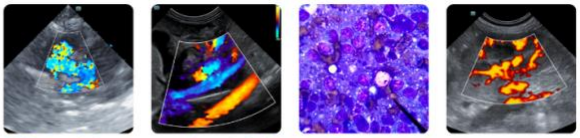

PATIENT

Lucy Schreiber

SPECIES

Canine

BREED

Maltipoo Mix

SEX

Spayed Female

AGE

11 Years

WEIGHT

10.4 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Vincent Ravancho CVT

HOSPITAL NAME

New Bridge Vet Practice

REFERRING VET

Dr. Glennon

INVOICE

15518

DATE

04/28/26

PRESENTING CLINICAL SIGNS

Lethargic, Grade IV/VI Murmur.

Current medications - Lasix (from emergency clinic). Worried about ruptured chordae tendineae

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	5.9	2.5	NM	1.2	55	86	0.15
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	96	1.5	0.7	10.4	2.6	2.6	--

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 thickening consistent with endocardiosis (anterior greater than posterior) with mild prolapse of the septal leaflet. The chordae tendineae appeared to be intact when visualized. Doppler revealed severe eccentric MR. 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 mild thickening with mild TR 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 cardiac / pericardial tumors was visible. No evidence of arrhythmia or hepatic congestion.

ULTRASONOGRAPHIC FINDINGS

- Chronic mitral valve disease with mitral valve prolapse (B1).
- Mild tricuspid insufficiency- no overt current clinical pulmonary hypertension.

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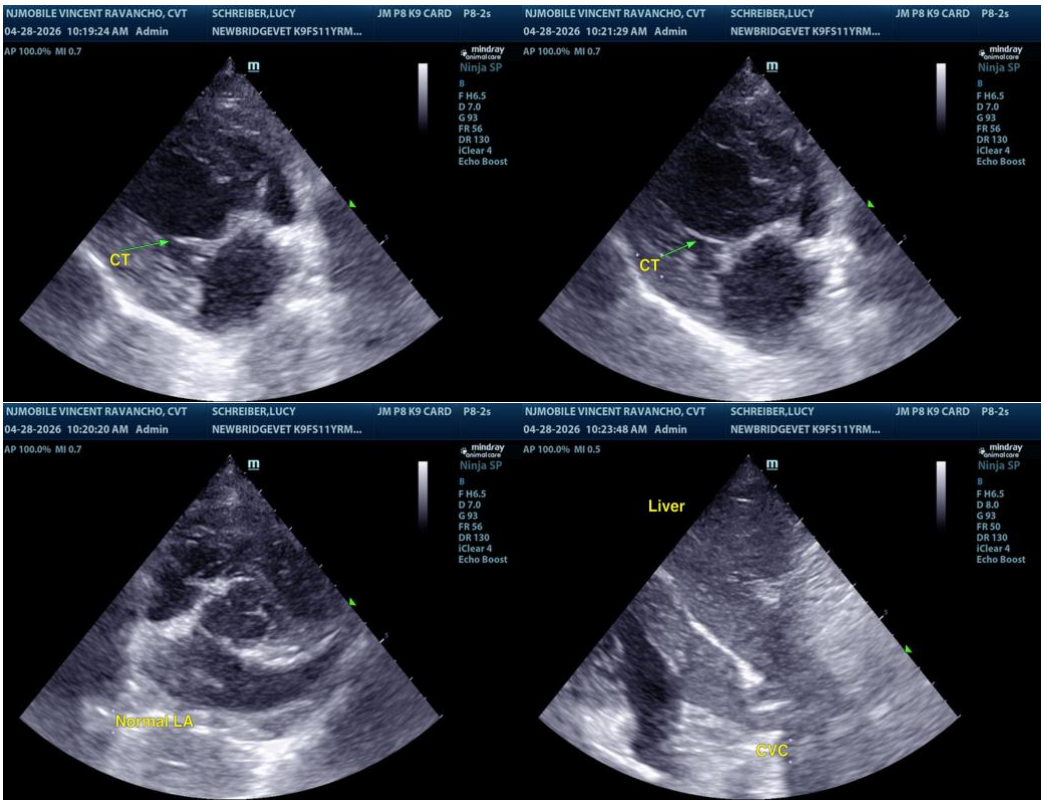
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of the murmur is chronic degenerative valvular changes with secondary primary eccentric mitral valve insufficiency and concurrent tricuspid valve insufficiency. Moderate thickened mitral valve leaflets are present with valvular prolapse. Definitive evidence of chordae tendineae rupture and flail leaflet was not obvious. The lack of left atrial enlargement implies that the risk of complication secondary to mitral valve insufficiency is low at this stage.

Although no evidence of chamber enlargement yet with significant to severe mitral valve insufficiency, Pimobendan 0.3 mg/kg PO BID is recommended as degree of MR may accentuate left chamber enlargement. No obvious indication for diuretic therapy given current chamber size, yet if clinical signs consistent with emerging congestion in conjunction with radiographic pulmonary edema, LASIX trial at lowest effective dose with clinical monitoring would be appropriate.

Prognosis remains highly variable and sonographic monitoring is advised. Recheck echo is recommended in four to six months, sooner if progressive clinical signs. Anesthetic risk is considered mild to moderately elevated yet possible mildly reduced once on Pimobendan for three to five days. If required, the following protocol is indicated with limited anesthetic time and judicious IV fluid use. 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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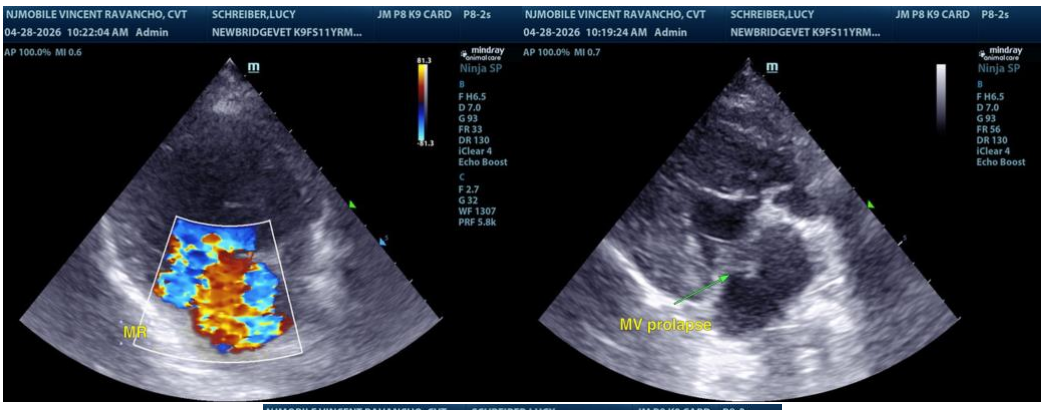

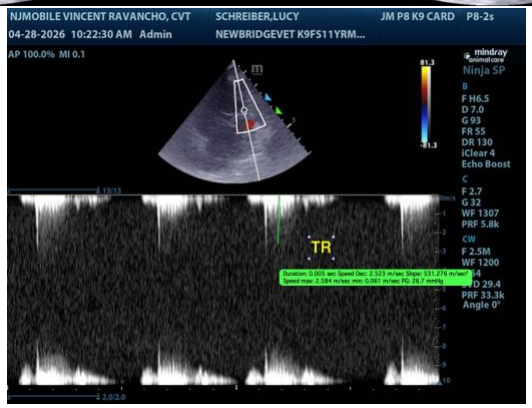

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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