



PATIENT

Anubis Anderson

SPECIES

Canine

BREED

Doberman

SEX

Male

AGE

12 years

WEIGHT

35.60

INTERPRETED BY

Maggie Machen Lamy,
DVM, DACVIM
(Cardiology)

IMAGING PERFORMED BY

Lauren Kuzimski, DVM

HOSPITAL NAME

Animal Emergency
Hospital Deland

REFERRING VET

Dr. Lauren Kuzimski

INVOICE

46060

DATE

12/6/25

PRESENTING CLINICAL SIGNS

History: Seen 11/22 for breathing issues. Diagnosed with CHF and presumptive DCM. BP: 176mmHg.
-CXR report: mild cardiomegaly. PV dilation with concern for CHF.
-CXR report (24 hours later): Improved pulmonary infiltrate consistent with CHF.

ELECTROCARDIOGRAPHIC FINDINGS *Note: Single lead ECGs are evaluated as a rhythm strip. Morphology/MEA cannot be definitively commented on.

A single lead ECG is available; 25mm/s, 20mm/mV. The average heart rate is 155bpm. The rhythm is sinus in origin, with a p for every QRS complex and vice versa. The P and QRS morphologies are positive. No ectopic beats, pauses or other dysrhythmias observed.
ECG diagnosis: Normal sinus tachycardia.

*VPCs are noted throughout the study (single-lead ECG attached).

ECHOCARDIOGRAM FINDINGS

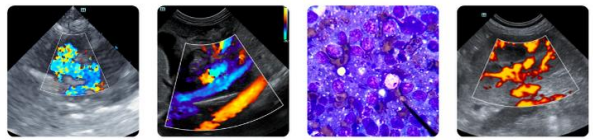
2D, m-mode and color flow is available. The LV is dilated in both systole in diastole (LVIDdN: 1.85, LVIDsN: 1.46) with moderate systolic dysfunction. Decreased LV wall thickness with increased sphericity. Moderate left atrial enlargement. The mitral valve is mildly thickened with no prolapse and mild eccentric MR. No tricuspid regurgitation. Mild right atrial and ventricular dilation. The aortic valve is normal in morphology and mobility. No subvalvular ridge present. No aortic insufficiency. Normal pulmonic valve with no pulmonic insufficiency seen. No pericardial or pleural effusion noted. No obvious cardiac tumors.

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	NM	NA	NM	1.7	15	28	NM
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT	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	NM	NM	35.6	3.5	5.3	4.5
*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)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The diagnosis is DCM phenotype with both LA and LV dilation and dysfunction. What is somewhat unusual is this degree of dilation and dysfunction is not expected to lead to organic CHF; however, this patient responded well to diuretic therapy, suggesting this is the diagnosis. Mild MR is likely secondary to annular stretch; however, concurrent valve disease cannot be



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ruled out. No additional issues are noted. It is worth noting that spectral doppler is not adequately utilized and additional issues, such as pulmonary hypertension, are not ruled out.

Systolic failure can be primary in nature (DCM) or secondary to taurine deficiency, myocarditis, hypothyroidism, tachycardia-induced cardiomyopathy, or infiltrative disease such as lymphoma. Primary disease is suspected until ruled otherwise in this breed.

Given these findings, full cardiac support should be continued going forward. Regardless of cause, prognosis is guarded at this stage in the disease process, with an average survival time of <1 year. The only treatable cause of systolic failure is diet/taurine deficiency, which is uncommon on commercially formulated dog foods. If the diet is of concern, highly recommend immediate diet change and taurine supplement regardless of blood taurine results. Please see the FDA website for more information.

The ECG is normal showing a normal sinus tachycardia. That being said, isolated VPCs were noted throughout the echocardiogram. These are not unexpected in a Doberman in active CHF. What is seen here does not warrant therapy; however, monitoring for sustained arrhythmias is advised, which typically presents as acute collapse. This patient certainly has risk for sudden death (as is common in this breed) and the owner should be warned of this possibility.

Elective anesthesia is not advised due to high risk for complications.

Omega fatty acid supplementation and mild salt restriction may be of some long-term benefit. Monitor for development of a cough, worsening labored breathing, abdominal distention, exercise intolerance or collapse episodes in the future. Monitoring of sleeping breathing rates at home is recommended to assess response to medications and recurrence of CHF in the future.

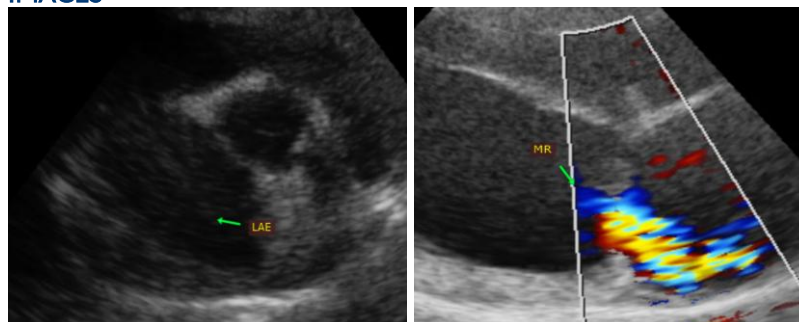
PLAN:

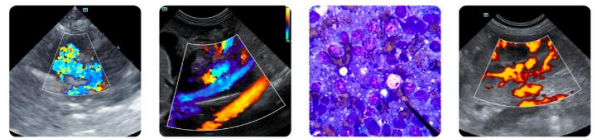
Institute aldosterone antagonist Spironolactone 1-2mg/kg PO q12h. Institute Furosemide 1mg/kg PO q12h. Institute Pimobendan 0.3mg/kg PO q12h. Institute taurine 1000mg PO q12h. Diet history/thyroid status as discussed.

Monitor a renal panel and blood pressure in 1-2 weeks to ensure tolerance. If BP >130mmHg, institute ACEI 0.5mg/kg PO q12h. A repeat ECG is recommended at this visit.

A recheck echocardiogram is recommended in 6 months to screen for progression, sooner if clinical issues arise in the interim.

IMAGES





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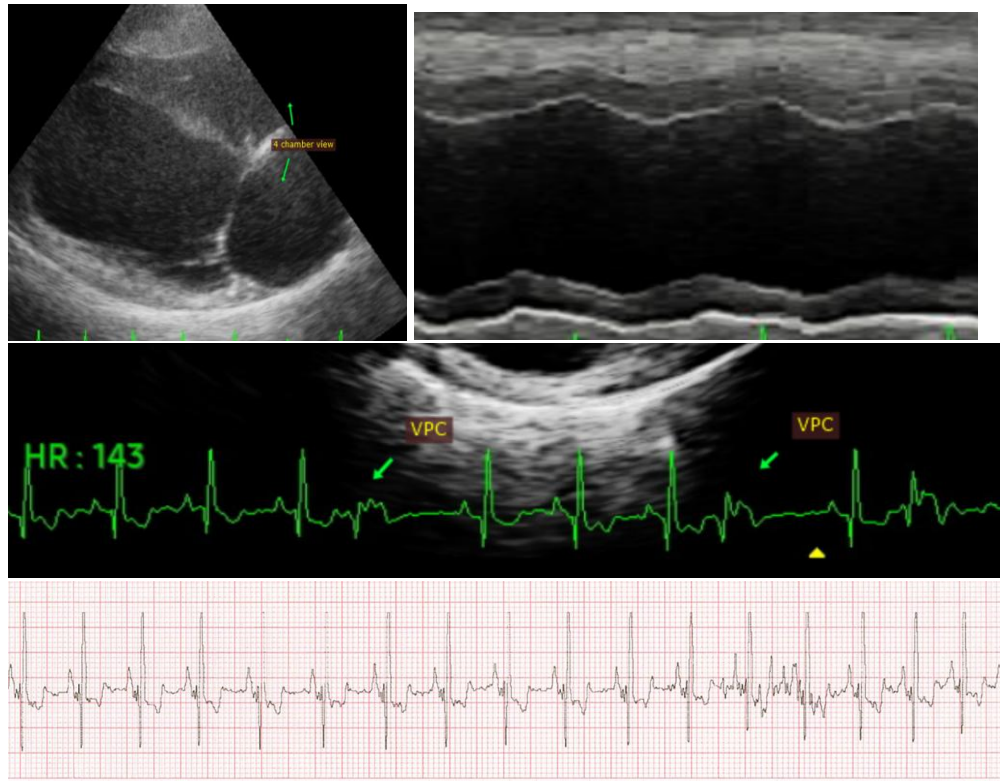
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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