

**PATIENT**  
**Tiberius Mensinger**

**SPECIES**  
Canine

**BREED**  
Beagle

**SEX**  
Male Neutered

**AGE**  
13 years

**WEIGHT**  
38.3lbs

**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**  
20456

**DATE**  
8/10/21

**PRESENTING CLINICAL SIGNS**

History: Recheck echo. History chronic valvular disease, severe. Current presentation: Tiberius had a collapse episode in mid-July when he was out for a walk. Occasional cough - no dyspnea. Eating well. CV/RESP: NSR, grade IV/VI murmur with PMI left apical area radiating to right, PSS, lung fields clear. BP: 130-140mmHg.

-Current medications: 1) Pimobendan 5mg 1 tab three times a day 2) Enalapril 10mg 1 tab twice a day 3) Spironolactone 25mg 1 tab twice a day 4) Dasaquin chews daily 5) Perio support EFA daily 6) Ursodiol/actigal 250mg 1/2 tab with food daily 7) Lasix/furosemide 20mg 2 tabs three times a day.

-Pertinent previous echo findings 1/12/21 (MML): LA 4.6 cm; LA:Ao 2.2; LV 4.7 cm; severe MR; mild TR (2.6 m/s); severe LAE; LVE.

**ECHOCARDIOGRAM FINDINGS**

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

**Left ventricle:** Significant LV dilation with hyperdynamic myocardial function.

**Left atrium:** The left atrium is markedly dilated. Region of dropout along the intra-atrial septum consistent with an acquired septal defect. Left to right flow is identified across the defect.

**Mitral valve:** Marked diffuse thickening of mitral valve leaflets with prolapse into the left atrial lumen. Severe eccentric mitral regurgitation with a decreased velocity.

**Aortic valve/Aorta:** The aortic valve is normal in morphology and mobility. Normal aortic outflow velocity; laminar flow. No aortic insufficiency.

**Right ventricle:** Moderate RV dilation.

**Right atrium:** Moderate right atrial dilation.

**Tricuspid valve:** The tricuspid valve appears thickened, with moderate tricuspid regurgitation. Velocity consistent with mild pulmonary hypertension.

**Pulmonic valve/Pulmonary artery:** The pulmonic valve is normal in morphology and mobility. The MPA appears mildly dilated. Normal pulmonic outflow velocities with laminar flow. No PI.

**Pericardium/other:** Scant pericardial effusion. No pleural effusion noted. Ascites seen on subcoastal views. No obvious cardiac masses.

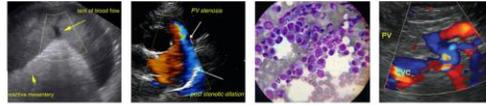
**Heart rhythm:** ECG reveals a sinus rhythm with an average HR of 140bpm.

**2-Dimensional Measurements**

Ao diam (cm)	1.9
LA diam (cm)	6.0
LA:Ao (Swe)	3.0
IVS thickness (cm)	0.82
LVID diastole (cm)	4.7
PW thickness (cm)	0.84
LVID systole (cm)	2.4
FS (%)	49

**Doppler Measurements**

PV Vmax (m/s)	0.9
AoV Vmax (m/s)	1.1
MR Vmax (m/s)	4.4
TR Vmax (m/s)	3.1
TR PG (mmHg)	38



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**INTERPRETATION OF THE FINDINGS**

Chronic degenerative valve disease persists with evidence of significant progression. The most significant finding is marked left atrial enlargement has led to a rupture along the septum consist with an acquired ASD. Fortunately, the rupture is within the cardiac chambers (rather than into the pericardial space) and has left to right flow. This is likely the cause of bicavitary effusion and likely occurred at the time of the prior syncopal episode. The degree of TR has worsened likely secondary to this as well. No additional issues are identified.

Given the development of pericardial and peritoneal effusions, this patient is certainly now in CHF and continued diuretic therapy is recommended. The patient is on a very high dose of Lasix despite having residual effusion which is somewhat concerning. That being said, there is no clinical concern at home at this time and I would not necessarily increase the dose based upon this. Should any progressive effusions be noted in the future, we may need to consider changing to a more potent diuretic such as Torsemide. For now, monitoring renal values is advised to ensure the current high dose is tolerated.

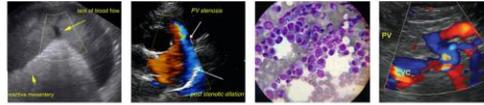
Prognosis is poor long-term as this is certainly a case of refractory disease. Patient will always be at risk for recurrent CHF, development of arrhythmias/LA tear, syncope and/or sudden death in the future.

**RECOMMENDATIONS**

- Continue Lasix, Pimobendan Spironolactone and Enalapril as prescribed.
- Should the patient become symptomatic for effusions (i.e., discomfort due to abdominal distention or any change in breathing), consider change to Torsemide 5mg PO q12h and discontinue Lasix.
- Cough suppression to improve QOL can also be considered (hydrocodone, 0.2-0.4mg/kg up to q4-6h PRN) for any residual mechanical cough in the face of normal sleeping respiratory rates.
- Monitor for development of a cough, labored breathing, exercise intolerance or collapse episodes.
- Monitoring of sleeping respiratory rates will be paramount to screen for congestive heart failure at home.
- Elective anesthesia is not advised.
- Omega fatty acid supplementation and mild salt restriction may be of some long-term benefit.

**PLAN**

- Monitor renal values and BP every 3-4 months lifelong.
- Recommend conservative monitoring with a recheck echocardiogram in 6 months, sooner if any development of clinical signs.



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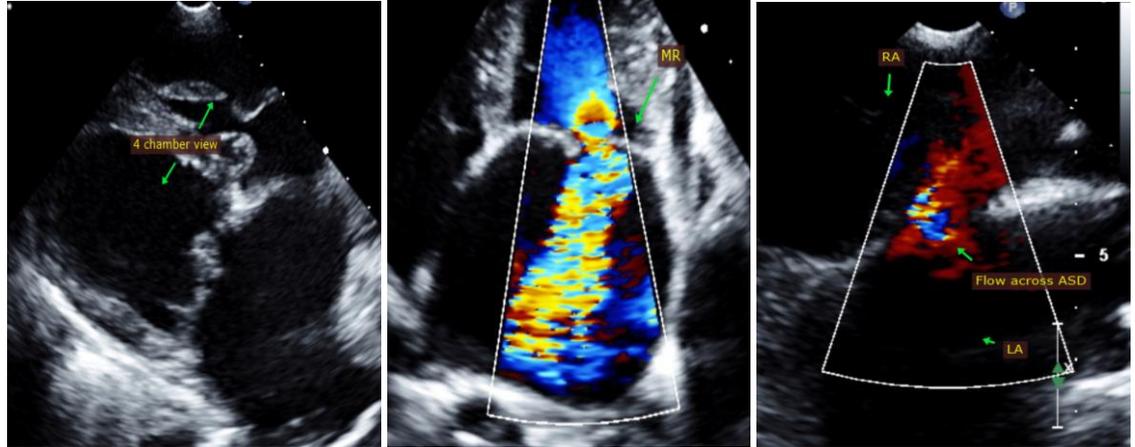
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**IMAGES**



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)