



PATIENT
Emmy Beauregard

SPECIES
Canine

BREED
Spaniel Mix

SEX
Female Spayed

AGE
11 years

WEIGHT
20lbs

INTERPRETED BY
Maggie Machen
Lamy, DVM
DACVIM (Cardiology)

IMAGING PERFORMED BY
Pamela Harrigan,
RDCS

HOSPITAL NAME
Mass Veterinary
Services

REFERRING VET
Dr. Masloski

INVOICE
30017

DATE
4/4/23

PRESENTING CLINICAL SIGNS

History: Recheck echo. History chronic valvular disease - advanced. Presently, Emmy has been decompensating. She had a collapse episode this morning and has collapsed 3 times since last visit here in February. She has been dyspneic for the past week with a decreased appetite. Constant coughing. On exam: sinus arrhythmia, grade V/VI with PMI left apical area radiating to right and palpable thrill, PSS, lung fields harsh on inspiration on right; abdominal component to respirations; no cough with tracheal palpation, mm pink, moist, CRT<2. BP: 110mmHg x 5. Current medications: 1) Pimobendan/vetmedin 15mg 1/3 tab twice a day 2) Enalapril 5mg 1.5 tabs twice a day 3) Snip tips---not taking 4) Torsemide 5mg 1/2 tab twice a day 5) Sildenafil 20mg 1/2 tab three times a day 6) Diphenoxylate with atropine 2.5mg 1 tab am and pm with 1/2-tab mid-day.
-Pertinent previous echo findings (10/4/22 MML): LA 4.1 cm; LA:Ao 2.8; LV 4.8 cm; moderate LVE, marked LAE, marked MR, mild-moderate TR (3.6 m/s; 53 mmHg), moderate pulmonary hypertension.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available.
Left ventricle: The LV is severely dilated with adequate function.
Left atrium: The left atrium is markedly dilated.
Mitral valve: Diffuse thickening of mitral valve leaflets with prolapse into the left atrial lumen. Marked eccentric mitral regurgitation. Lack of coaptation in systole. Decreased velocity.
Aortic valve/Aorta: The aortic valve is normal in morphology and mobility. Normal aortic outflow velocity; laminar flow. Trace aortic insufficiency.
Right ventricle: Moderate RV dilation.
Right atrium: Moderate RA dilation.
Tricuspid valve: The tricuspid valve appears mildly thickened with moderate tricuspid regurgitation. Velocity consistent with severe pulmonary hypertension.
Pulmonic valve/Pulmonary artery: The pulmonic valve is normal in morphology and mobility. Normal pulmonic outflow velocities. Trace pulmonic insufficiency.
Pericardium/other: No pericardial or pleural effusion noted. Ascites seen on subcostal views. No obvious cardiac masses.
Heart rhythm: ECG reveals a sinus rhythm with an average HR of 140bpm.

2-Dimensional Measurements

Ao diam (cm)	1.3
LA diam (cm)	4.6
LA:Ao (Swe)	3.5
IVS thickness (cm)	0.7
LVID diastole (cm)	5.0
PW thickness (cm)	0.7
LVID systole (cm)	2.5
FS (%)	50

Doppler Measurements

PV Vmax (m/s)	0.55
AoV Vmax (m/s)	1.3
MR Vmax (m/s)	3.5
TR Vmax (m/s)	4.7
TR PG (mmHg)	87

INTERPRETATION OF THE FINDINGS

Chronic degenerative valve disease persists with continued progression. Marked left heart enlargement continues to increase with worsening pulmonary hypertension. There is now development of ascites, suggesting biventricular failure. No obvious additional issues are identified.



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Given that the patient's quality of life is dwindling despite being on full cardiac support, euthanasia should be considered in this case. We can attempt medication adjustments as below; however, these changes are a band aid over a much bigger issue. If no significant improvement in the next few days there may be limited options remaining in this case.

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The prognosis is grave, our goal being to improve quality of life for the short-term. Patient is at high risk for acute sudden death and/or decompensation at any time.

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RECOMMENDATIONS

- Increase Pimobendan to TID dosing.
- Discontinue Enalapril.
- Institute Spironolactone 1-2mg/kg PO q12h.
- Increase Sildenafil to 20mg q8h.
- Consider abdominocentesis if needed for comfort/appetite.
- Monitor renal values, BP and quality of life in 5-7 days. If patient continues to decline despite these changes, euthanasia should be considered. If there is improvement at home, monitor renal values every 2-3 months going forward.
- Continue Hydrocodone if needed for quality of life.
- Elective anesthesia is not advised.
- Omega fatty acid supplementation and mild salt restriction may be of some long-term benefit.
- Monitor for development of a cough, labored breathing, exercise intolerance or collapse episodes. Monitoring of sleeping breathing rates is the best way to screen for progression to CHF at home.

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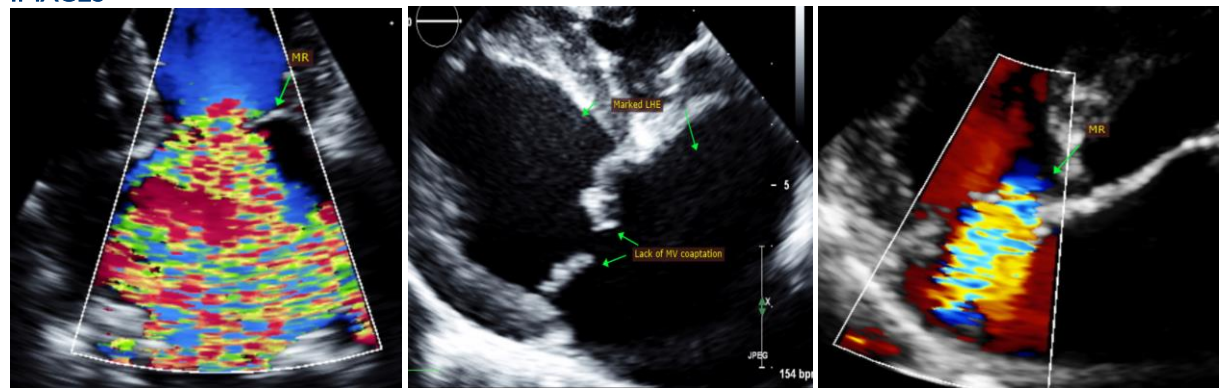
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PLAN

- A recheck echocardiogram is recommended in 6 months to screen for progression, sooner if clinical signs arise.

IMAGING PERFORMED BY
Pamela Harrigan,
RDCS

IMAGES



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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.

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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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Echocardiogram performed by: Pamela Harrigan, RDCS
Pet Animal Ultrasound Service (4paus.com)

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