

**PATIENT**

Abel Waltz

**SPECIES**

Canine

**BREED**

Pitbull Mix

**SEX**

Male Neutered

**AGE**

11 years

**WEIGHT**

100.3lbs

**INTERPRETED BY**

Maggie Machen Lamy,  
DVM, DACVIM  
(Cardiology)

**IMAGING PERFORMED BY**

Loetitia Saint-Jacques,  
LVT

**HOSPITAL NAME**

North Fork Veterinary  
Clinic

**REFERRING VET**

Dr. Whitten

**INVOICE**

47652

**DATE**

4/22/26

**PRESENTING CLINICAL SIGNS**

History: Grade IV/VI murmur. Has been weak . recent visit on 04-21-2026 was for acute lethargy, vomiting, and hard breathing, revealing a new, significant cardiac arrhythmia. On 04-21-2026, Abel presented for a one-week history of being unwell, with vomiting, lethargy, and a 4.4 lbs weight loss since 03-16-2026. A physical exam revealed an irregular HR, fever (103.6°F), and slightly delayed CRT. An EKG confirmed a sinus tachycardia with multifocal ventricular premature contractions (VPCs). A point-of-care ultrasound (POCUS) showed subjectively decreased cardiac contractility. Bloodwork indicated inflammation (leukocytosis with neutrophilia), hemoconcentration (HCT 61%), and abnormalities suggesting hepatobiliary disease (elevated ALP, GGT, and total bilirubin). A urinalysis was consistent with a urinary tract infection. Abel was started on Sotalol for the arrhythmia, along with antibiotics and supportive care. Abel has a history of intermittent seizures, with the last reported episode in late 2025 or early 2026. previously on Gabapentin, but the med was not given as of the 03-16-2026 visit. On 06-16-2022, Gabapentin was prescribed to be given at the start of an episode. On Cerenia, Augmentin, Denamarin, Sotalol 120mg BID  
-Abnormal PE/Chem/CBC/UA Results: HCT 61.2 WBC 20.64 Neut 17.03 Bands lymph's 2.23 Mono 1.33 PLT low but not on blood smear, Alb 2.0, ALP 1762, GGT 14, T bili 1.0

**ELECTROCARDIOGRAPHIC FINDINGS**

A six lead ECG is available at 25mm/s; 10mm/mV. The average heart rate is 130bpm. The rhythm is sinus in origin, with a p for every QRS complex and vice versa. The P wave morphology is positive with a normal dimension. Normal PR. The QRS morphology is positive with normal dimension. MEA is normal. Isolated VPCs, singles only, monomorphic. One single APC. No pauses or other dysrhythmias observed.

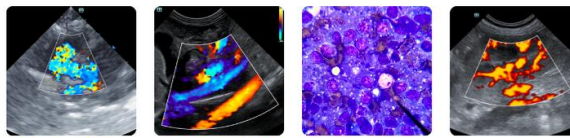
ECG diagnosis: Normal sinus rhythm with frequent single VPCs and one isolated APC.

**ECHOCARDIOGRAM FINDINGS**

2D, m-mode, color flow and doppler imaging is available. Mild diffuse thickening of mitral valve leaflets with no prolapse into the left atrial lumen. Mild eccentric mitral regurgitation with no left atrial dilation. Normal MR velocity. No LV dilation with adequate myocardial function. The tricuspid valve appears normal with no tricuspid regurgitation. A small (1.2cm in diameter) hypochoic lesion is seen along the roof of the right atrium near the auricle. 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 or pulmonic insufficiency. No pericardial or pleural effusion noted. A single-lead ECG is attached throughout the study showing rare isolated VPCs.

**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	NA	NM	1.2	28	50	0.6



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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	1.7	1.2	45.5	3.5	4.6	3.3
*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)
<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)
Adapted from June Boon, Veterinary Echocardiography, 1998 Rishniw M and Hollis NE, J Vet Intern Med 2000; 14:429-435 Hansson et al, Vet Rad and Ultrasound 2002 Bonagura et al. Echocardiography: principles of interpretation, Vet Clin North Am 15:1177, 1995				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 causing mild mitral regurgitation. Lack of significant left atrial enlargement indicates the current risk for complication is low. Of additional concern, a soft tissue lesion is seen that appears associated with the right atrium. This is concerning given the signalment, clinical signs and development of arrhythmias. An origin is difficult to determine given the small size of the lesion. That being said, there is great concern for a neoplastic process at play. Further workup is recommended, such as a thoracic CT scan, abdominal imaging in search for additional lesions, etc. No additional structural issues are noted in this study.

The ECG does show VPCs are present with a single APC noted. Without a prior tracing for comparison, it is difficult to know if the frequency is similar or if the change is minimal. Of concern, the patient is on quite a high dose of Sotalol for this body size and there is still frequent VPCs noted. Based upon this, a holter monitor should be considered for further evaluation in this case. If declined or not possible, simply continuing the medication may be reasonable.

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.

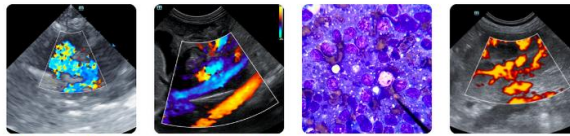
Fish oil supplementation is recommended for dogs with arrhythmias (500-1000mg of omega 3 and 6 once to twice daily).

Monitor at home for collapse, exercise intolerance, and/or lethargy. If a holter monitor is elected, this will dictate whether therapy is needed and follow up protocol.

Anesthetic risk is considered moderately elevated. 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**

Consider full systemic evaluation as discussed (AUS, CT scan, etc. A holter monitor is strongly recommended. If declined, continue Sotalol as prescribed.



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A recheck echocardiogram/ECG is recommended in 6 months.

Abel Waltz

### IMAGES

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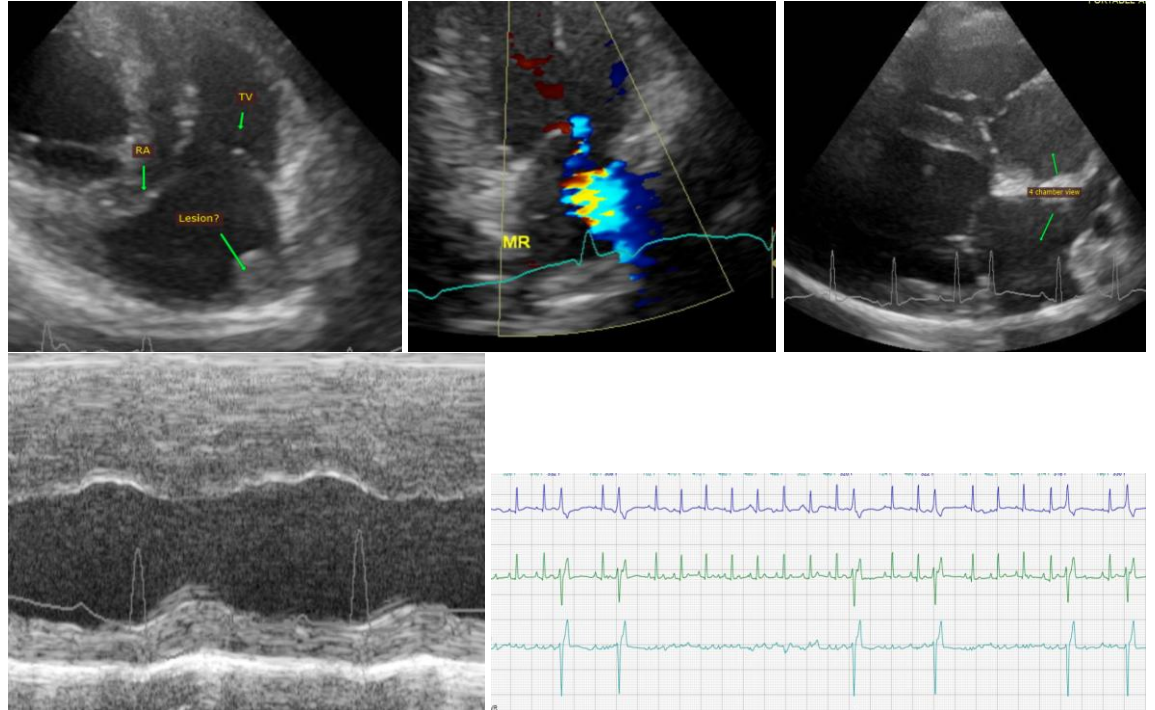
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**  
**Diplomate of the American College of Veterinary Internal Medicine (Cardiology)**  
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