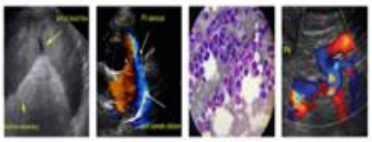
Mass Veterinary Services



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

PATIENT
Molly Styckiewicz

SPECIES
Canine

BREED
German SH Pointer

SEX
Female Spayed

AGE
14 years

WEIGHT
49.2lbs

INTERPRETED BY
Maggie Machen Lamy, DVM DACVIM (Cardiology)

IMAGING PERFORMED BY
Pamela Harrigan, RDCS

HOSPITAL NAME
Mass Veterinary Services

REFERRING VET
Dr. Masloski

INVOICE
24644

DATE
6/8/22

PRESENTING CLINICAL SIGNS

History: Recheck echo. History chronic valvular disease - Stage B1. Currently, increased coughing. Her respirations at home have remained normal. Continued good appetite. On exam today; NSR, grade IV/VI murmur with PMI left apical area radiating to right, PSS, lung fields clear. BP: 210-220mmHg. No medications. *Sedated with propofol for study.
-Pertinent previous echo findings (6/1/21 Maggie Machen Lamy, DVM, DACVIM-Cardiology): LA 3.1 cm; LA:Ao 1.1; LV 4.3 cm; mild LAE; mild-moderate MR; mild TR (2.1 m/s).

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available.
Left ventricle: The LV diameter with borderline with low normal myocardial 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 anterior-directed mitral regurgitation with a 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: 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 moderate tricuspid regurgitation; normal velocity.
Pulmonic valve/pulmonary artery: The pulmonic valve is normal in morphology and mobility. No pulmonic insufficiency. Normal RVOT velocity; laminar flow.
Pericardium/other: No pericardial or pleural effusion noted. No obvious cardiac masses.
Heart rhythm: ECG reveals a sinus rhythm with an average HR of 140bpm.

2-Dimensional Measurements

Ao diam (cm)	2.3
LA diam (cm)	3.7
LA:Ao (Swe)	1.6
IVS thickness (cm)	0.86
LVID diastole (cm)	4.6
PW thickness (cm)	0.85
LVID systole (cm)	3.2
FS (%)	39

Doppler Measurements

PV Vmax (m/s)	0.53
AoV Vmax (m/s)	1.0
MR Vmax (m/s)	4.8
TR Vmax (m/s)	2.0
TR PG (mmHg)	16

INTERPRETATION OF THE FINDINGS

Chronic degenerative valve disease causing moderate mitral and tricuspid regurgitation persists with evidence of mild progression. Previously mild LA dilation is now moderate, with a slightly increased LV diameter as well. Quantitatively, both the MR and TR are increased as well. This is concerning for progressive issues going forward, and Pimobendan is warranted at this juncture. No additional issues such as pulmonary hypertension is noted.

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Prognosis is guarded at this stage (B2), with risk for spontaneous CHF, development of arrhythmias, LA tear and/or sudden death going forward.

The reported blood pressure is elevated and should be reassessed for accuracy particularly given no reported clinical signs of severe hypertension (retinal changes, etc.) or evidence of LVH on echo. Ideally obtain serial measurements in a controlled, low stress environment and continue until 3 consecutive readings plateau within 5mmHg of variability. If persistently >180mmHg despite a relatively calm demeanor, recommend institution of amlodipine to effect. Additionally, if deemed accurate, screening for predisposing underlying causes of SHT is recommended (Cushings, PLN, adrenal tumor, etc.), as primary disease is relatively uncommon and a rule out diagnosis.

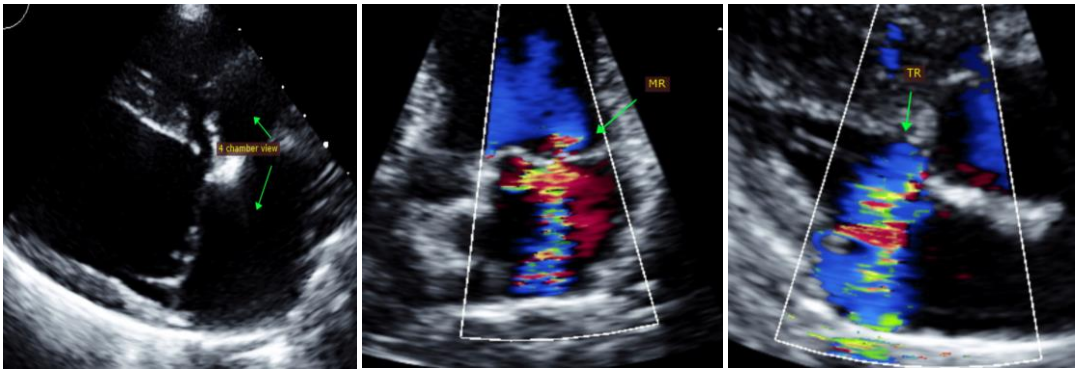
RECOMMENDATIONS

- Institute Pimobendan 0.2-0.3mg/kg PO q12h.
- Reassess BP as discussed.
- Omega fatty acid supplementation and mild salt restriction may be of some long-term benefit.
- Once on Pimobendan for 3-5 days, anesthetic risk is considered mildly elevated. 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.
- Monitor for development of a cough, labored breathing, exercise intolerance or collapse episodes. Monitoring of sleeping breathing rates is recommended to screen for CHF at home.

PLAN

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

IMAGES



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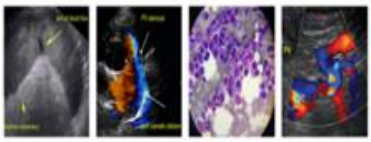

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)