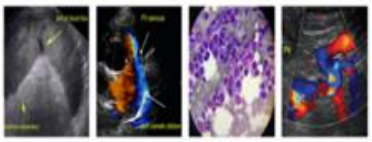
Mass Veterinary Services



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT
Lilah Metivier

SPECIES
Canine

BREED
Pitbull Mix

SEX
Female Spayed

AGE
1.8 years

WEIGHT
64.8lbs

INTERPRETED BY
Maggie Machen Lamy, DVM DACVIM (Cardiology)

IMAGING PERFORMED BY
Pamela Harrigan, RDCS

HOSPITAL NAME
Mass Veterinary Services

REFERRING VET
Dr. Masloski

INVOICE
25800

DATE
8/16/22

PRESENTING CLINICAL SIGNS

History: Recheck echo. History valvular pulmonary stenosis. Current presentation: Lilah is doing well. She does have a bilateral cruciate tear. Occasionally gets winded after rough play but breathes normally at rest. No collapse episodes. Good appetite and energy. On exam: NSR, IV/VI murmur with PMI at base radiating to right, PSS, lung fields clear. BP: 130 mmHg. Current medications: 1) Atenolol 25mg 1/4 tab twice a day 2) Fish oils 3) Apoquel 16mg daily 4) Fortiflora daily *Sedated with propofol for study.
-Pertinent previous echo findings (2/15/22 Maggie Machen Lamy, DVM, DAVIM-Cardiology): LA 2.4 cm; LA:Ao 1.3; LV 4.0 cm; thickening, tethering and doming of the PV; post-stenotic dilation of PA; mild RAE; mild RVH; PV Vmax 3.2 m/s.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available.
Left ventricle: The LV diameter is normal with mildly depressed myocardial function. LV wall thicknesses are normal.
Left atrium: The left atrium is normal.
Mitral valve: The mitral valve appears normal with no mitral regurgitation.
Aortic valve/Aorta: The aortic valve is normal in morphology and mobility. Normal aortic outflow velocity; laminar flow. No aortic insufficiency.
Right ventricle: The RV is prominent with mild hypertrophy. No septal flattening.
Right atrium: Mild RA enlargement.
Tricuspid valve: The tricuspid valve appears normal. No obvious stenosis. Trivial tricuspid regurgitation.
Pulmonic valve/Pulmonary artery: Pulmonic outflow velocities are elevated at the level of the valve. The max velocity is consistent with a moderate stenosis. The pulmonic valve appears thickened and highly abnormal with a tethered appearance. Mild pulmonic insufficiency. Moderate post-stenotic dilation of the MPA and branches.
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)	2.1
LA diam (cm)	2.6
LA:Ao (Swe)	1.2
IVS thickness (cm)	1.0
LVID diastole (cm)	4.1
PW thickness (cm)	1.0
LVID systole (cm)	2.8
FS (%)	32

Doppler Measurements

PV Vmax (m/s)	3.6
AoV Vmax (m/s)	1.5
MR Vmax (m/s)	NA
TR Vmax (m/s)	NA
TR PG (mmHg)	NA

INTERPRETATION OF THE FINDINGS

Valvular pulmonic stenosis persists with evidence of stability. The stenosis itself is similar with a mild increase in velocity. This is suspected reflect overall stability as the prior study was likely an underestimation. The right heart is slightly increased comparatively, although overall mildly enlarged. No obvious additional issues are identified.

Given these findings, reasonable to continue Atenolol going forward. The heart rate appears within the target range, although sedation must also be considered. Referral remains recommended; however, if declined annual monitoring is advised.

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Monitor for development of associated clinical signs (collapse, abdominal distention, cough, labored breathing). Mild exercise restriction is advised. Omega fatty acid supplementation may have some long-term benefit, given these cases are predisposed to development of arrhythmias going forward.

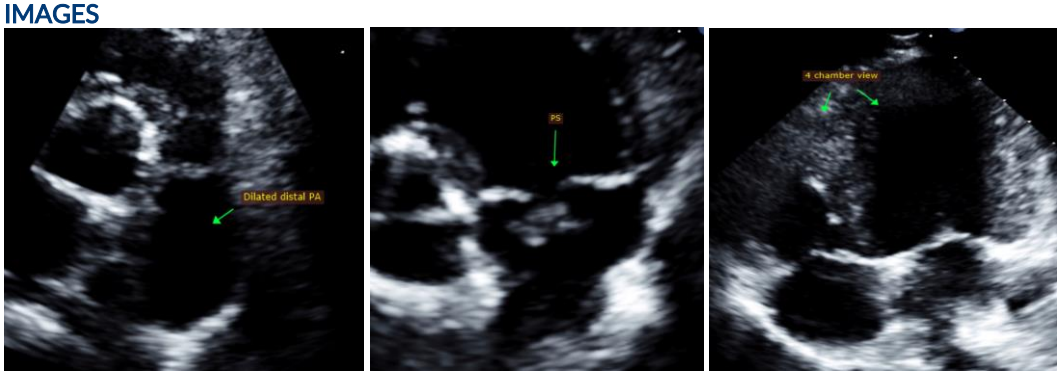
RECOMMENDATIONS

- If referral is declined, continue Atenolol lifelong with a target of <130bpm in hospital.
- Omega fatty acid supplementation and mild salt restriction may be of some long-term benefit.
- Anesthetic risk is mild to moderate at this time. Avoid heart rate stimulating drugs such as atropine or glycopyrrolate unless absolutely necessary. Avoid vasodilators such as acepromazine. Mild IV fluid restriction is advised. Cardiac protective drug choices (opioid/benzodiazepine premedication, propofol or alfaxalone induction, isoflurane gas) are recommended. Pre-oxygenate for 5-10 minutes prior to induction and recover in O2 if possible.
- Monitor for arrhythmias, hypotension, and hypoxia both intra and post-operatively and intervene as necessary.
- Mild activity restriction is advised.

PLAN

- If referral is declined, recommend conservative monitoring with a recheck echocardiogram annually, 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)
info@sonopath.com

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