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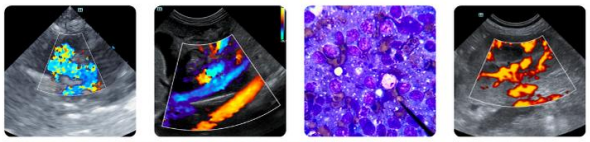

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT
Coco Goldring

SPECIES
Canine

BREED
CKCS

SEX
Female Spayed

AGE
11 years

WEIGHT
19.8lbs

INTERPRETED BY
Maggie Machen Lamy, DVM, DACVIM (Cardiology)

IMAGING PERFORMED BY
Meredith Swart, DVM

HOSPITAL NAME
Swart Veterinary Imaging

REFERRING VET
Dr. Swart

INVOICE
45902

DATE
11/24/25

PRESENTING CLINICAL SIGNS

History: Recheck echo. Historical murmur. Development of ascites.
-Current medications: Pimobendan 2.5mg 1.5 tabs in the am and 1 in pm, Lasix 25mg BID, Spironolactone 25mg SID, Enalapril 5mg BID.
-Pertinent previous echo findings (7/2025)L severe LAE. LVIDd: 4.54, LVIDs: 2.88 FS 66%, AO: 1.57, LA 3.71 LAAO: 2.36, MR 6 m/s, TR 1.95 m/s.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and doppler imaging is available. The mitral valve is diffusely thickened with prolapse into the left atrial lumen. There is marked eccentric mitral regurgitation present. The MR velocity is normal. There is marked left atrial enlargement. There is marked left ventricular dilation. Left ventricular systolic function is hyperdynamic. No significant right heart enlargement. Mild thickening of the tricuspid valve with mild TR. Velocity consistent with moderate to severe pulmonary hypertension. The MPA and branches are mildly dilated. The aortic valve appears trileaflet with normal mobility. No significant AI. There is normal systolic flow velocity across the aortic valve. The pulmonic valve is normal in appearance. Flow through the RVOT/PV is normal in velocity. Trace PI. No obvious pericardial effusion. Scant pleural effusion and ascites noted. No cardiac masses are seen. Irregular rhythm throughout.

CARDIAC CHART

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	<1.6	28-40	40-100	<0.6
PATIENT	4.5	4.3	>2.0	2.5	46	77	0.6
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	BELOW	BELOW	BELOW	BELOW
PATIENT	NM	1.4	1.1	9.0	4.5	4.6	2.5
*Normal chamber parameters expressed as a mean value (SD)				3	1.27 (5.3)	2.46 (2.46)	1.36 (5.5)
BODY WEIGHT DEPENDENT PARAMETERS				5	1.40 (4.5)	2.74 (5.2)	1.60 (4.7)
**Note: All measurements based upon multi-modal images and methods. An average value is reported.*				10	1.50 (3.8)	3.27 (3.5)	2.06 (3.1)
				15	1.83 (2.0)	3.71 (2.4)	2.43 (2.1)
				20	2.02 (1.9)	4.14 (2.2)	2.80 (2.0)
				25	2.18 (2.4)	4.48 (2.9)	3.10 (2.5)
				30	2.33 (3.3)	4.83 (3.9)	3.39 (3.4)
				35	2.48 (4.3)	5.17 (5.0)	3.69 (4.5)
				40	2.62 (5.2)	5.48 (6.1)	3.96 (5.4)
				50	2.88 (7.1)	6.07 (8.3)	4.46 (7.4)

Adapted from June Boon, Veterinary Echocardiography, 1998
Rishniw M and Hollis NE, J Vet Intern Med 2000; 14:429-435
Hansson et al, Vet Rad and Ultrasound 2002
Bonagura et al. Echocardiography: principles of interpretation, Vet Clin North Am 15:1177, 1995

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Chronic degenerative valve disease persist with marked mitral and mild tricuspid regurgitation. Marked left atrial enlargement indicates the risk for spontaneous congestive heart failure is elevated. Moderate to severe pulmonary hypertension is noted; however, the right heart is only mildly abnormal. **There is some concern for atrial fibrillation in this case, which would explain development of right-sided CHF and an ECG should be obtained.**

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Given these findings, full cardiac support is recommended going forward, as the ascites is certainly cardiogenic in origin. Use of Sildenafil is not yet indicated, unless the effusion is refractory and AF is ruled out. An abdominocentesis should be performed, as needed for patient comfort. Monitoring of sleeping respiratory rates will be paramount to screen for congestive heart failure at home. Cough suppression to improve QOL can also be considered (hydrocodone, 0.2-0.4mg/kg up to q4-6h PRN) for any residual mechanical cough in the face of normal sleeping respiratory rates. If able to be stabilized, the average survival time of canine patients with active pulmonary edema is 8-9 months on medications; however, most are able to maintain a good quality of life for that period on medications. Patient will always be at risk for recurrent CHF, development of arrhythmias/LA tear, syncope and/or sudden death in the future.

Omega fatty acid supplementation and mild salt restriction may also be of some long-term benefit. Monitor for acute progression of the cough, labored breathing, exercise intolerance or collapse episodes in the future.

Elective anesthesia is not advised, as there is high risk for complication.

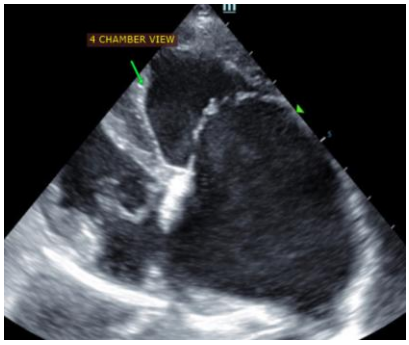
PLAN

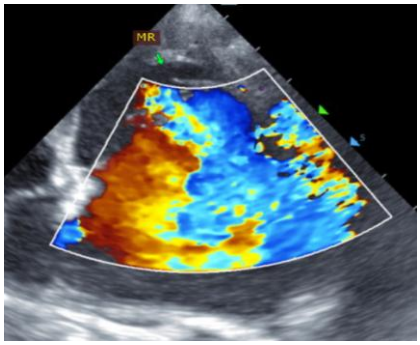
An ECG should be obtained to rule in or out atrial fibrillation. Continue Pimobendan increasing TID dosing if possible. Continue Furosemide 1-2mg/kg PO q12h. Continue Spironolactone increase to BID dosing. Pending BP >130mmHg, continue ACE-I 0.5mg/kg PO q12h.

Monitor renal values and BP in 10-14 days, then every 3-4 months while on diuretics to ensure tolerance of medications. Consider hydrocodone if needed for QOL. If ascites is refractory and AF is ruled out, consider Sildenafil 1-2mg/kg PO q12h.

Recommend conservative monitoring with a recheck echocardiogram in 6 months, sooner if any development of associated clinical signs occurs in the interim.

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
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info@sonopath.com