

## PATIENT

Teddy Shields

## SPECIES

Canine

## BREED

Golden Retriever

## SEX

MN

## AGE

11 y

## WEIGHT

22.9 kg

## INTERPRETED BY

Keith Blass, DVM, MS,  
DACVIM (Cardiology)

## IMAGING PERFORMED BY

Dr. Kuzimski

## HOSPITAL NAME

Animal Emergency  
Hospital Deland

## REFERRING VET

Dr. Kuzimski

## INVOICE

## DATE

5/8/26

## PRESENTING CLINICAL SIGNS

Presented for labored breathing, which has been on and off for a month. No murmur. Inconsistent arrhythmia noted, pulses weak. Radiographs showed an enlarged cardiac silhouette and a cranioventral pulmonary infiltrate suggestive of bronchopneumonia.

## ECHOCARDIOGRAPHIC FINDINGS

2D, M-mode, and Doppler study.

Left atrial size is normal. The mitral valve appears normal, though a mild jet of centrally-directed mitral regurgitation is present. There is moderate left ventricular dilation. Left ventricular systolic function is severely depressed. The aorta and aortic valve appear normal, though trace aortic insufficiency is present. Right atrial and right ventricular dimensions are normal. The tricuspid valve leaflets are mildly thickened, and a mild jet of tricuspid regurgitation is present. The pulmonary artery and pulmonic valve are normal. No shunting lesions are visualized. No pericardial effusion or cardiac masses are seen.

ECG during echo: Sinus rhythm with intermittent VPCs

LA - 42.4 mm  
LVIDd - 57.3 mm  
LVIDs - 53.6 mm  
FS - 6.5%  
RA - 29.7 mm  
LVOT - 1.46 m/s  
RVOT - 0.41 m/s

## ELECTROCARDIOGRAPHIC FINDINGS

A single lead ECG is submitted for review.

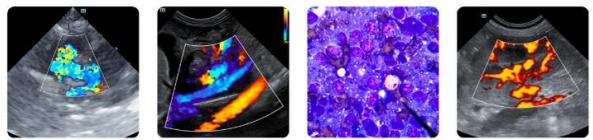
HR: 150 bpm  
Rhythm: Sinus with VPCs

The underlying rhythm is sinus in origin. All sinus complex amplitudes and intervals are within normal limits. There are intermittent single VPCs. No atrial ectopy or conduction blocks are seen.

## ASSESSMENT/RECOMMENDATIONS

Dilated cardiomyopathy (DCM)  
Degenerative tricuspid valve disease  
Ventricular premature complexes (VPCs)

This examination demonstrates severe depression of Teddy's left ventricular systolic function, consistent with the presence of DCM. It's possible that Teddy could be suffering from a primary genetically-determined form of the disease, however, consideration should also be given to the presence of a diet-associated cardiomyopathy and myocarditis. Secondary to his myocardial dysfunction, Teddy has moderate dilation of his left ventricle, though his left atrial size is normal. The absence of left atrial dilation suggests that Teddy's radiographic infiltrate is less likely to be cardiogenic pulmonary edema, however, given the severity of his myocardial dysfunction, it potentially could be. Teddy's myocardial dysfunction puts him at high risk for the development of exercise intolerance and



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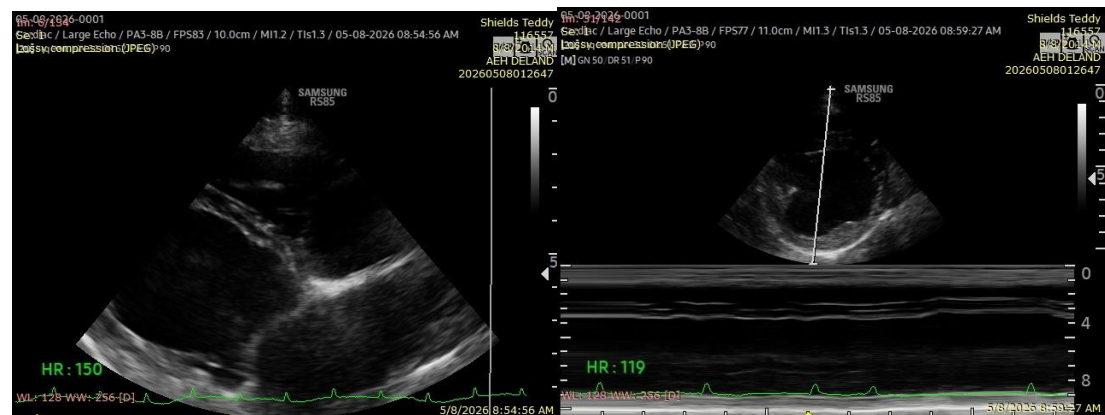
syncope, therefore, careful monitoring for these is recommended.

Teddy's ECG demonstrates the presence of intermittent VPCs. Single VPCs are typically well-tolerated in dogs, though careful monitoring for progression is recommended, as a more advanced arrhythmia could potentially result in sudden death.

A diet change would be warranted if Teddy is receiving one linked to the development of myocardial dysfunction (ex. one high in peas, lentils, and/or legumes). Taurine supplementation (1000 mg BID) would also be warranted if Teddy is receiving one of these diets.

Recommended therapy to help support Teddy's myocardial function includes pimobendan (5 mg TID), enalapril (10 mg BID), and spironolactone (25 mg BID). If Teddy experiencing cardiogenic shock, a dobutamine CRI can be considered, however, this could worsen his arrhythmia. Given the possibility of cardiogenic pulmonary edema being present, a trial with furosemide (50 mg BID-TID) appears to be warranted. Avoidance of strenuous activity is recommended.

Recheck radiographs and a renal/electrolyte profile are recommended in 48 hours. A recheck echocardiogram and ECG are recommended in 6 months.



The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. 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.

Keith Blass, DVM, MS, DACVIM (Cardiology)

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