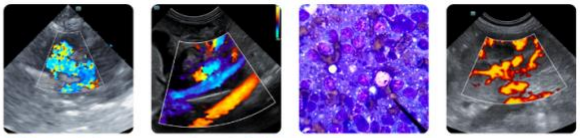

PATIENT

Charlie Riger

SPECIES

Canine

BREED

Mini Schnauzer

SEX

Neutered Male

AGE

16 Years 2 Months

WEIGHT

10.7 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Kerri Becker

HOSPITAL NAME

Wyckoff Veterinary Hospital

REFERRING VET

Dr. Eisenberg

INVOICE

15687

DATE

05/01/26

PRESENTING CLINICAL SIGNS

Grade 4/6 murmur. Vetmedin and benaz

Abnormal PE/Chem/CBC/UA Results: alp-700

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	6.5	--	NM	2.1	45	78	0.3
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	1.6	1.0	10.7	3.8	3.3	--

Cardiac Presentation

The echocardiogram in this patient demonstrated moderate to severe increased **left atrial** size based on 2 different LA measurement methods with associated intra-atrial septal deviation. The cranial and caudal **mitral** valve leaflets presented thickening consistent with endocardiosis. Mild valvular prolapse. Doppler indicated measurable significant eccentric MR with elevated measured MR velocity. The **left ventricle** presented thicknesses with linear contour and moderate 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 mild thickening with mild valve prolapse and 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 hepatic congestion or arrhythmia.

ULTRASONOGRAPHIC FINDINGS

- Chronic mitral valve disease with valve prolapse (ACVIM stage B2).
- Mild tricuspid valve prolapse and insufficiency- no obvious clinical pulmonary hypertension.

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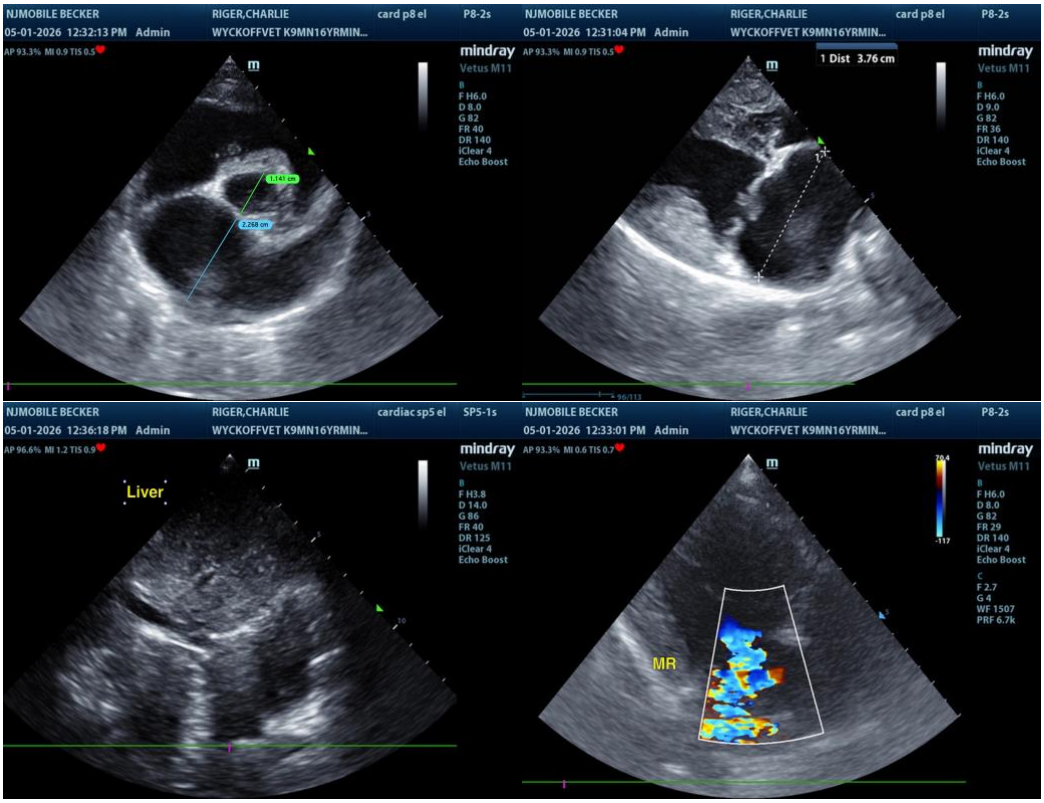
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given no reported clinical signs, the degree of LA/LV enlargement is consistent with B2 chronic mitral valve disease. Baseline monitoring of resting respiration going forward is indicated as possible emerging to clinical left-sided congestion is possible. Omega-3 fatty acid supplementation and mild salt restriction may prove beneficial.

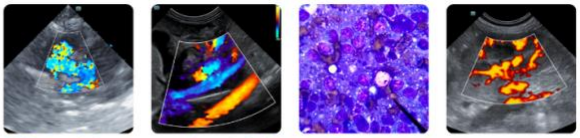
Continued Vetmedin and 0.3 mg/kg BID and ACE inhibitor would be reasonable assuming no evidence of emerging left-sided congestion. Weak diuretic spironolactone 1.0 to 2.0 mg/kg could be considered if emerging elevated resting respiration rate without evidence of radiographic pulmonary edema.

Prognosis going forward is highly variable to guarded with serial sonographic monitoring indicated. Recheck echo is suggested in six months, sooner if clinical signs initiate.

Anesthetic risk is at least moderate with elective anesthesia not advised unless absolutely necessary. If required, the following protocol is recommended 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.



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



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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