



PATIENT

Brody Stiner

SPECIES

Canine

BREED

Bichon Mix

SEX

Male Neutered

AGE

11 years

WEIGHT

24.2lbs

INTERPRETED BY

Maggie Machen
Lamy, DVM
DACVIM (Cardiology)

IMAGING PERFORMED BY

Pamela Harrigan,
RDMS

HOSPITAL NAME

Chase Veterinary
Clinic

REFERRING VET

Dr. Caffarella

INVOICE

30115

DATE

4/7/23

PRESENTING CLINICAL SIGNS

History: Grade III/VI murmur. Elevated ProBNP 1334. Needs dentistry. On Levothyroxine 0.2 mg PO BID.

-Abnormal PE/Chem/CBC/UA Results: ALT: 173/ ALP: 1551.

ECHOCARDIOGRAM FINDINGS

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

Left ventricle: Moderate to severe LV hypertrophy. Normal LV chamber with adequate function.

Left atrium: The left atrium is normal.

Mitral valve: The anterior leaflet of mitral valve is thickened with an abnormal protrusion into the LVOT. Mild mitral regurgitation.

Aortic valve/aorta: The aortic valve is normal in morphology and mobility. Mild to moderately elevated aortic outflow velocity with a dynamic profile. Mild to moderate aortic insufficiency.

Right ventricle: Normal right ventricular diameter and morphology indicating no overt evidence of pulmonary arterial hypertension.

Right atrium: Normal RA dimension.

Tricuspid valve: The tricuspid valve appears normal with mild tricuspid regurgitation. Normal velocity.

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.

Heart rhythm: ECG reveals a sinus rhythm with an average HR of 140bpm.

2-Dimensional Measurements

| | |
|--------------------|-----|
| Ao diam (cm) | 1.7 |
| LA diam (cm) | 2.0 |
| LA:Ao (Swe) | 1.2 |
| IVS thickness (cm) | 1.2 |
| LVID diastole (cm) | 2.0 |
| PW thickness (cm) | 1.2 |
| LVID systole (cm) | 0.8 |
| FS (%) | 59 |

Doppler Measurements

| | |
|----------------|-----|
| PV Vmax (m/s) | 0.8 |
| AoV Vmax (m/s) | 2.8 |
| MR Vmax (m/s) | NM |
| TR Vmax (m/s) | 2.2 |
| TR PG (mmHg) | 20 |

INTERPRETATION OF THE FINDINGS

The diagnosis is suspected to be mitral valve dysplasia leading to an LVOT obstruction and secondary LV hypertrophy. Depending on murmur chronicity, dysplasia (a congenital abnormality) may be unlikely, and an atypical form of valve degeneration is also possible. Moderate to severe hypertrophy is concerning and a primary hypertrophic component is also a possible. Regardless of categorical classification, there is significant pressure overload of the left heart, which should be monitoring going forward. A baseline BP is strongly recommended, given a concurrent aortic insufficiency as a contributing factor. No additional issues are identified.

Heart rate control with atenolol is recommended, as the dynamic nature of the obstruction will be reduced at lower heart rates. No other medications are indicated at this juncture.



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Prognosis is guarded prior to monitoring for progression and response to medication. Patient will be at risk for associated clinical signs including arrhythmias, CHF, and/or sudden death lifelong.

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RECOMMENDATIONS

- Baseline BP is strongly recommended.
- Institute titrating dose of atenolol: 25mg tablets; Give 1/2 tab once daily. Recheck heart rate in 1-2 weeks with target stressed rate of <140bpm. Increase as needed until target reached.
- Omega fatty acid supplementation and mild salt restriction may be of some long-term benefit.
- Mild activity restriction is advised lifelong.
- Monitor at home for any respiratory signs, clinical lethargy or collapse.
- Anesthetic risk is considered mild, however judicious IV fluid rates are advised to avoid fluid overload. Additionally, drugs that stimulate heart rate should be avoided unless clinically necessary (glycopyrrolate, atropine). Avoid vasodilators as this may worsen the obstruction. A reasonable protocol includes opioid/benzodiazepine premedication, propofol induction, and isoflurane maintenance.

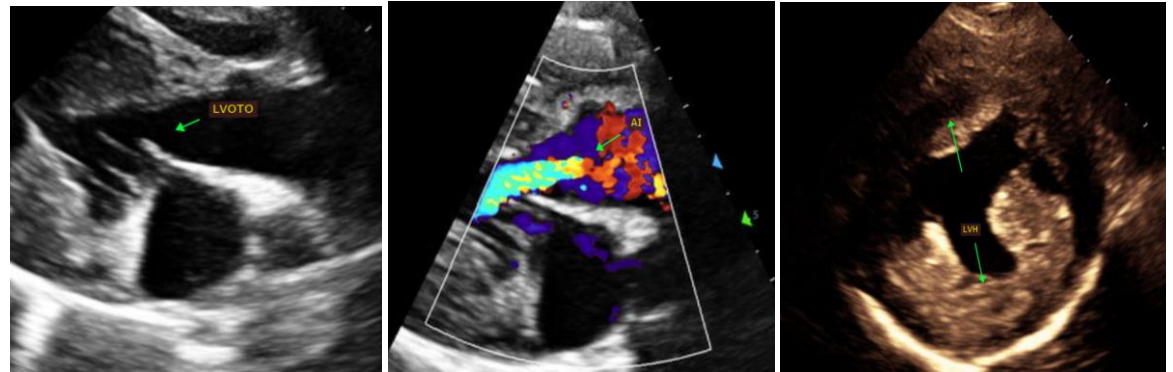
PLAN

- Recommend recheck echocardiogram in 6 months to assess for progression, sooner if clinical issues arise.

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IMAGES



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 RDCS

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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.

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 info@sonopath.com

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