


PATIENT

Talon Phoenix

SPECIES

Canine

BREED

Great Dane

SEX

Male

AGE

2 years

WEIGHT

140 lbs

INTERPRETED BY

 Maggie Machen Lamy,
 DVM, DACVIM
 (Cardiology)

IMAGING PERFORMED BY
HOSPITAL NAME

 Mass Veterinary
 Services

REFERRING VET

Dr. Masloski

INVOICE

23643

DATE

4/13/22

PRESENTING CLINICAL SIGNS

History: Talon was seen at an OFA clinic for an echocardiogram. The echo revealed a normal heart structure and function but A fib was noted on his EKG. Talon did have a collapse episode when went in (without owner) for OFA eye testing. Talon is eating well with normal activity. He does have some loud breathing when excited but no labored breathing noted. Talon does not have any current C/S/V/D

HOLTER MONITOR FINDINGS AND RHYTHM ASSESSMENT

Time analyzed	23:59h
Mean heart rate	101bpm
Maximum heart rate	250bpm
Minimum heart rate	43bpm
VPCs	10
APCs	NA

Interpretation: The underlying rhythm is atrial fibrillation with no identifiable P waves and an irregularly irregular rhythm. Max and minimum heart rates correlate with activity/sleep. Occasional sinus pause/arrest while sleeping (longest RR 4s). Rare single premature beats.

Rhythm diagnosis: Atrial fibrillation; suspect primary. Rare VPCs.

RECOMMENDATIONS

The arrhythmia is confirmed to be lone or primary atrial fibrillation. Giant breed dogs are predisposed to primary AF, which develops simply due to a relatively large myocardial size (also common in horses). The difference between lone AF and a malignant AF that develops secondary to structural disease is heart rate and atrial dimension; lone AF is typically a normal rate, while structural AF is rapid and >200bpm, often accompanying acute congestive signs. Given a lack of structural disease on the OFA exam, systemic abnormalities or clinical signs, this is the presumed diagnosis.

Dogs with lone AF typically exhibit minimal clinical signs if the rate is normal and can often remain asymptomatic for some time with this abnormal rhythm. That being said, lone AF dogs are at increased risk for eventually developing DCM down the road and long-term prognosis is guarded. Lifelong monitoring is advised. Electrical conversion can be considered in some sustained cases depending on activity level of the patient but is typically not necessary. Mild activity restriction is advised.

Monitor at home for any related clinical signs such as lethargy/exercise intolerance. No obvious correlation with a collapse episode is suspected; however, should the episodes recur further evaluation is advised. Rate control is certainly not indicated in this case. Omega fatty acid supplementation may be of some long-term benefit in arrhythmic patients. Ensure that grain free/boutique/exotic ingredient diets are avoided in this case lifelong.

Given the increased risk for development of DCM, breeding this animal is not advised.

Recheck echocardiogram and ECG in 6 months to screen for any progressive issues.

