



PATIENT

Oshie Bulger

SPECIES

Canine

BREED

Whippet

SEX

MN

AGE

9.5 years

WEIGHT

33 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

A. Rodriguez

HOSPITAL NAME

Foxfield VS

REFERRING VET

A. Rodriguez

INVOICE

14884

DATE

8/23/23

PRESENTING CLINICAL SIGNS

Presented for a dental today and a heart murmur of 2/6 was noted.
Abnormal PE/Chem/CBC/UA Results: WNL

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

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				1.1	39	69.6	0.15
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	NM	2.1	1.2		3.0	3.5	

Cardiac Presentation

The echocardiogram in this patient demonstrated normal **left atrial** size based on 2 different LA measurement methods. Chamber volumes and echogenicity were normal. The cranial and caudal **mitral** valve leaflets presented mild thickening consistent with mild endocardiosis. There was no evidence of valvular prolapse. Doppler indicated mild eccentric insufficiency. 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. Borderline elevated measured LVOT velocity was present without evidence of stenotic disease criteria. 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. No overt TR was noted 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). Normal measured RVOT velocity was noted. 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.



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ULTRASONOGRAPHIC FINDINGS

- Compensated chronic mitral valve disease (ACVIM B1)
- Borderline elevated measured LVOT velocity - nonspecific, no evidence of stenotic disease criteria

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of the murmur is most consistent with mild chronic degenerative valvular changes with secondary mild MR. The hemodynamic effects of the MR at this stage appear to be low, given no evidence of left-sided chamber enlargement which indicates that the current and future risk of complications secondary to MR is low. In a nonclinical patient without evidence of significant chamber enlargement, there is no indication for cardiac medications. There are no anesthetic contraindications. Conservative monitoring of the murmur is recommended. Prognosis is variable and sonographic monitoring is suggested. Recheck echocardiogram would be ideal in 6-12 months, sooner if clinical signs arise. The following anesthetic protocol may be considered.

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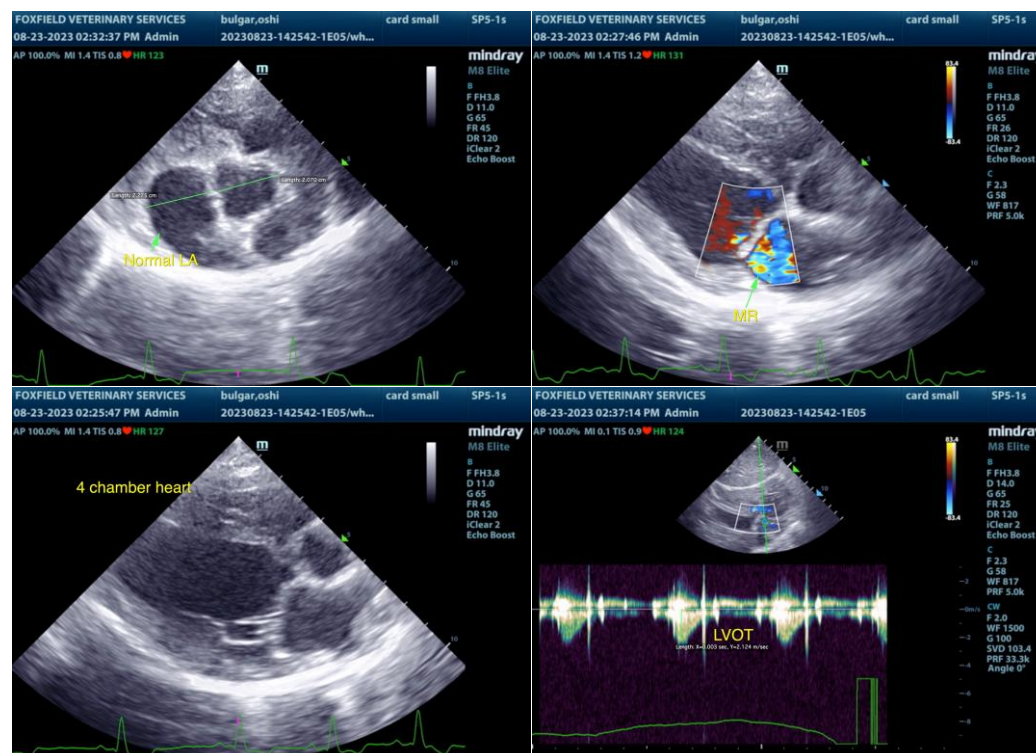
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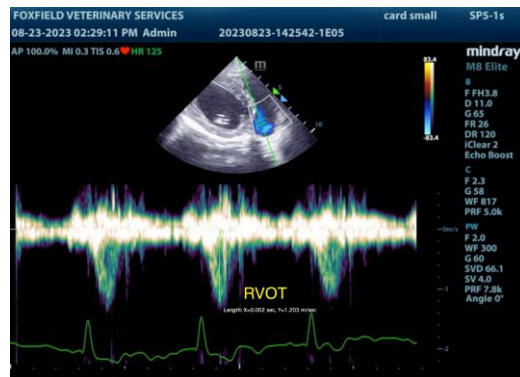
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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