



PATIENT

Lolo Rivera

SPECIES

Canine

BREED

American Pitbull
Terrier Mix

SEX

Male Neutered

AGE

11 years

WEIGHT

47.2lbs

INTERPRETED BY

Maggie Machen Lamy,
DVM, DACVIM
(Cardiology)

IMAGING PERFORMED BY

G. Ferrer, DVM

HOSPITAL NAME

Pulse: Pet Ultrasound
Services

REFERRING VET

Dr. Davila

INVOICE

46102

DATE

12/9/25

PRESENTING CLINICAL SIGNS

History: Presented for coughing, increased respiratory rate and severe stridor, cardiomegaly, and abdominal mass. Has a previous history of thyroid cancer; currently been treated with Palladia by Oncologist. Also, on Doxycycline and Temaril P. History of HW disease; treated about 10 yrs ago.

RADIOGRAPHIC FINDINGS *NOTE: Images submitted for supplemental cardiac information only.

Globoid cardiomegaly. No obvious evidence of CHF.

ECHOCARDIOGRAM FINDINGS

2D, MM, color/spectral Doppler study available for interpretation. The mitral valve appears mildly thickened with mild prolapse into the left atrial lumen. Mild mitral regurgitation with mild left atrial dilation. Normal MR velocity. Normal LV diameter with adequate myocardial function. The tricuspid valve appears thickened with moderate tricuspid regurgitation. TR velocity consistent with moderately elevated pulmonary arterial pressures. Moderate to severe right heart enlargement. Significant MPA and branch dilation. The pulmonic and aortic valves are normal in morphology and mobility. Moderate pulmonic insufficiency. Normal pulmonic and aortic outflow velocities. Scant pericardial effusion. No pleural effusion is visualized. 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	5.4	3.9	NM	1.5	40	75	0.4
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	0.9	0.6	21.4	3.0	4.2	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)
<i>*Note: All measurements based upon multi-modal images and methods. An average value is reported.</i>				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

Significant pulmonary hypertension (PAH) is present, as evidenced by an elevated TR velocity and right heart compensatory changes. The estimated systolic pulmonary arterial pressure is >70mmHg, with normal being <25mmHg. This is causing significant hypertrophy and dilation of the right ventricle (indicating right-heart pressure overload). The finding of scant pericardial effusion likely suggests right-sided CHF is imminent. No intra or extra-cardiac tumors are visualized to explain to finding; however, it is important to note these are easily missed on 2D ultrasound. Consider advanced imaging if elected. There is also mild left heart disease with a mild mitral regurgitation.



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Clinical signs of weakness, heavy breathing, cyanosis, ascites and syncope are attributed to severe PAH. The underlying genesis of PAH is poorly understood in cases other than heartworm infestation, though it occurs with increased frequency in a variety of forms of chronic lung disease and in patients with idiopathic pulmonary fibrosis. Given the history in this case, the historical heartworm infestation is the likely cause.

Patients with this degree of PAH can develop right-sided congestive heart failure (ascites, pleural, and/or pericardial effusion) as is seen in this case, debilitating cyanosis/labored breathing and exertional syncope if poorly controlled. The prognosis is poor with an MST of < 1 year after the onset of CHF, however a reasonable quality of life is expected once controlled.

These findings are unlikely to be related to a reported splenic mass; however, will certainly limit therapeutic options. Follow up as dictated by the AUS results.

Medical management of PAH and CHF is indicated as below and initial therapeutic dosages are indicated.

Omega fatty acid supplementation may be of some long-term benefit.

Elective anesthesia is not advised.

Monitor for development of a labored breathing, exercise intolerance or collapse episodes.

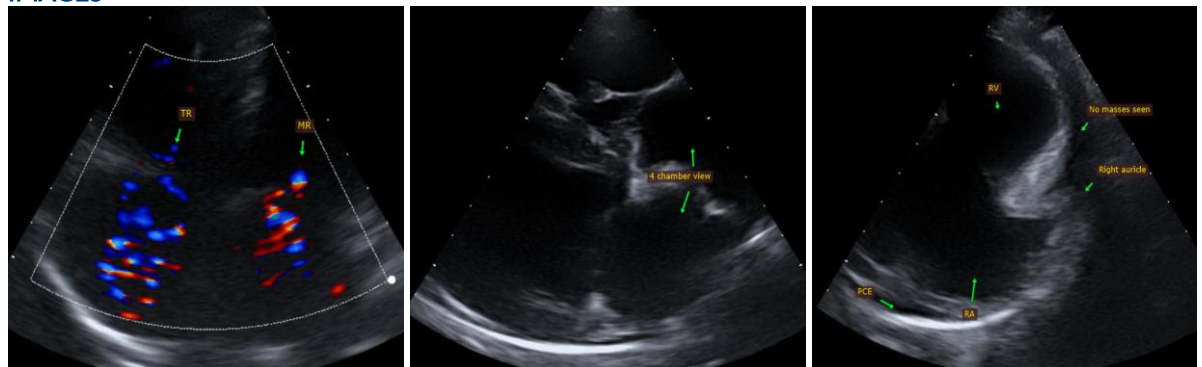
PLAN:

Screening BP recommended. Institute sildenafil 1-2mg/kg PO q8h. Institute Pimobendan 0.3mg/kg PO q8h. Institute Lasix 1-2mg/kg PO q12h. Institute spironolactone 1-2mg/kg PO q12h. If BP is >130mmHg, institute ACE-I (benazepril or enalapril) 0.5mg/kg PO q12h.

Recommend renal panel in 10-14 days, then every 3-4 months lifelong.

Recommend recheck echocardiogram in 6 months to screen for progression, sooner if clinical signs develop in the interim.

IMAGES





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Lolo Rivera

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.

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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.

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

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