



PATIENT

Ozzy Dobosz

SPECIES

Canine

BREED

Boxer

SEX

Male Neutered

AGE

11 years

WEIGHT

66.5lbs

INTERPRETED BY

Maggie Machen
Lamy, DVM
DACVIM (Cardiology)

IMAGING PERFORMED BY

Pamela Harrigan,
RDCS

HOSPITAL NAME

Mass Veterinary Services

REFERRING VET

Dr. Masloski

INVOICE

23475

DATE

4/6/22

PRESENTING CLINICAL SIGNS

History: Ozzy was noted to have an arrhythmia in March when presented for a collapse episode. The family had used Frontline for the first time in years a week prior to the event. Ozzy appeared dizzy, flopped over on one side and kept trying to get up. He was panting throughout. During episode number 2, he lost bladder control as well as vomited. During this time, his heart felt very strong and irregular and then very weak. Initially he was doing well after the event but then became lethargic. His appetite has also decreased. At this point, Ozzy's appetite and activity level are both normal. This morning when he jumped off the couch, his LF paw curled under but then corrected---this is not normal for him. On exam today; arrhythmia noted which seemed to self-resolve, no murmurs noted, femoral pulses adequate to strong and synchronous, lung fields clear. BP: 190mmHg x 3 (appeared calm). Medications: 1) Apoquel 16mg 1 tab daily 2) CBD oil 15mg daily.

ELECTROCARDIOGRAPHIC FINDINGS *Note: Single lead ECGs are evaluated as a rhythm strip. Morphology/MEA cannot be definitively commented on.

Multiple single lead ECG are available; 25mm/s, 20mm/mV.

-The 1st tracing shows ventricular tachycardia with a heart rate of 300bpm. Lidocaine was administered at 2mg/kg.

-Follow up ECG show conversion to a sinus rhythm with an average heart rate of 130bpm. No obvious persistent ventricular beats are identified.

ECG diagnosis: Sustained ventricular tachycardia with successful conversion.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available.

Left ventricle: The LV diameter is normal with adequate myocardial function. LV wall thicknesses are normal.

Left atrium: The left atrium is normal

Mitral valve: The mitral valve is normal with no prolapse into the left atrial lumen. Trace mitral regurgitation.

Aortic valve/aorta: The aortic valve is normal in morphology and mobility. Normal aortic outflow velocity; laminar flow. No aortic insufficiency.

Right ventricle: Right ventricular is normal without significant hypertrophy.

Right atrium: RA is normal.

Tricuspid valve: The tricuspid valve appears normal with no tricuspid regurgitation.

Pulmonic valve/pulmonary artery: The pulmonic valve is normal in morphology and mobility. No pulmonic insufficiency. Normal RVOT velocity; laminar flow.

Pericardium/other: No pericardial or pleural effusion noted. No obvious cardiac masses.

2-Dimensional Measurements

Ao diam (cm)	2.2
LA diam (cm)	3.1
LA:Ao (Swe)	1.4
IVS thickness (cm)	1.3
LVID diastole (cm)	3.6
PW thickness (cm)	1.2
LVID systole (cm)	2.5
FS (%)	30

Doppler Measurements

PV Vmax (m/s)	0.85
AoV Vmax (m/s)	NM
MR Vmax (m/s)	NA
TR Vmax (m/s)	NA
TR PG (mmHg)	NA



PATIENT INTERPRETATION OF THE FINDINGS

Ozzy Dobosz

Overtly normal cardiac dimensions and function. The right heart appears normal and systolic function is intact. No obvious structural issues are identified.

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The ECG did show sustained ventricular tachycardia. VT is a highly dangerous rhythm generated for abnormal conductive or fibrotic tissue in the ventricles. Frequent single VPCs will often cause no clinical signs in dogs. When sustained however, ventricular tachycardia can lead to symptoms such as lethargy and collapse.

BREED

Boxer

VPCs/VT are a very non-specific finding. They can be primary in origin such as ARVC, be secondary to significant cardiac disease (not present in this study) or be extra-cardiac in origin, i.e., due to pain, stress, inflammation, cancer, GI disease, DIC/sepsis, etc. Given the signalment, primary arrhythmic disease (ARVC) is highly suspected. The most common age of onset of this disease is 6-8 years old and often the patient is asymptomatic. Reasonable to rule out all differentials given the advanced age; however, suspicion for the former is high particularly given the history. There are two forms of ARVC; a purely arrhythmic form as is seen here and a DCM-phenotype. Monitoring of systolic function is recommended going forward.

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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.

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Based upon the positive response to Lidocaine, lifelong Sotalol is recommended as below. If the patient has any further syncopal episodes in the future or significant lethargy, emergent re-evaluation and potential hospitalization should be considered. Once sotalol is on board, an extended time 6 lead ECG and/or holter monitor is a reasonable next step to allow monitoring of the rhythm throughout 24 hours of a normal day to ensure good rhythm control.

IMAGING PERFORMED BY

Pamela Harrigan,
RDCS

RECOMMENDATIONS

- Following a loading dose of Sotalol at 80mg (administered yesterday), give ½ tab PO q12h as the chronic dose.
- Recheck ECG in 1-2 weeks to assess response (goal is significant reduction in ectopy without a significant change in underlying sinus rate).
- Consider recheck holter at this time if desired.
- Fish oil supplementation is recommended for dogs with arrhythmias (1000mg of omega 3 and 6 once to twice daily as tolerated).
- Monitor at home for collapse, exercise intolerance, and/or lethargy.
- Anesthesia is not recommended until good arrhythmic control is achieved. Lifelong mild to moderate activity restriction is advised.

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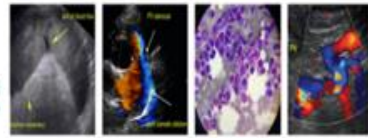
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PLAN

- Recheck ECG and echocardiogram is recommended in 6 months to determine progression/control, sooner if any development of associated clinical signs.

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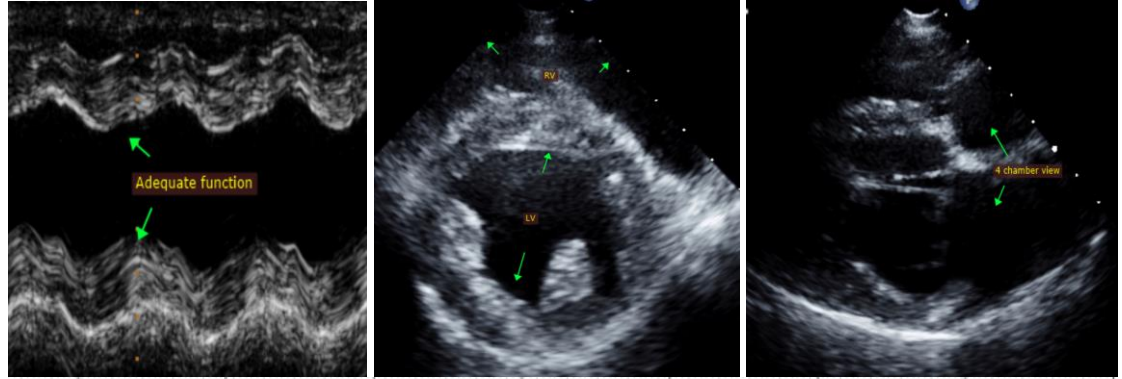
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IMAGES



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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.

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.

IMAGING PERFORMED BY

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

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