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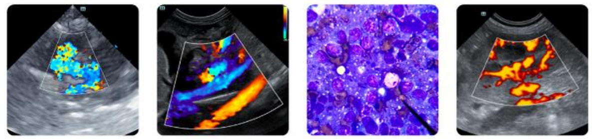


Clinical Sonography & Telecytology

Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

Pacer Gilluley

SPECIES

Canine

BREED

Min. Dachshund

SEX

MN

AGE

8 y

WEIGHT

8.7 kg

INTERPRETED BY

Keith Blass, DVM, MS, DACVIM (Cardiology)

IMAGING PERFORMED BY

Dr. Sarah Barthelemy

HOSPITAL NAME

Fish Creek PH

REFERRING VET

Dr. Johnson

INVOICE

DATE

1/2/26

PRESENTING CLINICAL SIGNS

Presented to ER for increased respiratory rate and hyporexia. Is oxygen dependent. Radiographs showed a mild bronchial pattern and possible right-sided cardiomegaly.

ECHOCARDIOGRAPHIC FINDINGS

2D, M-mode, and Doppler study.

The left atrium is underfilled. The mitral valve leaflets are mildly thickened, and a mild jet of eccentric mitral regurgitation is present. The left ventricle is significantly underfilled. Left ventricular systolic function is hyperdynamic. The aorta and aortic valve are normal. There is mild right atrial and right ventricular dilation. The tricuspid valve leaflets are mildly thickened, and a moderate jet of tricuspid regurgitation is present. TR velocity is consistent with the presence of severe pulmonary hypertension (PG 123 mmHg). There is flattening of the interventricular septum. The main pulmonary artery and pulmonic valve are normal. There is dilation of the right main branch pulmonary artery. No heartworms are visualized. No shunting lesions are visualized. No pericardial effusion or cardiac masses are seen.

ECG during echo: Sinus rhythm

LA – 19.4 mm
LVIDd – 11.5 mm
LVIDs – 4.8 mm
FS – 58.2%
RA – 24.5 mm
LVOT – 1.33 m/s
RVOT – 0.94 m/s
TR – 5.55 m/s

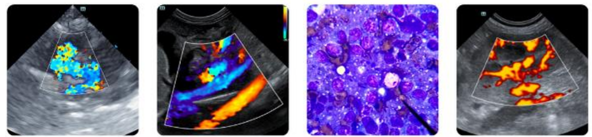
ASSESSMENT/RECOMMENDATIONS

Degenerative mitral and tricuspid valve disease
Pulmonary hypertension

This examination demonstrates regurgitation of blood across Pacer's mitral and tricuspid valves resulting from degenerative valve disease. Pacer's mitral valve disease is mild, and appears to be well-compensated at this time. His tricuspid valve disease is more advanced, as Pacer has moderate tricuspid regurgitation present. More importantly, Pacer's tricuspid regurgitation velocity is consistent with the presence of severe pulmonary hypertension. Secondary to the two diseases, Pacer has mild dilation of both his right atrium and right ventricle, while the pulmonary hypertension has also resulted in underfilling of Pacer's left heart chambers, flattening of his interventricular septum, and dilation of his right main branch pulmonary artery. It's likely that Pacer's pulmonary hypertension is contributing to his respiratory difficulty, though consideration should also be given to an underlying cause of the pulmonary hypertension, such as respiratory/pulmonary disease, heartworm disease, and pulmonary thromboembolism, as a possible contributor. Pacer's pulmonary hypertension also puts him at high risk for the development of exercise intolerance, syncope, and/or right-sided congestive heart failure, therefore, careful monitoring for these is recommended.

Recommended therapy for Pacer's pulmonary hypertension is sildenafil (20 mg am, 10 mg midday, 20 mg pm), while recommended therapy for his tricuspid valve disease is pimobendan (2.5 mg BID).

A recheck echocardiogram is recommended in 4 months.



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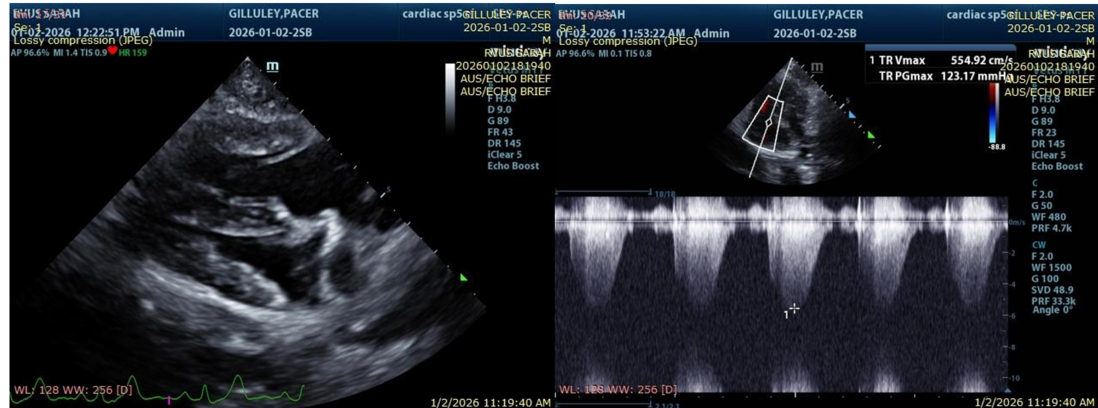

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Keith Blass, DVM, MS, DACVIM (Cardiology)

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