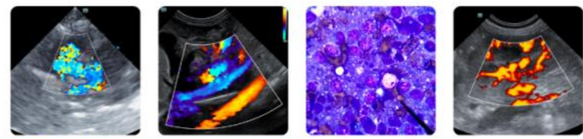


PATIENT

Christee Cancel

SPECIES

Canine

BREED

Bernadoodle

SEX

Spayed Female

AGE

14 Years 8 Months

WEIGHT

17 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

Wyckoff Veterinary Hospital

REFERRING VET

Dr. Eisenberg

INVOICE

16211

DATE

05/14/26

PRESENTING CLINICAL SIGNS

Recheck echo. meds: Vetmedin 0.3 mg/kg Q12

Abnormal PE/Chem/CBC/UA Results: ^ ALT 234, ^ BUN 47, Urine: USG 1.019

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

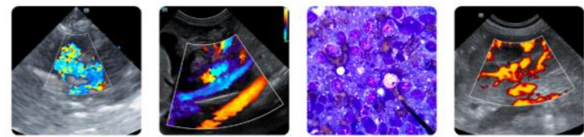
CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (M-Mode)	LA/AO (Heart Base; Swe)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	Up to 1.6	28-40	40-100	<0.6
PATIENT	5.9	--	NM	2.2	55	86	0.3
CANINE CARDIAC PARAMETERS	**HR (BPM)**	**AV VMAX (m/s)**	**PV MAX (m/s)**	**BODY WEIGHT (lbs)**	**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	145	1.5	1.1	17	3.9	3.5	--

Cardiac Presentation

The echocardiogram in this patient demonstrated moderate to significant increased **left atrial** dimension based on 2 different LA measurement methods with mild intra-atrial septal deviation. The cranial and caudal **mitral** valve leaflets presented thickening (anterior greater than posterior) consistent with endocardiosis. Minor valvular prolapse. Doppler revealed significant eccentric MR. The **left ventricle** presented thicknesses with linear contour and moderate to mildly progressive increased LV dimension. The **myocardium** presented normal echogenicity without subjective evidence of significant fibrotic or ischemic disease. **Contractility** of the ventricular walls was adequate to mildly hyperdynamic as evidenced by the fracture shortening measurement and subjective evaluation 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 cardiac / pericardial tumors was visible. No evidence of arrhythmia or hepatic congestion.

ULTRASONOGRAPHIC FINDINGS

- Mildly progressive chronic mitral valve disease (ACVIM B2 – possible B2+).



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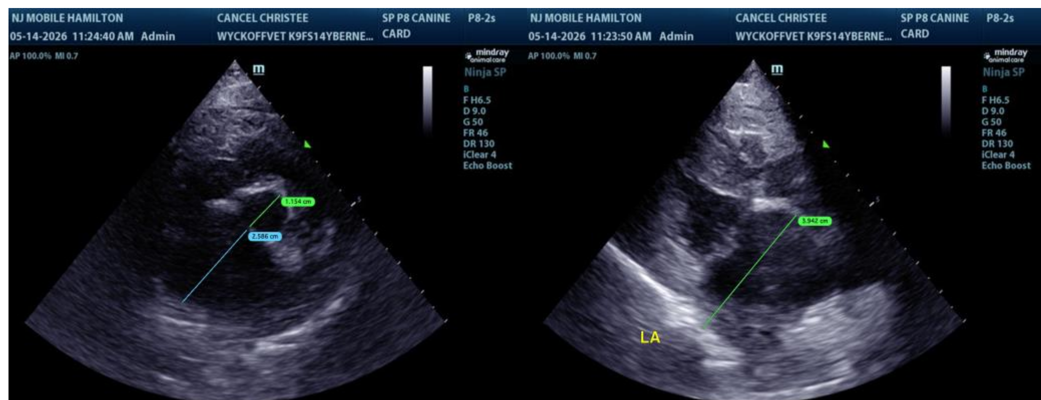
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

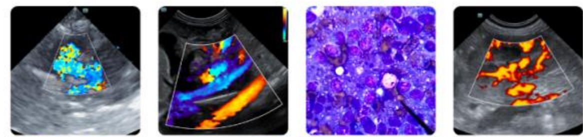
Evidence of progression compared to the previous study with mild progressive increased LA/LV dimension. Some degree of measurement variability is possible, yet the subjective mild progressive increased left chamber dimension indicates the current and future risk of complication, secondary to MR, is elevated.

Continued Pimobendan at 0.3 mg/kg BID is indicated. Correlation with current clinical signs and assessment of resting respiration rate is indicated. Lowest effective dose LASIX 1-2 mg/kg PO BID is indicated if elevated resting respiration rate or non-reported signs of congestion. ACE inhibitor at 0.5 mg/kg SID to BID is warranted if systemic BP is greater than 130. Omega-3 fatty acid supplementation and mild salt restriction may prove beneficial. Antitussive medication is indicated if continued or non-reported coughing.

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

Anesthetic risk is at least moderately elevated. Elective anesthesia is not overtly advised unless absolutely necessary. If required, the following protocol is suggested with limited anesthetic time and judicious IV fluid administration. 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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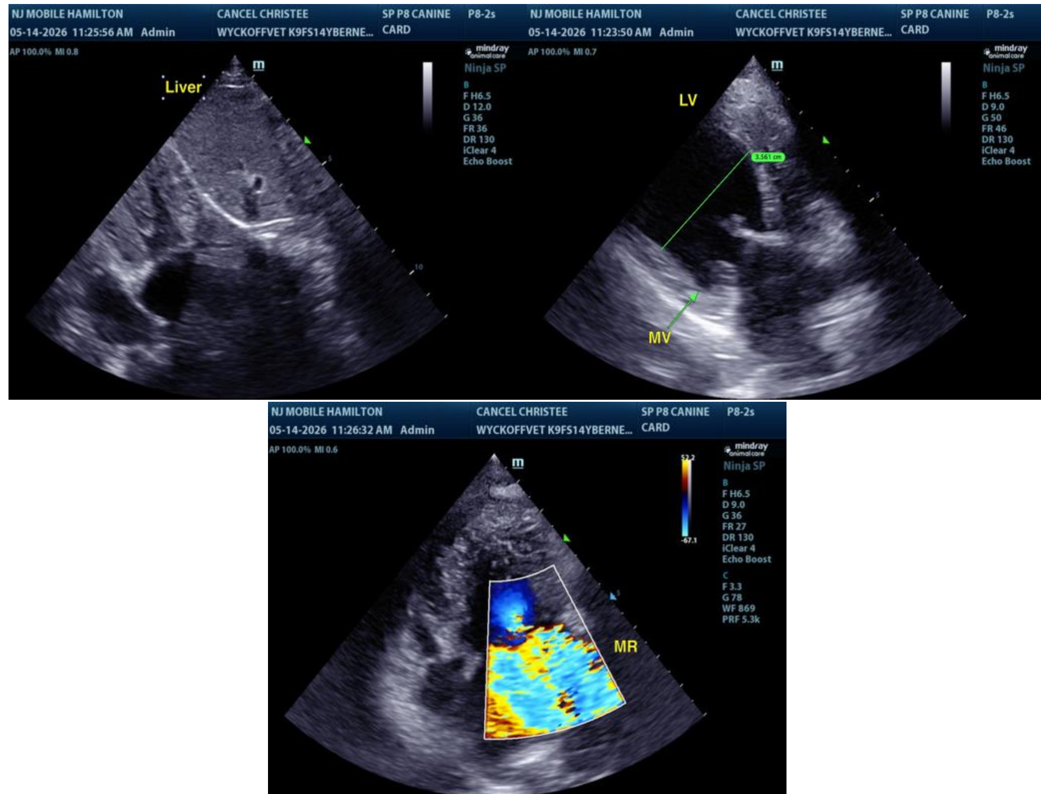

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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