



PATIENT

Dakota Gero

SPECIES

Canine

BREED

English Pointer

SEX

FS

AGE

11 years

WEIGHT

46lbs

INTERPRETED BY

Maggie Machen Lamy,
DVM, DACVIM
(Cardiology)

IMAGING PERFORMED BY

Dr. Abdul-Chani

HOSPITAL NAME

Byram Animal Hospital

REFERRING VET

Dr. Abdul- Chani

INVOICE

47838

DATE

5/13/26

PRESENTING CLINICAL SIGNS

History: Abnormal complexes can sometimes run for 20-30 seconds, sporadically, very unpredictable episodes of syncope, lethargic, anorexic
current medication : Metronidazole (diarrhea)
Abnormal PE/Chem/CBC/JA Results: SGOT 123/SGPT 361 Alk Phos 312 CBC/T4 WNL HW Neg. tick diseases neg.

ELECTROCARDIOGRAPHIC FINDINGS

A brief six lead ECG is available at 25mm/s; 10mm/mV. The average heart rate is 100bpm. 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 monomorphic VPCs; brief ventricular bigeminy. No supraventricular ectopic beats, pauses or other dysrhythmias observed.
ECG diagnosis: Normal sinus rhythm with isolated monomorphic VPCs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The ECG confirms ventricular premature contractions (VPCs) are present. VPCs are generated from abnormal conductive or fibrotic tissue in the ventricles of the heart muscle, and even frequent single VPCs will often cause no clinical signs in animals (as is seen here). When sustained however, ventricular tachycardia can lead to symptoms such as lethargy and collapse, and ultimately can lead to fibrillation and sudden death.

When addressing arrhythmias, two things must be considered; 1. Is an underlying cause evident or is this primary arrhythmic disease? And 2. Is anti-arrhythmic therapy warranted?

VPCs are a very non-specific finding. They can be due to significant cardiac disease or be extra-cardiac in origin; ie due to pain, stress, inflammation, cancer, GI disease, DIC/sepsis, etc. In this senior dog with non-specific symptoms, all differentials should be ruled out. An echocardiogram to assess cardiac structure and function, an abdominal ultrasound to monitor for any underlying abnormalities or lesions, baseline CXR, etc are all recommended.

Electing to treat arrhythmias is based upon clinical signs and amount/degree of arrhythmia identified. 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. Based strictly upon the amount of arrhythmia present on the available ECG, **anti-arrhythmic therapy is not indicated**. The markers of malignancy (such as polymorphism, sequential VPCs, tight coupling interval, etc are low with only single monomorphic beats identified. A longer tracing or ideally a holter monitor would be ideal to understand the true extent of the abnormality if desired.

It is important to note that at this point in the workup it is unclear if the arrhythmia is the cause of clinical signs (ie ventricular tachycardia is present intermittently and not captured here), or if potentially the VPCs are a marker of some alternative pathology such as splenic disease, a hemoabdomen, etc. that is causing the clinical decline. Immediate full work up should be obtained. Initially it must be noted that this tracing is extremely brief and does not necessarily reflect a full clinical picture. A longer tracing within hospital monitoring



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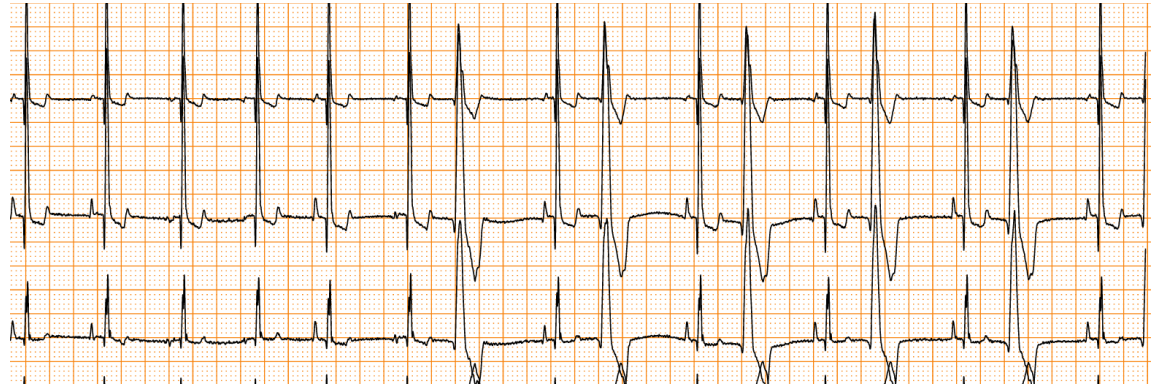
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should certainly be considered. If these steps cannot be performed at your practice, referral should be considered.

Plan: Immediate further work up as discussed.

Pending results, a holter monitor, longer tracing, etc should be considered.

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