

**PATIENT**

Bonnie Fitzpatrick

**SPECIES**

Canine

**BREED**

Chihuahua

**SEX**

Female Spayed

**AGE**

9 years

**WEIGHT**

11.4lbs

**INTERPRETED BY**Maggie Machen Lamy,  
DVM, DACVIM  
(Cardiology)**IMAGING PERFORMED BY**

Amy Mayhew, LVT

**HOSPITAL NAME**

SVS Imaging MI

**REFERRING VET**

Dr. Fitz

**INVOICE**

24033

**DATE**

5/4/22

**PRESENTING CLINICAL SIGNS**

History: Panting, abnormal breathing since yesterday. Decreased appetite, cough, lethargy. History of grade 3 heart murmur.

-Pertinent abnormal lab results: BUN: 50, Creat: 1.7

**RADIOGRAPHIC FINDINGS** \*NOTE: Images submitted for supplemental cardiac information only.

Mild right-sided cardiomegaly. Heavy mixed interstitial pattern. No evidence of CHF.

**ECHOCARDIOGRAM FINDINGS**

2D, m-mode, color flow and doppler imaging is available. Mild thickening of mitral valve leaflets with no obvious prolapse into the left atrial lumen. No mitral regurgitation with a small left atrial dimension. Small LV diameter with adequate myocardial function. The tricuspid valve appears thickened with septal prolapse and mild tricuspid regurgitation. Moderate right atrial enlargement; moderate right ventricular dilation and hypertrophy consistent with pulmonary arterial hypertension. TR velocity consistent with moderate PAH; however, this is thought to be an underestimation. The pulmonic and aortic valves are normal in morphology and mobility. Mild main PA and branch dilation. No pulmonic insufficiency. Normal pulmonic and aortic outflow velocities. No pericardial or pleural effusion. No cardiac tumors observed.

**CARDIAC CHART**

CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (Boon method)	LA/AO (Heart Base; Swe)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	<1.6	28-40	40-100	<0.6
PATIENT	NA	4.2	NM	1.3	50	94	NM
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT (kg)	LA 2D short axis Base view (cm)	LVIDd Avg; 2D and m-mode short axis (cm)	LVIDs Avg; 2D and m-mode short axis (cm)
NORMAL PARAMETER	50-100	0.7-1.7	0.7-1.6	BELOW	BELOW	BELOW	BELOW
PATIENT	NM	0.8	0.7	5.2	1.3	1.2	0.6
*Normal chamber parameters expressed as a mean value (SD)				3	1.27 (5.3)	2.46 (2.46)	1.36 (5.5)
<b>BODY WEIGHT DEPENDENT PARAMETERS</b>				5	1.40 (4.5)	2.74 (5.2)	1.60 (4.7)
*Note: All measurements based upon multi-modal images and methods. An average value is reported.				10	1.50 (3.8)	3.27 (3.5)	2.06 (3.1)
				15	1.83 (2.0)	3.71 (2.4)	2.43 (2.1)
				20	2.02 (1.9)	4.14 (2.2)	2.80 (2.0)
				25	2.18 (2.4)	4.48 (2.9)	3.10 (2.5)
				30	2.33 (3.3)	4.83 (3.9)	3.39 (3.4)
				35	2.48 (4.3)	5.17 (5.0)	3.69 (4.5)
				40	2.62 (5.2)	5.48 (6.1)	3.96 (5.4)
				50	2.88 (7.1)	6.07 (8.3)	4.46 (7.4)

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Severe pulmonary hypertension (PAH) is present, as evidenced by an elevated TR velocity and right heart/MPA enlargement. The estimated systolic pulmonary arterial pressure is >80mmHg, with normal being <25mmHg. This is causing hypertrophy and dilation of the right heart and

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MPA (indicating right-heart pressure overload). The left heart dimensions are normal to small. No tumors or effusions are appreciated.

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Clinical signs of weakness, heavy breathing, cyanosis, and syncope are attributed to PAH. The underlying genesis of PAH is poorly understood in cases other than heartworm infestation, though it occurs with increased frequency in a variety of forms of chronic lung disease and in patients with idiopathic pulmonary fibrosis. If not performed, a heartworm antigen test is recommended. Given the chronicity of the disease seen here (no chronic case history provided), COPD/chronic bronchitis and/or primary PF as an underlying cause with an acute secondary exacerbating insult (infectious or inflammatory) is suspected. Patients with this degree of PAH and pulmonary disease can develop right-sided congestive heart failure (ascites/pleural effusion), debilitating cyanosis, labored breathing and exertional syncope if poorly controlled.

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Given the recent history of respiratory signs, the most common cause is an infectious or inflammatory insult causing a decline in already poor oxygenation status. A PTE cannot be ruled out. Coverage with broad spectrum pulmonary antibiotic (fluoroquinolone) is recommended, in addition to aggressive vasodilation using pimobendan and sildenafil. I would not utilize a diuretic, as decreasing blood volume can further decrease preload and worsen clinical signs. There may be risk for right-sided CHF in the future; however, no effusions are noted making this unlikely. If the patient experiences any additional respiratory compromise, continued hospitalization for oxygen support and IV antibiotics may be necessary. The lab work shows dehydration, which is supported by the appearance of the left heart. Consider fluid therapy to help increase free load.

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Once stable, use of theophylline and/or taper course of anti-inflammatory steroids can also be beneficial in these cases, to treat exertional dyspnea or acute flare ups and decrease the inflammatory component as much as possible. PRN use of cough suppressants may also be beneficial. Unfortunately, the prognosis overall is poor, however I am hopeful we can provide some medical relief going forward.

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(Cardiology)

Omega fatty acid supplementation (anti-inflammatory) may be of some long-term benefit. Monitor for worsening of labored breathing, exercise intolerance or collapse episodes.

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**PLAN**

Consider a Radiologist review of the films. Institute Pimobendan 0.3mg/kg PO q12h. Institute sildenafil (Viagra) 1-2mg/kg PO q8h. Consider course of Baytril and oxygen support. Can also use hydrocodone and/or theophylline depending on chronic clinical signs of cough/exertional dyspnea. Consider fluid therapy.

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Recommend recheck echocardiogram in 6 months to reassess pulmonary pressures, sooner if any

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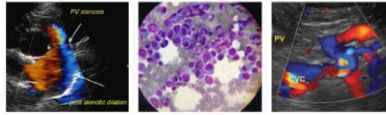
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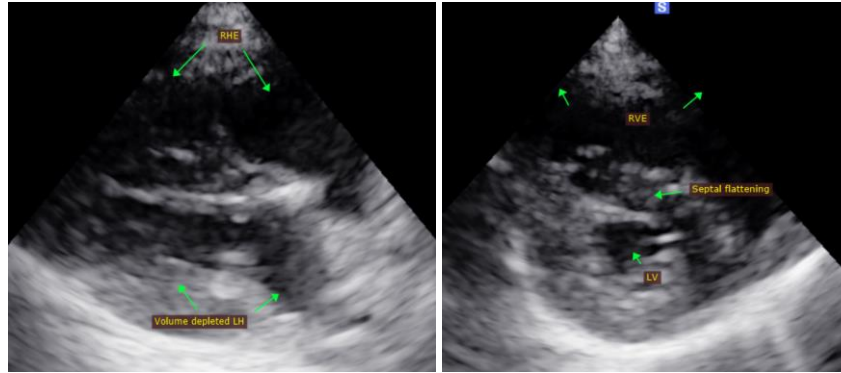
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**IMAGES**



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. 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**  
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