PATIENT

Charlie Hendricks

SPECIES

Canine

BREED

Pitbull

SEX

Neutered Male

AGE

14 Years 7 Months

WEIGHT

56.6 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

Rondout Valley Veterinary Associates

REFERRING VET

Dr. Eh

INVOICE

16263

DATE

05/15/26

PRESENTING CLINICAL SIGNS

3 syncopal episodes in past 3 weeks, preceded by vomiting. Grade 3/6 left systolic murmur, pronounced sinus arrhythmia with occasional premature beats. Meds: Vetmedin 5 mg BID, Carprofen 50 mg BID, Clomicalm 40mg q 48 h.

Abnormal PE/Chem/CBC/UA Results: Labwork WNL, Urine not done

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	--	--	NM	1.2	45	76	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	2.5	1.1	56.6	4.4	4.9	--

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 mild thickening consistent with mild degenerative changes. Doppler revealed mild to moderate 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. Mild increased measured LVOT velocity with mild aortic insufficiency on doppler. 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

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- Compensated mitral valve insufficiency (B1).
- Mild increased measured LV outflow velocity with concurrent mild aortic valve insufficiency.

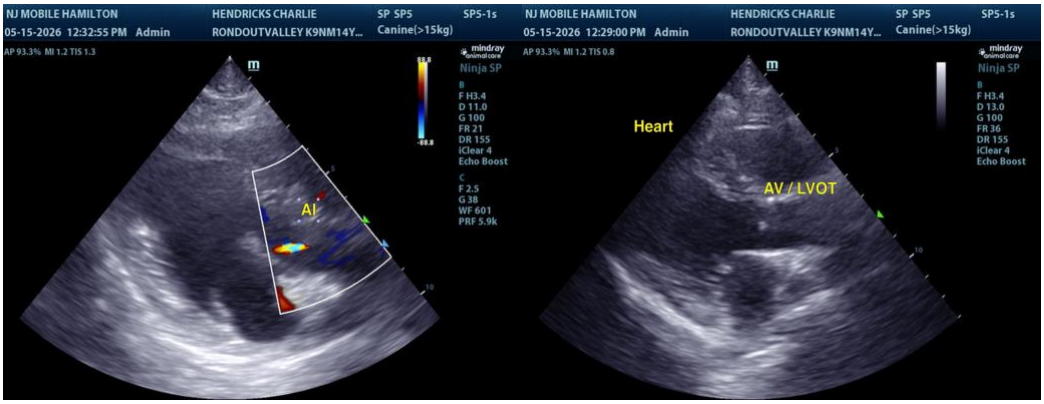
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The primary cause of the murmur is most consistent with mild degenerative valvular changes and secondary eccentric mitral valve insufficiency. A contributing factor to the murmur may include non-specific mild increased measured LV outflow velocity, which without evidence of aortic valvular pathology or subvalvular abnormality, may be classified as a concurrent flow murmur.

Regardless of classification, the current hemodynamic effects of the murmur appear low given lack of cardiac chamber enlargement or LV hypertrophy. From a structural/functional cardiac standpoint, no indication for cardiac medications. A definitive significant arrhythmia was not present in this study, yet intermittent arrhythmia may be possible.

Correlation with ECG +/- Holter monitor recommended if continued syncopal episodes. No evidence of pulmonary hypertension as a contributing factor. Sonographic monitoring is indicated recheck echo suggested in six months, sooner if clinically indicated.

If anesthesia is required and pending ECG/Holter monitor, the following protocols is suggested with close clinical monitoring. 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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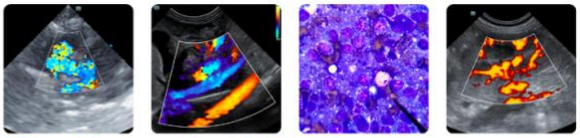

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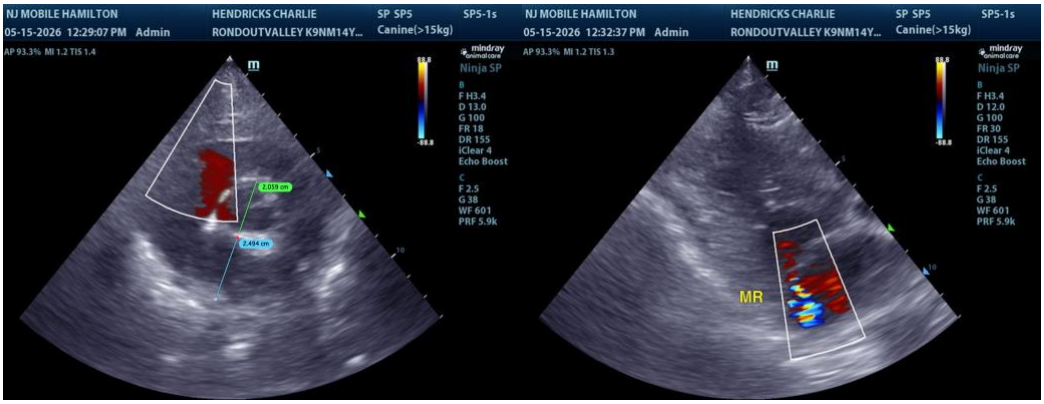

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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