secondary eccentric mitral valve insufficiency. The mild left atrium enlargement indicates that the risk of current and future complications going forward is mildly elevated, yet overall the heart appears to be compensated. No other additional clinical issues such as LV systolic dysfunction or evidence of clinical pulmonary hypertension were noted.

In a nonclinical patient with only mild cardiac changes, medications are not specifically indicated. However, serial sonographic monitoring is recommended for further prognosis. No overt anesthetic contraindications yet this patient may be at some risk for fluid overload. Judicious IV fluid use under anesthesia is advised. Recheck echocardiogram is suggested in 6 months, sooner if clinical signs arise.

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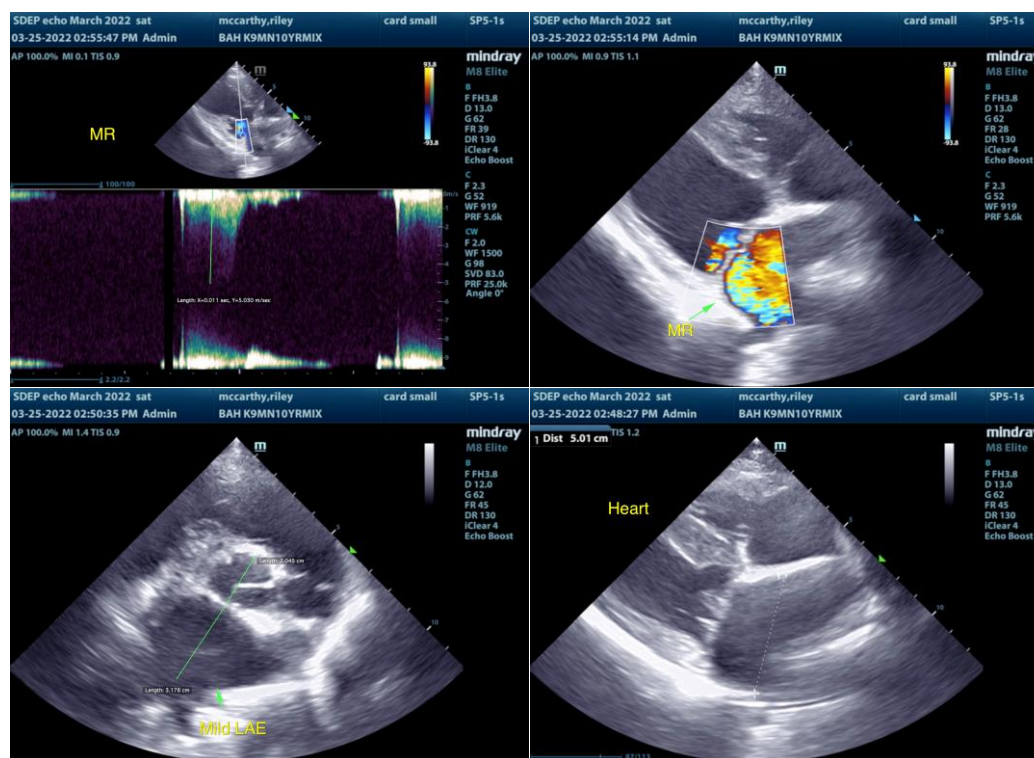
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I



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can be of any further assistance please contact me.

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