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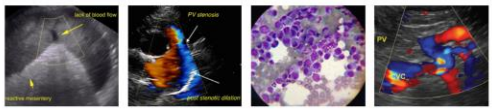

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT
Leah Sposato

SPECIES
Canine

BREED
Yorkshire Terrier

SEX
Female Spayed

AGE
11 years

WEIGHT
10.7lbs

INTERPRETED BY
Maggie Machen Lamy, DVM DACVIM (Cardiology)

IMAGING PERFORMED BY
Pamela Harrigan, RDCS

HOSPITAL NAME
Wood River Animal Hospital

REFERRING VET
Dr. Fischer

INVOICE
24321

DATE
5/22/22

PRESENTING CLINICAL SIGNS

History: Recheck echo. History chronic valvular disease - Stage late B2. Cough. BP: 145 mmHg.
-Previous echoes include 7/19/21 Maggie Machen Lamy, DVM, DACVIM-Cardiology and, subsequently, 11/16/21 Adam Kane DVM, DACVIM-Cardiology - (those results): LA 2.43 cm; LA:Ao 1.81; LV 3.33 cm; moderate LAE (no spontaneous contrast); MV thickened, prolapse, ruptured chordae; severe MR; mild TR (2.95 m/s; 35 mmHg); mild pulmonary hypertension.
-Current medications: Pimobendan 1.25 mg BID; Spironolactone 6.25 mg QD. Patient could not tolerate benazepril or enalapril due to cough.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available.
Left ventricle: LV is normal in dimension with adequate myocardial function.
Left atrium: The left atrium is moderate dilated.
Mitral valve: Mild thickening of mitral valve leaflets with mild prolapse into the left atrial lumen. Moderate to severe eccentric mitral regurgitation, normal velocity.
Aortic valve/Aorta: The aortic valve is normal in morphology and mobility. Normal aortic outflow velocity; laminar flow. No aortic insufficiency.
Right ventricle: RV dimension and morphology is normal.
Right atrium: Normal RA dimension.
Tricuspid valve: The tricuspid valve appears mildly thickened with septal prolapse and trace tricuspid regurgitation.
Pulmonic valve/Pulmonary artery: The pulmonic valve is normal in morphology and mobility. Normal pulmonic outflow velocities. No pulmonic insufficiency.
Pericardium/other: No pericardial or pleural effusion noted. No obvious cardiac masses.
Heart rhythm: ECG reveals a sinus rhythm with an average HR of 170bpm.

2-Dimensional Measurements

Ao diam (cm)	1.3
LA diam (cm)	2.4
LA:Ao (Swe)	1.7
IVS thickness (cm)	0.70
LVID diastole (cm)	2.8
PW thickness (cm)	0.66
LVID systole (cm)	1.2
FS (%)	55

Doppler Measurements

PV Vmax (m/s)	1.0
AoV Vmax (m/s)	1.7
MR Vmax (m/s)	5.3
TR Vmax (m/s)	NM
TR PG (mmHg)	NA

INTERPRETATION OF THE FINDINGS

Chronic degenerative valve disease persists with evidence of stability. Compared to the prior study, there is actually evidence of mild improvement in left heart dimensions. The mitral regurgitation is similar to previous, and no additional issues are identified.

Given these findings, continue Pimobendan and Spironolactone as prescribed. No obvious indication for additional medications.

The reported cough was noted previously and remains likely to be multi-factorial in origin. CXR are recommended if there is any clinical concern. Early CHF/pulmonary edema should also be considered; however, this is less likely based upon these findings. Pending response, cough suppression (up to q4-6 hours) may also be helpful for mechanical cough. Monitoring of sleeping breathing rates is recommended as the best way to screen for CHF at home.

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Prognosis remains guarded with risk for progression to CHF, development of arrhythmias/LA tear, syncope and/or sudden death going forward.

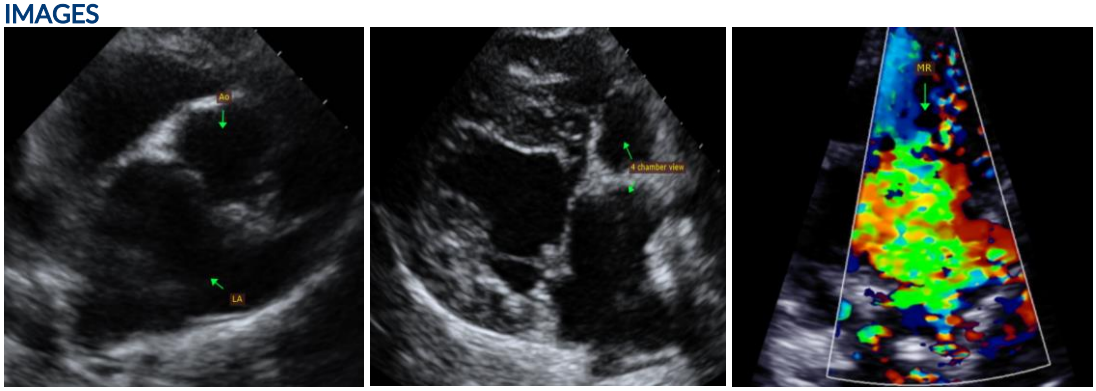
RECOMMENDATIONS

- Continue Pimobendan and Spironolactone as prescribed.
- Consider hydrocodone, CXR, etc.
- Anesthetic risk is considered moderate if needed. Cardiac protective drug choices (opioid/benzodiazepine premedication, propofol or alfaxalone induction, isoflurane gas) are recommended. Pre-oxygenate for 5-10 minutes prior to induction. Monitor for arrhythmias, hypotension, and hypoxia both intra and post-operatively and intervene as necessary. Mild IV fluid restriction is recommended to avoid fluid overload. Avoid heart rate stimulating drugs such as atropine unless clinically indicated.
- 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.

PLAN

- A renal panel is recommended every 3-4 months lifelong.
- A recheck echocardiogram is recommended in 6 months to screen for progression, sooner if clinical signs arise.

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