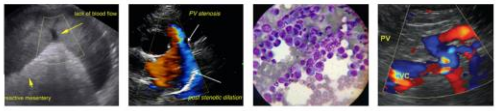
Mass Veterinary Specialty Services
1-413-734-1292



SonoPath
Clinical Sonography & Telecytology
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PATIENT

Fozzy Teel

SPECIES

Canine

BREED

Australian Shepherd

SEX

Male Neutered

AGE

13 years

WEIGHT

54lbs

INTERPRETED BY

Maggie Machen Lamy, DVM DACVIM (Cardiology)

IMAGING PERFORMED BY

Pamela Harrigan, RDCS

HOSPITAL NAME

Mass Veterinary Specialty Services

REFERRING VET

Dr. Masloski

INVOICE

20448

DATE

8/10/21

PRESENTING CLINICAL SIGNS

History: Recheck echo. History chronic valvular disease, advanced. Currently, Fozzy has been relatively lethargic at home. He has been coughing daily with the cough occurring primarily in the evening. Some hyporexia has been noted with his appetite getting a bit picking but no weight loss noted. He has become a bit PU/PD with some accidents noted in the house. He does have some occasional bouts of labored breathing at home. CV/RESP: NSR, grade III/VI murmur with PMI left apical area and mild radiation to right, PSS, lung fields clear, cough with tracheal pressure. BP: 200-210mmHg.

-Current medications: 1) Liver support 2) Pimobendan 15mg 1/2 tab twice a day 3) Enalapril 10mg 2 tabs twice a day 4) Spironolactone 25mg 2 tabs twice a day 5) Amlodipine 2.5mg 1 tab twice a day 6) Trazodone 50mg for vet visits.

-Pertinent previous echo findings (1/12/21 MML): LA 3.9 cm; LA:Ao 1.7; LV 3.9 cm; severe MR; trace TR; moderate LAE; mild LVE.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available.

Left ventricle: LV is mildly dilated with hyperdynamic myocardial function. Increased sphericity.

Left atrium: The left atrium is moderately dilated.

Mitral valve: Significant thickening of mitral valve leaflets with mild prolapse into the left atrial lumen. Severe eccentric mitral regurgitation, 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: RV dimension and morphology are normal.

Right atrium: Normal RA dilation.

Tricuspid valve: The tricuspid valve appears mildly thickened with trace tricuspid regurgitation. Velocity consistent with early pulmonary hypertension.

Pulmonic valve/Pulmonary artery: The pulmonic valve is normal in morphology and mobility. Normal pulmonic outflow velocities. No pulmonic insufficiency.

Pericardium/other: No pericardial or pleural effusion noted. No obvious cardiac masses.

Heart rhythm: ECG reveals a sinus rhythm with an average HR of 110bpm.

2-Dimensional Measurements

Ao diam (cm)	2.3
LA diam (cm)	4.0
LA:Ao (Swe)	1.7
IVS thickness (cm)	1.2
LVID diastole (cm)	3.6
PW thickness (cm)	1.1
LVID systole (cm)	2.2
FS (%)	39

Doppler Measurements

PV Vmax (m/s)	0.7
AoV Vmax (m/s)	1.3
MR Vmax (m/s)	4.9
TR Vmax (m/s)	2.8
TR PG (mmHg)	32

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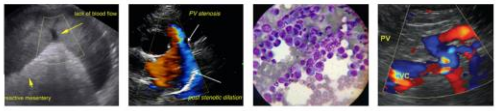

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INTERPRETATION OF THE FINDINGS

Chronic degenerative valve disease persists with relative stability. Severe mitral is unchanged with stable left heart dimensions. Mild pulmonary hypertension is noted which is likely secondary to chronic LA pressure elevation and a reported cough. No additional issues are seen here.

These findings would suggest non-cardiac cause for the current clinical issues. The cough has been noted on previous visits as well and remains multi-factorial in origin.

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.

Long term prognosis remains guarded; however, comparative stability is encouraging. Patient will always be at risk for progression to CHF, development of arrhythmias/LA tear, syncope and/or sudden death in the future.

RECOMMENDATIONS

- Consider cardiac supportive medications as previously prescribed.
- Consider Hydrocodone.
- Reassess BP as discussed.
- Elective anesthesia is not advised.
- Omega fatty acid supplementation and mild salt restriction may be of some long-term benefit.
- Monitor for development of a cough, labored breathing, exercise intolerance or collapse episodes. Monitoring of sleeping breathing rates is the best way to screen for progression to CHF at home.
-

PLAN

- A renal panel and BP are recommended every 3-4 months lifelong.
- A recheck echocardiogram is recommended in 6 months to screen for progression, sooner if clinical signs arise.

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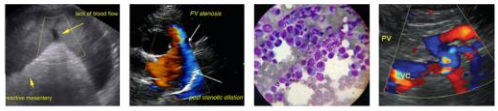

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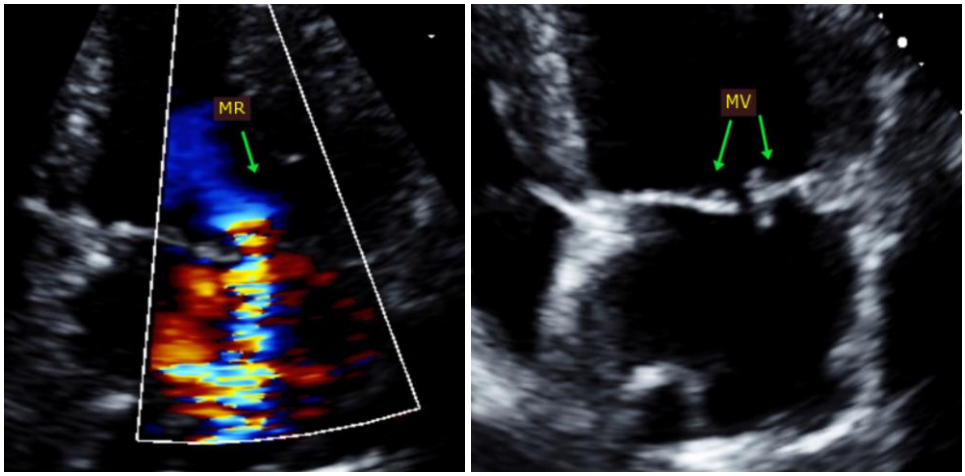
IMAGES



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)
info@sonopath.com

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