

PATIENT

Sheldon Carpino

SPECIES

Canine

BREED

Chihuahua Mix

SEX

Male Neutered

AGE

10 years

WEIGHT

14.75lbs

INTERPRETED BY

Maggie Machen Lamy, DVM DACVIM (Cardiology)

IMAGING PERFORMED BY

Pamela Harrigan, RDCS

HOSPITAL NAME

Mass Veterinary Services

REFERRING VET

Dr. Masloski

INVOICE

25699

DATE

8/10/22

PRESENTING CLINICAL SIGNS

History: Recheck echo. History chronic valvular disease - Stage B2. Currently, Sheldon has been coughing at home when the windows are open. Eating well with normal activity level. On exam: NSR, grade IV/VI murmur with PMI left apical area radiating to right, PSS, lung fields clear. BP: 140mmHg x 5. *No sedation for study. -Pertinent previous echo findings (9/2021 MML): Moderate MR, mild TR, moderate LAE. LA: 2.8, LV: 2.77, TR: 3.0.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available. **Left ventricle:** The LV diameter is dilated 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 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:** Mild RV enlargement. **Right atrium:** Mild RA enlargement. **Tricuspid valve:** The tricuspid valve appears mildly thickened with septal prolapse and a mild double jet of tricuspid regurgitation. Velocity consistent with mild PAH. **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 200bpm.

2-Dimensional Measurements

Ao diam (cm)	1.3
LA diam (cm)	3.5
LA:Ao (Swe)	2.7
IVS thickness (cm)	0.6
LVID diastole (cm)	3.6
PW thickness (cm)	0.6
LVID systole (cm)	1.6
FS (%)	55

Doppler Measurements

PV Vmax (m/s)	1.0
AoV Vmax (m/s)	1.3
MR Vmax (m/s)	5.2
TR Vmax (m/s)	3.4
TR PG (mmHg)	46

INTERPRETATION OF THE FINDINGS

Chronic degenerative valve disease persists with evidence of progression. Compared to the prior study, there is progression in pulmonary hypertension as well as left heart dilation. The LA is significantly dilated indicating an elevated risk for clinical signs going forward. No additional concurrent issues are documented.

With this degree of left heart changes, the risk for spontaneous congestive heart failure is elevated and additional cardiac supportive medications are indicated as below. A weak diuretic (spironolactone) is included given high risk for decompensation in the future even with no reported symptoms. 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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A progressive cough is likely related to these findings with mainstem bronchi compression contributing. Consider baseline CXR, Hydrocodone, etc.

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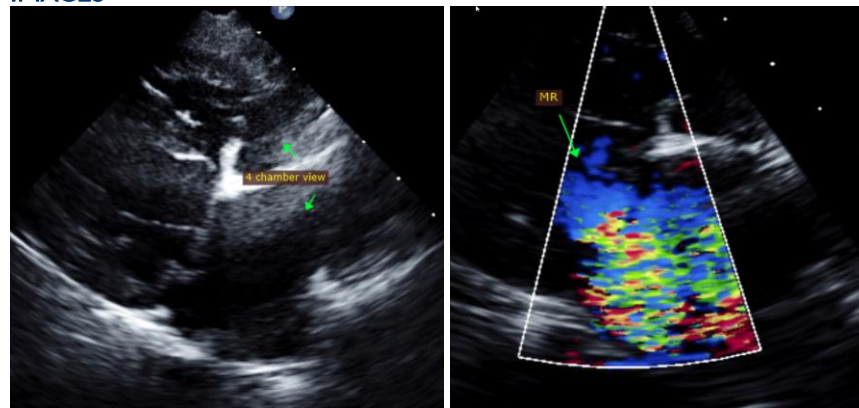
RECOMMENDATIONS

- Institute Pimobendan as prescribed.
- Institute ACE-I (benazepril or enalapril) 0.5mg/kg PO q12h.
- Institute Spironolactone 1-2mg/kg PO q12h.
- Consider CXR, Hydrocodone, etc. as discussed.
- 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



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RDCS

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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.

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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.

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Chihuahua Mix

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

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