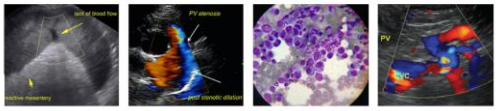
Mass Veterinary Specialty Services
1-413-734-1292



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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PATIENT
Calvin Serra

SPECIES
Canine

BREED
Poodle Mix

SEX
Male Neutered

AGE
8 years

WEIGHT
14.9lbs

INTERPRETED BY
Maggie Machen Lamy, DVM DACVIM (Cardiology)

IMAGING PERFORMED BY
Pamela Harrigan, RDCS

HOSPITAL NAME
Mass Veterinary Specialty Services

REFERRING VET
Dr. Masloski

INVOICE
21345

DATE
10/5/21

PRESENTING CLINICAL SIGNS

History: Calvin referred to evaluate a murmur noted in July. He has had a sporadic cough his entire life. He also occasionally has some labored breathing. His activity level is normal, but his appetite is finicky. He has chronic upper airway congestion/sneezing with nasal discharge. He was given acepromazine 1.5 tabs (10 mg) prior to his visit today. CV/RESP: NSR, grade III/VI murmur with PMI left apical area, PSS, lung fields clear. BP: 100mmHg x 4. No other medications.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available.
Left ventricle: Borderline LV diameter with adequate myocardial function. LV wall thicknesses are normal.
Left atrium: The left atrium is mildly dilated.
Mitral valve: The mitral valve is diffusely thickened with mild prolapse into the left atrial lumen. Mild to moderate eccentric mitral regurgitation with a normal velocity.
Aortic valve/aorta: The aortic valve is normal in morphology and mobility. Normal aortic outflow velocity; laminar flow. No aortic insufficiency.
Right ventricle: Normal right ventricular diameter and morphology indicating no overt evidence of pulmonary arterial hypertension.
Right atrium: Normal RA dimension.
Tricuspid valve: The tricuspid valve appears normal with no tricuspid regurgitation.
Pulmonic valve/pulmonary artery: The pulmonic valve is normal in morphology and mobility. No pulmonic insufficiency. Normal RVOT velocity; laminar flow.
Pericardium/other: No pericardial or pleural effusion noted. No obvious cardiac masses.
Heart rhythm: ECG reveals a sinus rhythm with an average HR of 150bpm.

2-Dimensional Measurements

Ao diam (cm)	2.1
LA diam (cm)	1.8
LA:Ao (Swe)	1.5
IVS thickness (cm)	0.7
LVID diastole (cm)	2.9
PW thickness (cm)	0.7
LVID systole (cm)	1.7
FS (%)	40

Doppler Measurements

PV Vmax (m/s)	0.9
AoV Vmax (m/s)	1.8
MR Vmax (m/s)	5.5
TR Vmax (m/s)	NA
TR PG (mmHg)	NA

INTERPRETATION OF THE FINDINGS

Chronic degenerative valve disease causing mild to moderate mitral regurgitation. Lack of significant left atrial enlargement indicates the current risk for complication is low. No concurrent issues such as pulmonary hypertension are noted in this study.

Given these findings, the cough is unlikely to be cardiac in origin and primary respiratory causes should be considered. Consider further respiratory work up/treatment (hydrocodone, taper course of steroids, Enrofloxacin, TTW/BAL, etc.).

Assessment of progression in the future will help predict long term prognosis, which is highly variable at this stage (B1).

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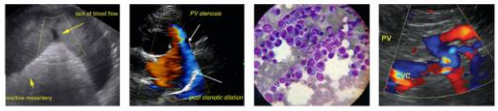

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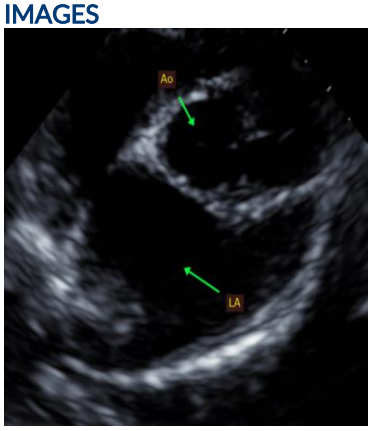
RECOMMENDATIONS

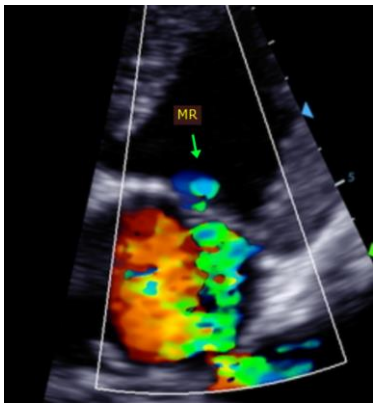
- Given these findings, no cardiac medications are clearly indicated.
- Omega fatty acid supplementation and mild salt restriction may be of some long-term benefit.
- Anesthetic risk is considered mild if needed. Cardiac protective drug choices (opioid/benzodiazepine premedication, propofol or alfaxalone induction, isoflurane gas) are recommended. Pre-oxygenate for 5-10 minutes prior to induction. Monitor for arrhythmias, hypotension, and hypoxia both intra and post-operatively and intervene as necessary. Mild IV fluid restriction is recommended to avoid fluid overload. Avoid heart rate stimulating drugs such as atropine unless clinically indicated.
- Monitor for development of a cough, labored breathing, exercise intolerance or collapse episodes.

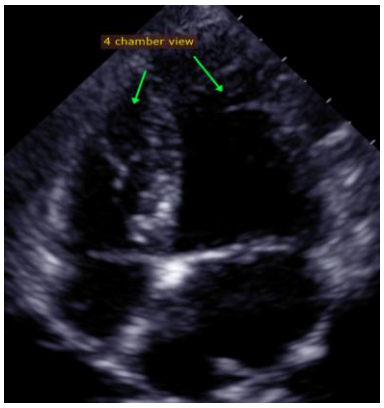
PLAN

- Recommend conservative monitoring with a recheck echocardiogram in 6 months, sooner if any development of clinical signs.

IMAGES







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

Thank you for this referral. This report was generated using transcription software, and minor dictation errors may be present. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

Maggie Machen Lamy, DVM
Diplomate of the American College of Veterinary Internal Medicine (Cardiology)
info@sonopath.com

Echocardiogram performed by: Pamela Harrigan, RDCS
Pet Animal Ultrasound Service (4paus.com)