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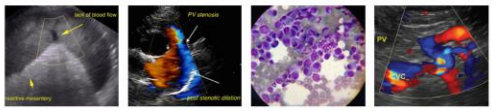

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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PATIENT
Louise Hiltz

SPECIES
Canine

BREED
Shih Tzu

SEX
Female Spayed

AGE
13 years

WEIGHT
19lbs

INTERPRETED BY
Maggie Machen Lamy, DVM DACVIM (Cardiology)

IMAGING PERFORMED BY
Pamela Harrigan, RDCS

HOSPITAL NAME
Mashpee Veterinary Hospital

REFERRING VET
Dr. Oldham

INVOICE
25530

DATE
7/25/22

PRESENTING CLINICAL SIGNS

History: Recheck echo. History chronic valvular disease - Stage B2. Currently doing well at home. BP: 110mmHg.
-Pertinent previous echo findings (11/26/21 Scott Forney, DVM, DACVIM-Cardiology): LA 2.36 cm; LA:Ao 2.02; LV 3.41 cm; moderate LAE/LVE; severe MR; mild TR (2.93 m/s). On Pimobendan 2.5 mg q12h. Excessive panting throughout study.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available.
Left ventricle: The LV diameter is increased with hyperdynamic function. LV wall thicknesses are normal.
Left atrium: The left atrium is severely dilated.
Mitral valve: The mitral valve is diffusely thickened with prolapse into the left atrial lumen. Severe eccentric mitral regurgitation with a normal velocity.
Aortic valve/Aorta: The aortic valve appears thickened with borderline increased 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 mild tricuspid regurgitation. Velocity consistent with early pulmonary hypertension.
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 80bpm.

2-Dimensional Measurements

Ao diam (cm)	1.2
LA diam (cm)	3.0
LA:Ao (Swe)	2.4
IVS thickness (cm)	0.64
LVID diastole (cm)	3.4
PW thickness (cm)	0.70
LVID systole (cm)	1.0
FS (%)	70

Doppler Measurements

PV Vmax (m/s)	0.6
AoV Vmax (m/s)	1.7
MR Vmax (m/s)	6.0
TR Vmax (m/s)	2.7
TR PG (mmHg)	30

INTERPRETATION OF THE FINDINGS

Chronic degenerative valve disease persists with evidence of mild progression. Severe mitral regurgitation is unchanged; however, the LA dimension is progressively dilated. The LV is stable and pulmonary pressures are similar to previous. No additional issues are documented.

Given these findings, Pimobendan should certainly be continued going forward. Additionally, given high risk for decompensation and evidence of progression Spironolactone may be of some long-term benefit. An ACE-I should not be utilized due to hypotension. Assessment of progression in the future will help predict long term outcome, however prognosis is guarded at this stage (late B2). Unfortunately, the patient will always be at risk for recurrent CHF, development of arrhythmias/LA tear, syncope and/or sudden death in the future.

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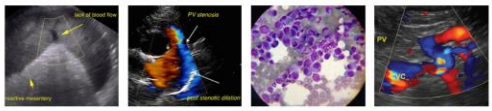

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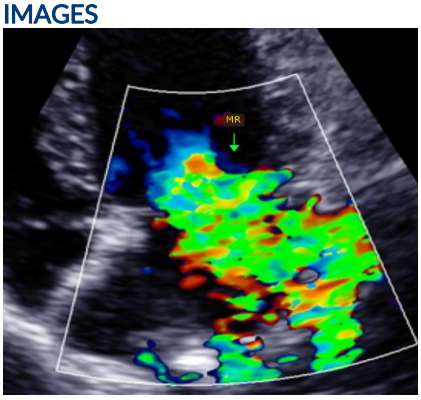
RECOMMENDATIONS

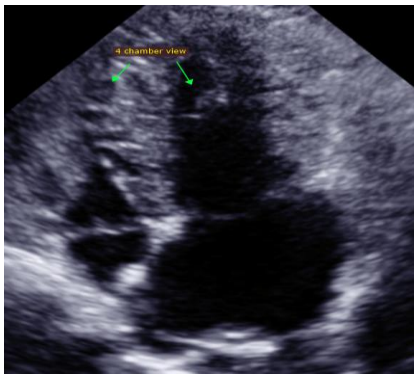
- Continue Pimobendan 0.3mg/kg PO q12h.
- Institute spironolactone 1-2mg/kg PO q12h.
- Close monitoring for development of associated clinical signs (development of a cough, labored breathing, exercise intolerance or worsening collapse episodes) is recommended. Monitoring of sleeping breathing rates is recommended as the best way to screen for CHF at home.
- Omega fatty acid supplementation and mild salt restriction may be of some long-term benefit. Mild activity restriction is advised.
- Elective anesthesia is not advised, as there is high risk for complication. If necessary, cardiac protective drug choices (opioid/benzodiazepine premedication, propofol or alfaxalone induction, iso or sevoflurane gas) are recommended. Pre-oxygenate for 5-10 minutes prior to induction and recover in O2 cage. Monitor for arrhythmias, hypotension, and hypoxia both intra and post-operatively and intervene as necessary. Moderate IV fluid restriction is recommended to avoid fluid overload. Avoid heart rate stimulating drugs such as atropine unless clinically indicated.

PLAN

- A renal panel is recommended in 1-2 weeks, then every 3-4 months lifelong.
- Recommend conservative monitoring with a recheck echocardiogram in 6 months, sooner if any development of clinical signs.

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)
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