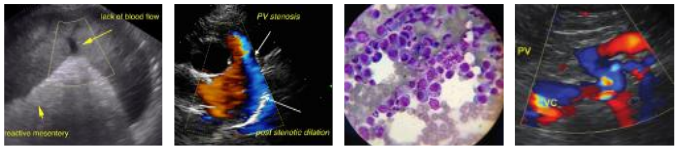
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Riley Dougherty

SPECIES
Canine

BREED
Boxer

SEX
FS

AGE
8 years

WEIGHT
58 lbs

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

IMAGING PERFORMED BY

HOSPITAL NAME
Mass Veterinary Services

REFERRING VET
Dr. Masloski

INVOICE
47142

DATE
3/9/26

PRESENTING CLINICAL SIGNS

History: Holter after echocardiogram performed on 3/3/26.
Riley is doing well at home. She is eating well and remains active. Riley has some gingival hyperplasia that needs to be dealt with. She does not have any C/S/V/D/PU/PD noted
Echo results (BS 3-3-26): CVD B1, no LA/LVE. VPCs noted.
DIARY: Included.

HOLTER MONITOR FINDINGS AND RHYTHM ASSESSMENT

Time analyzed	23:52h
Mean heart rate	87bpm
Maximum heart rate	234bpm
Minimum heart rate	43bpm
VPCs	5323 singles, 6 pairs
APCs	0

Interpretation: Underlying normal sinus rhythm with appropriate rate variation. Max HR is with excitement and is sinus in origin. Ventricular premature contractions noted throughout; bi and quadrigeminy, rare pairs noted. VPCs are indicative of an RV origin. No runs of VT appreciated.

Rhythm diagnosis: Normal sinus rhythm with frequent single and couplet VPCs; suspect ARVC

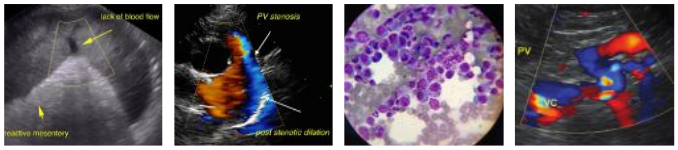
RECOMMENDATIONS

Sinus rhythm with frequent VPCs noted throughout the holter. While the frequency is notable (over 6\5000 in 24 hours), the vast majority are single beats coming from the RV. That said, couplets are documented as well, increasing concern. No additional abnormalitiis are seen.

When addressing arrhythmias, two things must be considered; 1. Is an underlying cause evident or is this primary arrhythmic disease? And 2. Is anti-arrhythmic therapy warranted?

VPCs are a very non-specific finding. They can be primary in origin (such as ARVC), be secondary to significant cardiac disease (mild in this case) or be extra-cardiac in origin; i.e., due to pain, stress, inflammation, cancer, GI disease, DIC/sepsis, etc. In an 8yo Boxer, there is high suspicion for ARVC (most common age of onset 6-8yo, often asymptomatic). ARVC can occur with or without systolic dysfunction and structural issues, however this should be monitored going forward for any progressive issues. It is always reasonable to rule out other differentials for VPCs (AUS, tick titers, troponin, etc.); however, suspicion is low given the signalment of the patient. Unfortunately, there is always an elevated risk for collapse and sudden death in any arrhythmic patient, and even on medications this risk unfortunately still persists. ARVC carries a HIGHLY variable prognosis, with some dogs able to remain asymptomatic for extended periods of time, and others developing exercise intolerance, syncopal episode, and refractory arrhythmias/sudden death imminently.

Electing to treat arrhythmias is based upon clinical signs and amount/degree of arrhythmia identified. **Unfortunately there is always an elevated risk for collapse and sudden death in**



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any arrhythmic patient, and even on medications this risk unfortunately still persists. Overall the markers of malignancy in this case are relatively low; however, I am concerned with both the frequency of VPCs as well as the finding of couplets. Based upon this, treatment with Sotalol is recommended as below.

Monitor at home for collapse, exercise intolerance, and/or cough. Mild activity restriction is advised in arrhythmic patients.

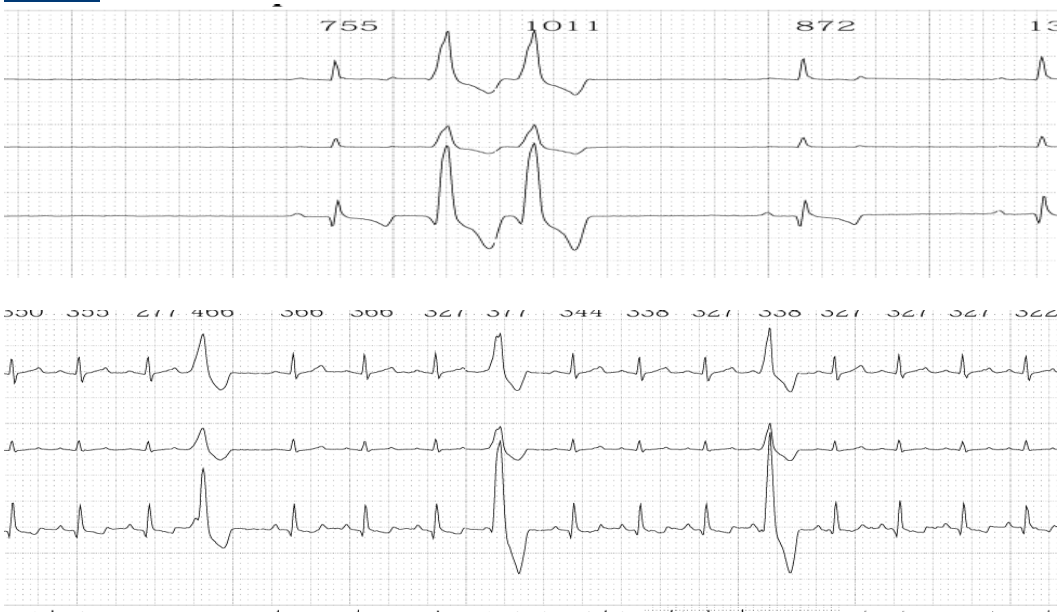
Anesthesia is NOT advised prior to obtaining adequate rhythm control. Once the arrythmia is controlled, anesthetic risk is considered moderate. Avoid ketamine, telazol, Dexdomitor (or other alpha-2 agonists) and acepromazine. Recommend having lidocaine CRI available for use in the event of worsening ventricular arrhythmias under anesthesia (CRI 50—75mcg/kg/min).

Plan: Institute Sotalol 1-2mg/kg PO q12h. Consider systemic screening.

Reassess ECG and/or holter in 2-4weeks to assess response (ie resolution or at least dramatic improvement in the frequency of the arrhythmia would be expected).

A recheck ECG is recommended in 6 months to assess for progression.

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. 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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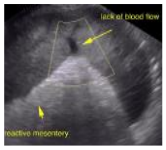

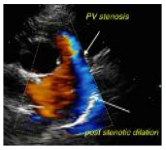

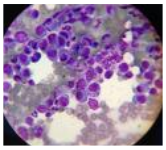
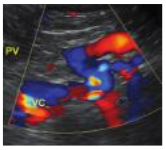

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