



PATIENT

Ted Harpel

SPECIES

Canine

BREED

Pomeranian

SEX

MN

AGE

12.6yr

WEIGHT

13.2lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal
Hospital

REFERRING VET

Dr. Kristen Carpenter

INVOICE

24882

DATE

05/19/2026

PRESENTING CLINICAL SIGNS

Hx: Patient not sedated

- Recheck echo from 2/4/26 (Stage C cardiac disease)

- Patient is much improved after increasing lasix and spironolactone with a reduction in coughing

- Heart murmur stable - Grade IV L systolic and Grd III R systolic. Mild RE. RR ~ 40 on awake exam today.

- Hx Cushing's well controlled

- Chronic meds: Vetmedin 1.25 mg PO BID, Furosemide 5 mg PO BID, Amlodipine 1.25 mg PO SID,

Ursodiol 62.5 mg PO SID, Hydrocodone 5mg/1.5mg- 1/4-1/2 tab every 8-12 hours, Vetoryl 10mg PO BID, Spironolactone 12.5 mg PO BID, Enalapril 5mg PO SID, Gabapentin as needed for anxiety

- Current Diet: Urinary s/o

Abnormal PE/Chem/CBC/UA Results: - 2/19/26 Full Bloodwork - NSF except mild ALP elevation, no azotemia - 5/19/26 Blood Pressure - 160 mm HG systolic

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	5.5	--	--	2.2	45	78	0.3
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT	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	13.2lb	3.8	3.7	--

Cardiac Presentation

The echocardiogram in this patient demonstrated severe static increased left atrial size based on 3 different LA measurement methods. The cranial and caudal mitral valve leaflets presented thickening consistent with endocardiosis. Minor valve prolapse. Doppler indicated measurable severe eccentric insufficiency. The left ventricle presented static to significant increased internal 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 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



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pleura fluid was noted. No echographically detectable evidence of cardiac / pericardial tumors was visible. No evidence of arrhythmia.

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Primary

- Chronic mitral valve disease with mitral valve prolapse (ACVIM stage C)
- Mild tricuspid insufficiency- no overt clinical pulmonary hypertension

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

SEX

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Overall, a similar cardiac presentation and chamber dimension compared to the previous study without evidence of progression. Possible mild reduction in LA dimension based on LA/AO heart base measurement, although measurement variability possible. Given improved clinical signs, current medication protocol is recommended with serial monitoring of resting RR, systemic BP, renal parameters and ECG.

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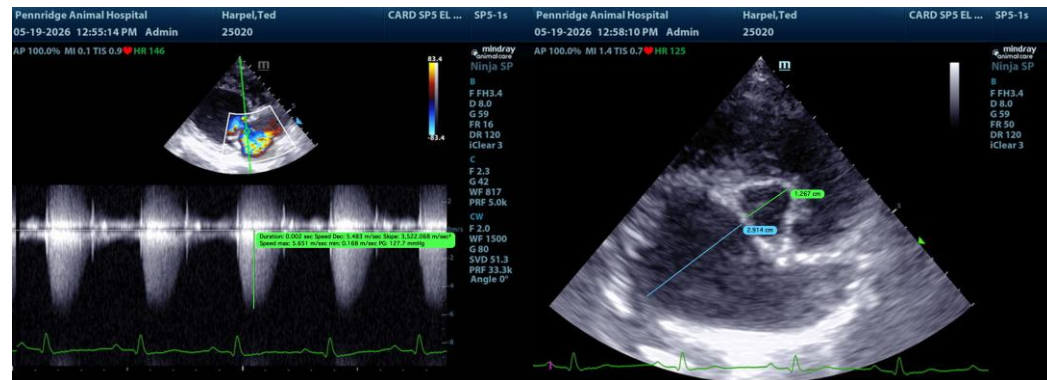
Prognosis remains highly guarded and echocardiographic monitoring indicated. Recheck echo suggested in 6 months sooner if recurrent or progressive clinical signs. Continued as needed respiratory support and antitussive medication is recommended. Elective anesthesia is not advised.

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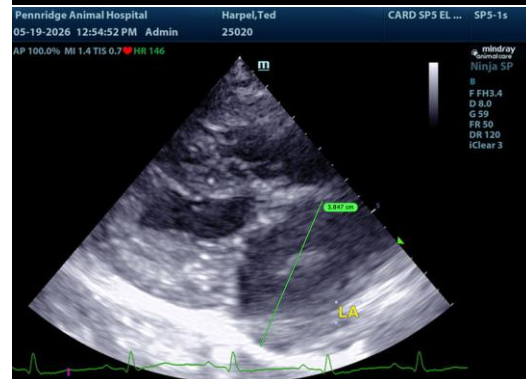
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.



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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.

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info@sonopath.com

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