



PATIENT PRESENTING CLINICAL SIGNS

Teddy Foulke Occasional cough, lethargy, 4/6 heart murmur

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

SPECIES

Canine

BREED

Papillon Mix

SEX

MN

AGE

2013

WEIGHT

14.8

CANINE	MR	TR	LA/AO	LA/AO	FS	EF	EPSS
CARDIAC PARAMETERS	VMAX (m/s)	VMAX (m/s)	(Boon method)	(Heart Base; Swe)	(%)	(%)	(cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	<1.3	28-40	40-100	<0.6
PATIENT	5.4	<1.0		1.57	35	66	0.22
CANINE	HR	AV	PV	BODY WEIGHT	LA	LVIDd	LVIDs
CARDIAC PARAMETERS	(BPM)	VMAX (m/s)	MAX (m/s)	(kg)	2D short axis Base view (cm)	Avg; 2D and m-mode short axis (cm)	Avg; 2D and m-mode short axis (cm)
NORMAL PARAMETER	50-100	0.7-1.7	0.7-1.6				
PATIENT	81	1.6	0.75		3.0	3.27	

INTERPRETED BY

R. McKenzie Daniel,
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(Canine and Feline)

IMAGING PERFORMED BY

Rebekah Jakum, CVT
ARDMS/RVT

HOSPITAL NAME

New Britain VC

REFERRING VET

Dr. Bandekar

INVOICE

14352

DATE

7/21/22

Cardiac Presentation

The echocardiogram in this patient demonstrated mildly enlarged **left atrial** size based on 3 different LA measurement methods. Subtle deviation of the interatrial septum towards the right atrium suggestive of minor increased left atrial pressure was present. The cranial and caudal **mitral** valve leaflets presented vegetative thickening consistent with endocardiosis more prominent in the anterior leaflet with minor anterior leaflet prolapse. Doppler indicated eccentric insufficiency. The **left ventricle** presented thicknesses with linear contour with minor increased left ventricle volume. 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 concurrent thickening with minor 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 infiltrative disease was visible. The cranial **mediastinum and pericardial regions** were free of masses in the visible window. No overt arrhythmia was noted.



PATIENT ULTRASONOGRAPHIC FINDINGS

Teddy Foulke

- Chronic mitral valve disease (ACVIM mild B2) with mild anterior mitral valve leaflet prolapse
- Minor TR - estimated pulmonary pressure gradient (<20 mmHg) not consistent with clinical pulmonary hypertension

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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The cause of the murmur is secondary to chronic degenerative valvular change with secondary eccentric mitral valve and minor tricuspid valve insufficiency. No other clinical issues such as LV systolic dysfunction or evidence of clinical pulmonary hypertension were present. The mild left atrium and left ventricle enlargement indicate that the relative risk of complication going forward is mildly elevated yet overall, the heart appears to be compensated at this stage.

SEX

MN

However, prognosis is highly variable. Serial sonographic monitoring is required for further assessment. Pimobendan 0.3 mg/kg PO BID is warranted. The overall cardiac presentation was not consistent with cardiogenic cough. Consideration for noncardiogenic causes of cough, i.e., primary upper or lower airway disease, is likely indicated. Recheck echocardiogram is suggested in 6 months, sooner if clinical signs consistent with left-sided heart disease or congestion arise.

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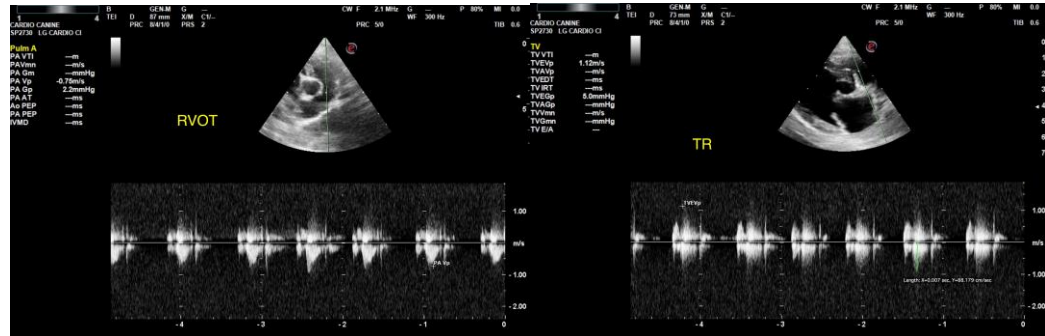
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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