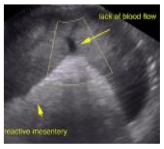
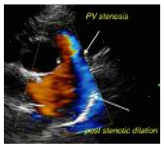
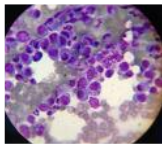
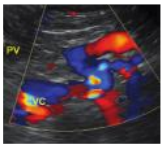
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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1-800-838-4268 info@sonopath.com

PATIENT

Navita Scott

SPECIES

Canine

BREED

Chihuahua Mix

SEX

F/S

AGE

~ 11 years

WEIGHT

8.5 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Meredith Swart

HOSPITAL NAME

Swart Veterinary Imaging

REFERRING VET

Dr. Meredith Swart

INVOICE

14502

DATE

8/4/22

PRESENTING CLINICAL SIGNS

-Patient is a referral to rDVM from military base so new patient to practice. Patient was referred due to new murmur auscultated during a wellness exam. Patient not having any clinical signs of CHF. Murmur grade III-IV left, systolic. There is nasal discharge. Patient also has dental disease with suspected ONF over R canine, which is suspected to be the origin of the nasal discharge. Patient was given 2 mg of torb IV for echo due to nervousness and tachycardia. EKG was run following the echo and a normal sinus rhythm with tachycardia was seen. No apparent arrhythmia.
Abnormal PE/Chem/CBC/UA Results: none reported

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (Boon method)	LA/AO (Heart Base; Swe)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	<1.3	28-40	40-100	<0.6
PATIENT				1.5	37	70.4	0.25
CANINE CARDIAC PARAMETERS	**HR** (BPM)	**AV VMAX** (m/s)	**PV MAX** (m/s)	**BODY WEIGHT** (kg)	**LA** 2D short axis Base view (cm)	**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	1.1	1.1		2.6	2.7	

Cardiac Presentation

The echocardiogram in this patient demonstrated normal **left atrial** size based on 3 different LA measurement methods. Chamber volumes and echogenicity were normal. The cranial and caudal **mitral** valve leaflets revealed mild thickening consistent with mild endocardiosis. 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. 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 infiltrative disease was visible. The cranial **mediastinum and pericardial regions** were free of masses in the visible window.

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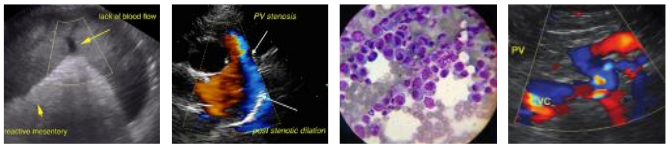

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ULTRASONOGRAPHIC FINDINGS

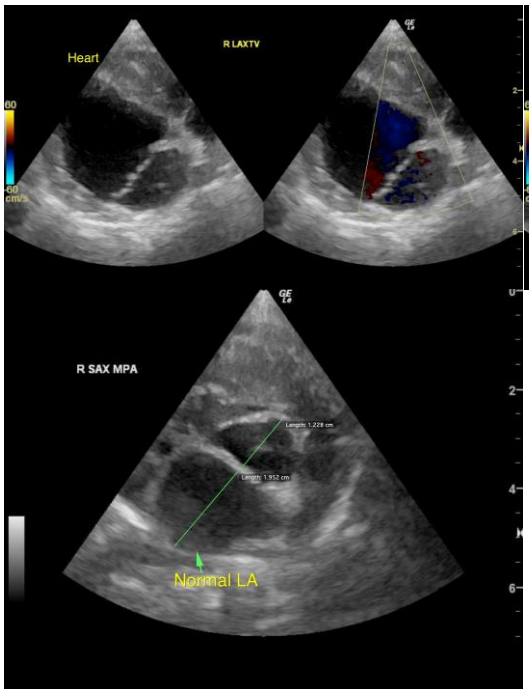
- Chronic mitral valve disease (ACVIM B1)

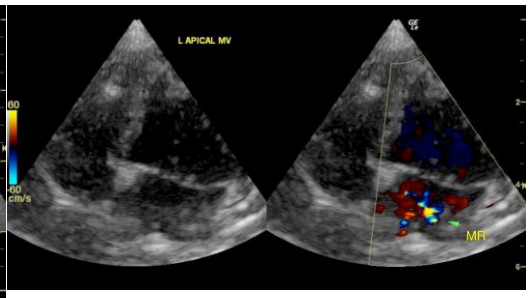
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of the murmur is most consistent with mild chronic degenerative valvular changes with secondary eccentric mitral valve insufficiency. No other clinical issues such as LV systolic dysfunction or overt evidence of clinical pulmonary hypertension were present. The lack of left atrium enlargement Indicates that the risk of complications secondary to mitral valve insufficiency is low at this stage. However, prognosis is highly variable, and serial sonographic monitoring is required for further assessment.

In a nonclinical patient without evidence of significant chamber enlargement, medical therapy Is not required. No anesthetic contraindications are evident. Recheck echocardiogram is suggested in 6-12 months, sooner if clinical signs arise.

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.





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