



PATIENT

Wesley Larabee

SPECIES

Canine

BREED

Toy Poodle

SEX

Male Neutered

AGE

12 years

WEIGHT

18.8lbs

INTERPRETED BY

Maggie Machen
Lamy, DVM
DACVIM (Cardiology)

IMAGING PERFORMED BY

Pamela Harrigan,
RDCS

HOSPITAL NAME

Mass Veterinary Services

REFERRING VET

Dr. Masloski

INVOICE

32056

DATE

8/1/23

PRESENTING CLINICAL SIGNS

History: Wesley was noted to have a heart murmur in July when he was seen for coughing. Chest films revealed cardiomegaly with a diffuse broncho-interstitial pattern. Wesley was started on Pimobendan, Enalapril, Hycodan, Doxycycline and Lasix. Coughing less. Wesley's activity level remains normal, and he is eating well. He did have a few episodes of vomiting in the past 2 weeks but that has self-resolved. On exam: NSR, grade III/VI murmur with PMI left apical area, PSS, lung fields clear, mm pink, moist, CRT<2. BP: 170 mmHg x 5. Current medications: 1) Pimobendan/vetmedin 2.5mg 1 tab twice a day 2) Lasix/furosemide 12.5mg 1/2 tab twice a day 3) Enalapril 5mg 1 tab twice a day 4) Hydrocodone with homatropine/hycodan 1.5mg/ml 2mls twice a day 5) Doxycycline 100mg 1/2 tab twice a day *Sedated lightly with propofol.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available.
Left ventricle: The LV diameter is slightly decreased with adequate myocardial function. LV wall thicknesses are moderate to severely increased. A small perimembranous VSD is visualized which complete aneurysmal closure.
Left atrium: The left atrium is minimally enlarged.
Mitral valve: The mitral valve is thickened with mild prolapse into the left atrial lumen. Mild eccentric mitral regurgitation. Normal velocity.
Aortic valve/aorta: The aortic valve is normal in morphology and mobility. Normal aortic outflow velocity; laminar flow. Trace aortic insufficiency.
Right ventricle: No significant RV dilation. Mild to moderate RV hypertrophy.
Right atrium: Normal RA dimension.
Tricuspid valve: The tricuspid valve appears normal with trace tricuspid regurgitation.
Pulmonic valve/pulmonary artery: The pulmonic valve is normal in morphology and mobility. No pulmonic insufficiency. The RVOT velocity is mildly elevated with a dynamic obstruction observed on color flow and 2D imaging.
Pericardium/other: No pericardial or pleural effusion noted. No obvious cardiac masses.
Heart rhythm: ECG reveals a sinus rhythm with an average HR of 180bpm.

2-Dimensional Measurements

Ao diam (cm)	1.6
LA diam (cm)	2.2
LA:Ao (Swe)	1.38
IVS thickness (cm)	1.0
LVID diastole (cm)	1.9
PW thickness (cm)	1.1
LVID systole (cm)	0.6
FS (%)	67

Doppler Measurements

PV Vmax (m/s)	1.7
AoV Vmax (m/s)	1.5
MR Vmax (m/s)	4.5
TR Vmax (m/s)	NM
TR PG (mmHg)	NM

INTERPRETATION OF THE FINDINGS

Chronic degenerative valve disease causing mild mitral and trace tricuspid regurgitation is identified. Lack of significant left or right atrial enlargement indicates the current risk for complication is low. As an incidental finding, a small VSD is identified with complete closure. This is a congenital issue of no hemodynamic significance. More importantly, significant biventricular hypertrophy is identified without dilation.



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Systemic hypertension is mentioned in the history with a BP of 170mmHg. While this level of elevation is unlikely to be the cause of significant LV hypertrophy, this certainly may not be helping. Vasodilator therapy using Amlodipine is recommended as below. Other primary causes of ventricular hypertrophy must also be considered, including volume depletion (pseudohypertrophy) or a primary infiltrative or myocardial issue (such as HCM). Lab work is recommended. Regardless, both atria are normal, indicating low risk for complication.

These findings would suggest CHF is unlikely to have been the cause for recent coughing. Lasix and Pimobendan can be safely discontinued. Reasonable to continue Enalapril pending further BP/renal value assessment; however, from a cardiac standpoint this is also unnecessary.

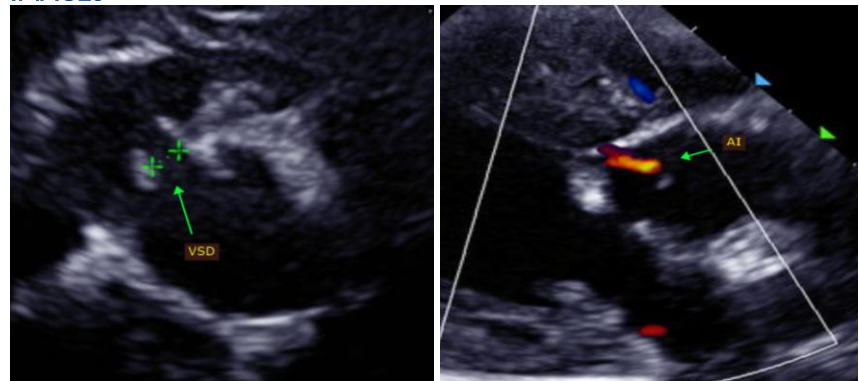
RECOMMENDATIONS

- Consider addition of Amlodipine to affect, as dictated by IM.
- Baseline lab work is recommended if not recently performed.
- Discontinue Lasix and Pimobendan as discussed.
- Reasonable to continue ACE-I pending further IM evaluation.
- Omega fatty acid supplementation and mild salt restriction may be of some long-term benefit.
- Anesthetic risk is considered mild if needed. 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.

PLAN

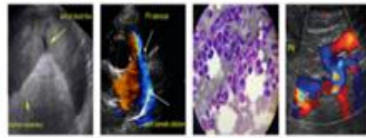
- Recommend conservative monitoring with a recheck echocardiogram in 6 months, sooner if any development of clinical signs.

IMAGES





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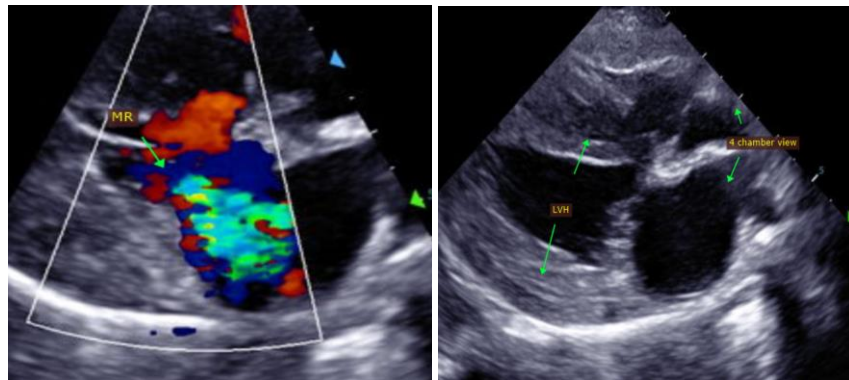
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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Echocardiogram performed by:

Pamela Harrigan, RDCS
Pet Animal Ultrasound Service (4paus.com)