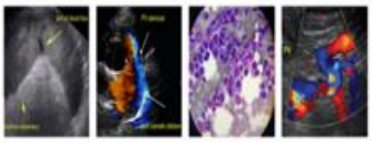
Mass Veterinary Services



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

PATIENT
Dobi Kislyuk

SPECIES
Canine

BREED
Coonhound Mix

SEX
Female Spayed

AGE
12 years

WEIGHT
72lbs

INTERPRETED BY
Maggie Machen Lamy, DVM DACVIM (Cardiology)

IMAGING PERFORMED BY
Pamela Harrigan, RDCS

HOSPITAL NAME
Mass Veterinary Services

REFERRING VET
Dr. Masloski

INVOICE
31559

DATE
6/27/23

PRESENTING CLINICAL SIGNS

History: Recheck echo. History chronic valvular disease - Stage B2. Presently, Dobi is doing well at home with a good appetite and normal activity level. He is being fed a homemade diet. On exam: NSR, grade III/VI murmur with PMI left apical area, PSS, lung fields clear, mm pink, moist, CRT<2. BP: *No sedation for study -Pertinent previous echo findings (9/21/22 MML): LA 4.5 cm; LA:Ao 1.8, LV 5.3 cm; moderate LAE, moderate MR, trace TR, borderline increased LV, FS 40%

ELECTROCARDIOGRAPHIC FINDINGS

A six lead ECG is available at 25mm/s; 10mm/mV. The average ventricular rate is 40bpm with 2nd degree AV block noted throughout the extended tracing. The sinus/P wave rate is variable from 75-125bpm. The block is low grade (2:1), with a brief period of 3:1 noted. The block is type II without PR prolongation. Period of extended ventricular bigeminy; single VPCs only. 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.
ECG diagnosis: Low grade type II 2nd degree AV block; brief 3:1 conduction noted. Ventricular bigeminy; intermittent.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available.
Left ventricle: The LV diameter is borderline increased with adequate function. LV wall thicknesses are normal.
Left atrium: The left atrium is moderately dilated.
Mitral valve: The mitral valve is diffusely thickened with no prolapse into the left atrial lumen. Moderate eccentric mitral regurgitation with a normal velocity.
Aortic valve/Aorta: The aortic valve is normal in morphology and mobility. Mildly elevated aortic outflow velocity; laminar flow. Trace/mild 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 mildly thickened with trivial tricuspid regurgitation.
Pulmonic valve/Pulmonary artery: The pulmonic valve is normal in morphology and mobility. Trace pulmonic insufficiency. Normal RVOT velocity; laminar flow.
Pericardium/other: No pericardial or pleural effusion noted. No obvious cardiac masses.

2-Dimensional Measurements

Ao diam (cm)	2.6
LA diam (cm)	4.33
LA:Ao (Swe)	1.7
IVS thickness (cm)	1.1
LVID diastole (cm)	5.3
PW thickness (cm)	0.9
LVID systole (cm)	2.8
FS (%)	47

Doppler Measurements

PV Vmax (m/s)	1.6
AoV Vmax (m/s)	2.8
MR Vmax (m/s)	NM
TR Vmax (m/s)	NM
TR PG (mmHg)	NM

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INTERPRETATION OF THE FINDINGS

Chronic degenerative valve disease persists with evidence of stability. Moderate mitral and trivial tricuspid regurgitation are unchanged, with stable 4 chamber dimensions. Moderate left atrial enlargement indicates there is relatively low risk for imminent complication; however, risk for progression to spontaneous congestive heart failure in the future remains elevated. A small aortic insufficiency has developed, and routine BP monitoring is advised. No additional structural issues are identified.

Of great concern, a complex arrhythmia has developed not apparent on prior evaluation. First there is 2nd degree AV block present, with slow ventricular conduction (HR 40bpm). The PR interval suggests type II block, which is most consistent with a conduction disorder. In addition there are frequent VPCs present, with extended periods of bigeminy. VPCs are actually of less clinical concern in this case, although monitoring for signs of VT is recommended (acute collapse or lethargy). There is some hesitation in performing an atropine challenge in this case due to frequent VPCs. Given the unusual nature of the arrhythmia, consider referral to a local Cardiologist in this case for advanced arrhythmia evaluation. If declined, consider a holter monitor as the next step for further evaluation. If both options are declined, simple monitoring for signs of brady or tachycardia are recommended such as syncope and reassess at that time.

Given LA dilation, continued Pimobendan is recommended as below. Assessment of progression in the future will help predict long term outcome, however prognosis is guarded at this stage (B2).

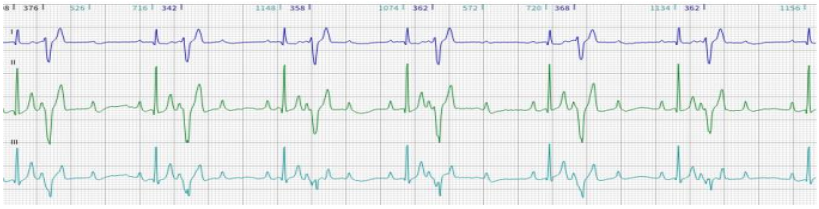
RECOMMENDATIONS

- Consider heart muscle support Pimobendan 0.3mg/kg PO q12h.
- Consider referral for arrhythmia evaluation v a holter monitor.
- BP every 6 months.
- Omega fatty acid supplementation and mild salt restriction may be of some long-term benefit.
- Anesthesia is NOT advised in this case.
- Monitor for development of a cough, labored breathing, exercise intolerance or collapse episodes.

PLAN

- Recommend conservative monitoring with a recheck echocardiogram and ECG in 6 months, sooner if any development of clinical signs.

IMAGES



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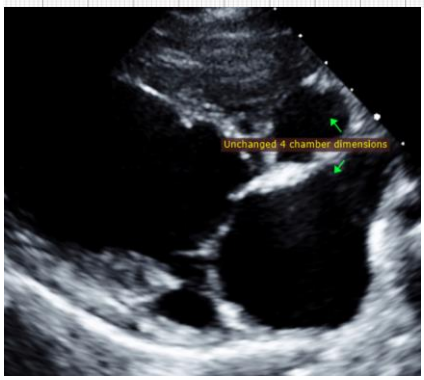

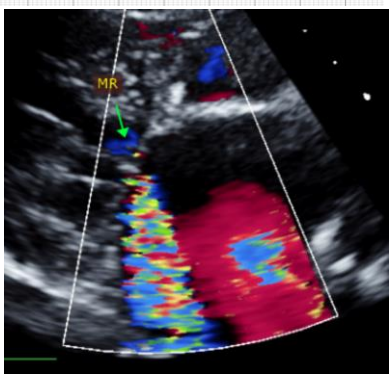

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Maggie Machen Lamy, DVM
Diplomate of the American College of Veterinary Internal Medicine (Cardiology)
info@sonopath.com

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