



**PATIENT**

Pixie Brema

**SPECIES**

Canine

**BREED**

Toy Poodle

**SEX**

Female Spayed

**AGE**

15 years

**WEIGHT**

11lbs

**INTERPRETED BY**

Maggie Machen Lamy,  
 DVM DACVIM  
 (Cardiology)

**IMAGING PERFORMED BY**

Kelly Reschny, RVT

**HOSPITAL NAME**

Southdown Animal  
 Clinic

**REFERRING VET**

Dr. Pocha

**INVOICE**

47569

**DATE**

4/15/26

**PRESENTING CLINICAL SIGNS**

History: Recheck echo. Grade 4-5/6 holosystolic heart murmur. Arrhythmia. On Vetmedin 1.25mg, Furosemide 20mg, Tracheal Cough Elixir (isoproterenol/phenobarbital 0.004mg/0.4ml). Elevated BUN. CXR show loss of caudal cardiac waist, dorsal displacement of trachea +/- CHF.  
 -Pertinent previous echo findings (11/2025 MML): CVD B1 with a cough noted. Trace MR, no LA or LVE. LA: 1.0, LV: 2.0.

**ECHOCARDIOGRAM FINDINGS**

2D, m-mode, color flow and doppler imaging is available. Diffuse thickening of mitral valve leaflets with marked prolapse into the left atrial lumen. Moderate eccentric mitral regurgitation with moderate left atrial dilation. Mild LV dilation with hyperdynamic myocardial function. The tricuspid valve appears mildly thickened with no significant tricuspid regurgitation. Normal right atrial and ventricular diameter and morphology indicating no overt evidence of pulmonary arterial hypertension. The pulmonic and aortic valves are normal in morphology and mobility. Normal pulmonic and aortic outflow velocities with laminar flow. No obvious aortic and trace pulmonic insufficiency. No pericardial or pleural effusion noted. No obvious cardiac masses.

**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)
<b>NORMAL PARAMETER</b>	4.5-5.5	<2.7	1.3	<1.6	28-40	40-100	<0.6
<b>PATIENT</b>	NM	NA	NM	1.7	60	88	NM
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)
<b>NORMAL PARAMETER</b>	50-100	0.7-1.7	0.7-1.6	BELOW	BELOW	BELOW	BELOW
<b>PATIENT</b>	NM	1.2	1.1	4.9	1.8	2.8	1.1
*Normal chamber parameters expressed as a mean value (SD)				3	1.27 (5.3)	2.46 (2.46)	1.36 (5.5)
<b>BODY WEIGHT DEPENDENT PARAMETERS</b>				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**

Chronic degenerative valve disease persists with evidence of progression. Previously trace MR has advanced to moderate, with increasing left heart dimensions. Moderate left atrial enlargement indicates there is relatively low risk for imminent complication; however, risk for progression to spontaneous congestive heart failure in the future is now elevated.



**PATIENT**

Pixie Brema

**SPECIES**

Canine

**BREED**

Toy Poodle

**SEX**

Female Spayed

**AGE**

15 years

**WEIGHT**

11lbs

**INTERPRETED BY**

Maggie Machen Lamy,  
 DVM DACVIM  
 (Cardiology)

**IMAGING PERFORMED BY**

Kelly Reschny, RVT

**HOSPITAL NAME**

Southdown Animal  
 Clinic

**REFERRING VET**

Dr. Pocha

**INVOICE**

47569

**DATE**

4/15/26

While mainstem bronchi compression may certainly be contributing to an increase in coughing, other primary airway contributions should also be considered (tracheal collapse, COPD/chronic bronchitis, etc.). Consider hydrocodone for any mechanical component due to cardiomegaly. If the cough is poorly controlled and/or progresses long term, pulmonary hypertension (PAH) can develop secondarily. Signs of clinically relevant PAH include exertional dyspnea or exertional syncope. It is important to note that PAH does not cause the cough; rather, the cough leads to PAH.

Given these findings, continued Pimobendan is recommended as below. Lasix is unnecessary in the absence of CHF, which is considered unlikely in this case. Consider a Radiologist review of the films, if concern persists. Continued assessment of progression is recommended, with a guarded prognosis once in stage B2. Fifty percent of stage B2 patients typically develop CHF within 2-2.5 years of diagnosis. The median time to development of CHF in B2 cases treated with pimobendan is 3.5 years. Patient may be at risk for development of CHF, arrhythmias, and/or sudden death going forward.

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

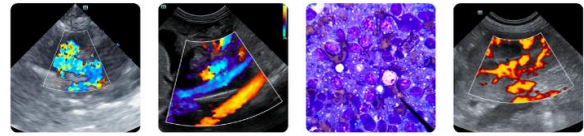
The reported blood pressure is elevated and should be reassessed for accuracy particularly given no reported clinical signs of severe hypertension (retinal changes, etc.) or evidence of LVH on echo. Ideally obtain serial measurements in a controlled, low stress environment and continue until 3 consecutive readings plateau within 5mmHg of variability. If persistently >180mmHg despite a relatively calm demeanor, recommend institution of amlodipine to effect. Additionally, if deemed accurate, screening for predisposing underlying causes of SHT is recommended (Cushing's, PLN, adrenal tumor, etc.), as primary disease is relatively uncommon and a rule out diagnosis.

Anesthetic risk remains mildly elevated. Cardiac protective drug choices (opioid/benzodiazepine premedication, Propofol or alfaxalone induction, iso or sevo gas) are recommended. Monitor for arrhythmias, hypotension, and hypoxia both intra and post-operatively and intervene as necessary. Judicious IV fluid rates are recommended to avoid fluid overload. Avoid heart rate stimulating drugs such as atropine unless clinically indicated.

**PLAN**

Reassess BP as discussed. Continue Pimobendan 0.25-0.3mg/kg PO q12h. Discontinue Lasix. Consider a CXR review.

Recommend monitor for progression with a recheck echocardiogram in 6 months, sooner if any development of clinical signs.



**PATIENT**

Pixie Brema

**SPECIES**

Canine

**BREED**

Toy Poodle

**SEX**

Female Spayed

**AGE**

15 years

**WEIGHT**

11lbs

**INTERPRETED BY**

Maggie Machen Lamy,  
DVM DACVIM  
(Cardiology)

**IMAGING  
PERFORMED BY**

Kelly Reschny, RVT

**HOSPITAL NAME**

Southdown Animal  
Clinic

**REFERRING VET**

Dr. Pocha

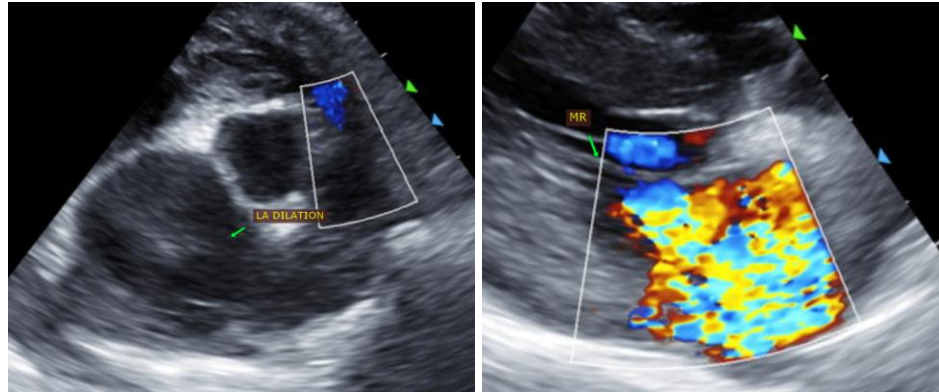
**INVOICE**

47569

**DATE**

4/15/26

**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. 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