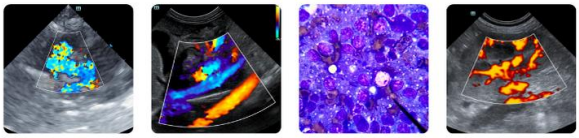


SonoPath FOSTERING THE ART OF VETERINARY MEDICINE™ www.thefocalzone.com info@thefocalzone.com 298.808.2608

PATIENT

Charlie Stea

SPECIES

Canine

BREED

Miniature Dachshund

SEX

Male Neutered

AGE

15 years

WEIGHT

15.9lbs

INTERPRETED BY

Maggie Machen Lamy, DVM DACVIM (Cardiology)

IMAGING PERFORMED BY

Kelly Reschny, RVT

HOSPITAL NAME

East Credit Veterinary Hospital

REFERRING VET

Dr. Gardiner

INVOICE

45954

DATE

12/2/25

PRESENTING CLINICAL SIGNS

History: Increased persistent cough that started 1-2 months ago, sounds like a hack and is non-productive. History of Cushing's disease, well-controlled on Trilostane 50mg/ml 0.1ml BID. Recent episode of collapsing, unsure if due to slipping or other factors; was confused but returned to normal quickly. Once last week and once the week before. Ann does not think these were seizures and suspects he just fell and was confused. The first time he had urinated and the second time he had passed a small amount of feces. He seemed responsive both times. Chronic grade 4/6 murmur PMI left apex. No arrhythmia. Synchronous pulses on PE.
-Current medications: Denamarin SID (can usually only get 1/2 tab into him),Trilostane 50mg/ml 0.1ml BID.

ECHOCARDIOGRAM FINDINGS

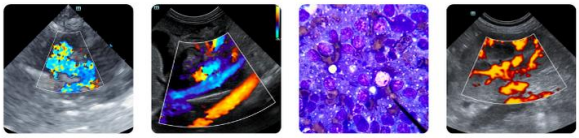
2D, m-mode and Doppler imaging are available. Diffuse thickening of mitral valve leaflets (anterior> posterior) with prolapse into the left atrial lumen. Marked eccentric mitral regurgitation with marked left atrial dilation. Marked LV dilation with mildly depressed myocardial function. The tricuspid valve appears mildly thickened, with moderate tricuspid regurgitation. Normal velocity. Mild right heart dilation. The pulmonic and aortic valves are normal in morphology and mobility. Normal pulmonic and aortic outflow velocities. No pulmonic or aortic insufficiency. No pericardial or pleural effusion noted. No cardiac tumors observed.

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	5.1	2.2	NM	2.8	48	80	0.2
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	107	1.0	1.2	7.2	2.8	3.5	1.8
*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)
Adapted from June Boon, Veterinary Echocardiography, 1998				25	2.18 (2.4)	4.48 (2.9)	3.10 (2.5)
Rishniw M and Hollis NE, J Vet Intern Med 2000; 14:429-435				30	2.33 (3.3)	4.83 (3.9)	3.39 (3.4)
Hansson et al, Vet Rad and Ultrasound 2002				35	2.48 (4.3)	5.17 (5.0)	3.69 (4.5)
Bonagura et al. Echocardiography: principles of interpretation, Vet Clin North Am 15:1177, 1995				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

The cause of the murmur is chronic degenerative valve disease causing marked mitral and moderate tricuspid regurgitation. Marked left heart enlargement indicates the risk for spontaneous congestive heart failure is elevated. No additional issues such as pulmonary hypertension are identified.



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The described cough is likely multi-factorial in origin, including a mechanical component due to cardiomegaly, possible concurrent airway disease and/or early CHF given the severity of disease. Screening chest radiographs are recommended. Given the symptoms and echo findings, full lifelong cardiac support is recommended as below, including continued Lasix therapy. Depending on clinical response to the medications, cough suppression may also be useful. Monitoring of sleeping breathing rates in the future will be paramount to determine the origin of any future cough. The average survival of canine patients with active pulmonary edema is 8-9 months on medications, however they generally are able to maintain a good quality of life for that period. Patient will always be at risk for recurrent CHF, development of arrhythmias/LA tear, syncope and/or sudden death in the future. Monitoring of renal values is recommended lifelong.

It is assumed that syncope is due to early congestion and poor cardiac output. If the episodes persist despite medical management, further workup, such as an ECG/holter monitor may be indicated.

Omega fatty acid supplementation and mild salt restriction may also be of some long-term benefit. Monitor for development of a worsening cough, labored breathing, exercise intolerance or collapse episodes.

Elective anesthesia is not advised, as there is high risk for complication. Risk: benefit ratio should be considered. Consider consultation with and/or referral to a facility with an anesthesiologist. Should you elect to proceed, cardiac protective drug choices (opioid/benzodiazepine premedication, propofol or alfaxalone induction, iso or sevoflurane gas) are recommended. Pre-oxygenate for 5-10 minutes prior to induction and recover in O2 cage. Monitor for arrhythmias, hypotension, and hypoxia both intra and post-operatively and intervene as necessary. Moderate IV fluid restriction is recommended to avoid fluid overload, while considering comorbidities, hydration status, BP, etc. Avoid heart rate stimulating drugs such as atropine unless clinically indicated.

PLAN

Screening BP, ECG and CXR are recommended as discussed. Institute Pimobendan 0.3mg/kg PO q12h. Institute Furosemide/Lasix 1-2mg/kg PO q12h. Institute Spironolactone 1-2mg/kg PO q12h. Pending BP >130mmHg, institute ACE-I 0.5mg/kg PO q12h. Consider Hydrocodone with homatropine (0.2-0.4mg/kg PO up to q4-6 hours PRN) if cough persists despite normal SRRs.

A renal panel and BP are recommended in 10-14 days, then every 3-4 months on diuretics to ensure tolerance of medications.

A recheck echocardiogram is recommended in 6 months to screen for progression, sooner if clinical signs arise/persist.

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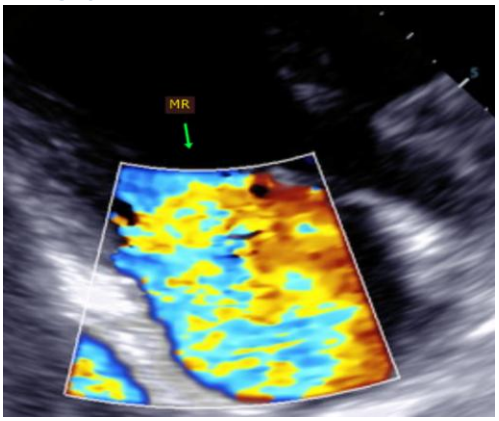

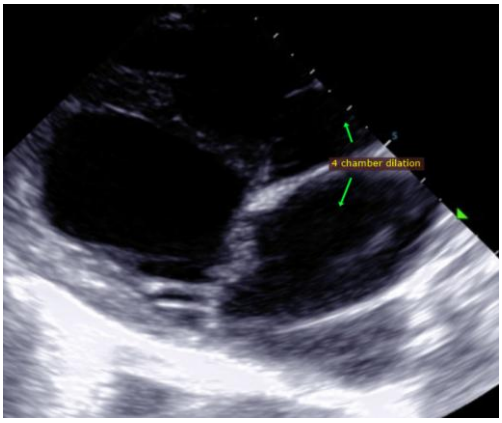

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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