



DATE PRESENTING CLINICAL SIGNS

12.16.25 History: Just adopted. Grade 3/6 heart murmur.
-Pertinent abnormal PE/Chem/CBC/UA Results: Lab work pending.
-Current medications: None listed.

PATIENT
-Sedation used: Not required to complete full diagnostic ultrasound.
-Pertinent previous ultrasound results: No previous.

Stormy Wajer
-STAT: Not requested.
-Imaging performed by: Stephanie Warga RDCS, RVT.

SPECIES ECHOCARDIOGRAM FINDINGS

Canine 2D, m-mode, color flow and doppler imaging is available. Normal mitral valve leaflets with no obvious prolapse into the left atrial lumen. No mitral regurgitation. Normal left atrial dimension. Normal LV diameter with normal myocardial function. The LV wall thickness is normal. The tricuspid valve appears normal in form and function with trace TR. Normal velocity. No right atrial dilation. Mild right ventricular prominence with mild hypertrophy. Mild elevation of pulmonic outflow velocities at the level of the valve. The PV appears mildly thickened, with mild post-stenotic dilatation of the branch PA's. Trace pulmonic insufficiency. The aortic valve appears to have normal morphology and mobility. Normal LVOT velocity. No pericardial or pleural effusion noted. No obvious cardiac masses.

FS

AGE

10.9.21

WEIGHT

56.7lbs

INTERPRETED BY

Maggie Machen Lamy,
DVM, DACVIM
(Cardiology)

HOSPITAL NAME

Chadwell AH

REFERRING VET

Dr. Gold

INVOICE

46212

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		2.7	NM	1.3	39	70	NM
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	3.4	25.7	3.2	3.6	2.2
*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)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Elevated flow velocity through the pulmonic valve is noted, consistent with congenital valvular pulmonic stenosis. The degree of obstruction is mild based upon the velocity/pressure gradient across the pulmonic valve and minimal secondary hypertrophy and remodeling of the right ventricle (mild PG

is <50mmHg). Trace tricuspid regurgitation is noted, which is likely secondary. No additional issues are noted.

Mild PS cases typically do not impact a patient clinically, and most are able to live a normal life free of complications. That being said, risk for progression to clinical signs will always remain and periodic monitoring is advised.

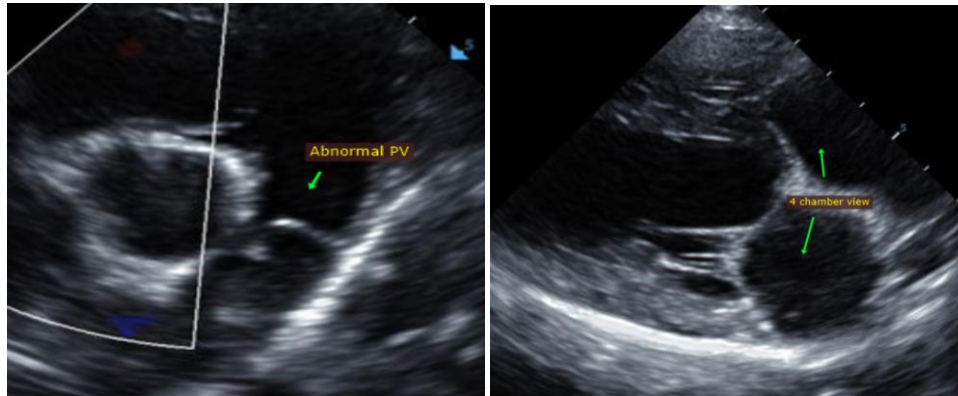
Given mild disease I would not recommend surgical intervention in this case. Medical management with Atenolol is often recommended in moderate or severe cases, with mild often not requiring therapy. Given that this case is free of symptoms and mild in severity, it is reasonable to simply monitor going forward rather than instituting lifelong medications.

Anesthetic risk is considered mildly elevated. **Avoid heart rate stimulating drugs such as atropine or glycopyrrolate.** Avoid excessive vasodilation/hypotension. Pre-oxygenate for 5-10 minutes prior to induction. A reasonable protocol would be as follows: premedicate with opioid/benzodiazepine, propofol or alfaxalone induction, isoflurane maintenance. Monitor ECG, BP as is standard. Monitor for hypoxia in recovery; utilize O2 chamber if needed. Mild IV fluid restriction is advised.

Monitor for development of associated clinical signs (exertional collapse, abdominal distention, cough, labored breathing). Omega fatty acid supplementation may have some long-term benefit, given that these cases are predisposed to development of arrhythmias going forward.

Recommend recheck echocardiogram annually, sooner if clinical signs arise 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
Diplomate of the American College of Veterinary Internal Medicine (Cardiology)
info@sonopath.com