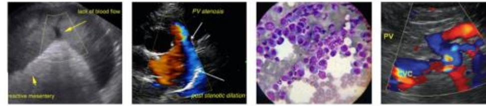
Mass Veterinary Specialty Services
1-413-734-1292



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

PATIENT
Minnie Romero

SPECIES
Canine

BREED
Pug

SEX
Female Spayed

AGE
14 years

WEIGHT
18.2lbs

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
21134

DATE
9/21/21

PRESENTING CLINICAL SIGNS

History: Recheck echo. History chronic valvular disease. Current presentation: Minnie has been a bit more lethargic and sleeping more. Coughing a fair amount throughout the day. She continues to eat well with normal activity. CV/RESP: NSR, grade I-II/VI murmur with PMI left apical area, PSS, lung fields clear, coughs easily with tracheal pressure. BP: 110mmHg x 4.
-Current medications: 1) DES 0.1mg once a week 2) Hydrocodone with homatropine/hycodan---not taking *No sedation.
-Pertinent previous echo findings (11/2020 MML): LA 1.3 cm; LA:Ao 1.4; LC 2.34 cm; normal LA size; mild MR; moderate TR (3.0 m/s) - early pHTN.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available.
Left ventricle: The LV diameter is normal with adequate myocardial function. LV wall thicknesses are normal.
Left atrium: The left atrium is normal.
Mitral valve: The mitral valve is diffusely thickened with no prolapse into the left atrial lumen. Mild eccentric 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: Normal right ventricular diameter and morphology indicating no overt evidence of pulmonary arterial hypertension.
Right atrium: Normal RA dimension.
Tricuspid valve: The tricuspid valve appears mildly thickened with moderate tricuspid regurgitation; Velocity consistent with early pulmonary hypertension.
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 110bpm.

2-Dimensional Measurements

Measurement	Value
Ao diam (cm)	1.6
LA diam (cm)	1.8
LA:Ao (Swe)	1.1
IVS thickness (cm)	0.75
LVID diastole (cm)	2.3
PW thickness (cm)	0.74
LVID systole (cm)	1.5
FS (%)	34

Doppler Measurements

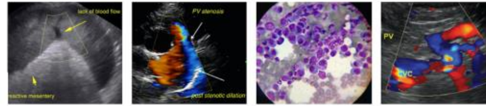
Measurement	Value
PV Vmax (m/s)	0.6
AoV Vmax (m/s)	0.91
MR Vmax (m/s)	NM
TR Vmax (m/s)	2.9
TR PG (mmHg)	34

INTERPRETATION OF THE FINDINGS

Chronic degenerative valve disease persists with evidence of stability. Mild mitral and moderate tricuspid regurgitation are unchanged without significant chamber enlargement. Pulmonary hypertension persists mild and unchanged. No additional issues are identified.

The cough remains noncardiac in origin. Hydrocodone should be reinstituted if the cough is impacting quality of life and to help decreased progression of PAH. No cardiac medications are indicated at this time.

Prognosis remains open at this stage.



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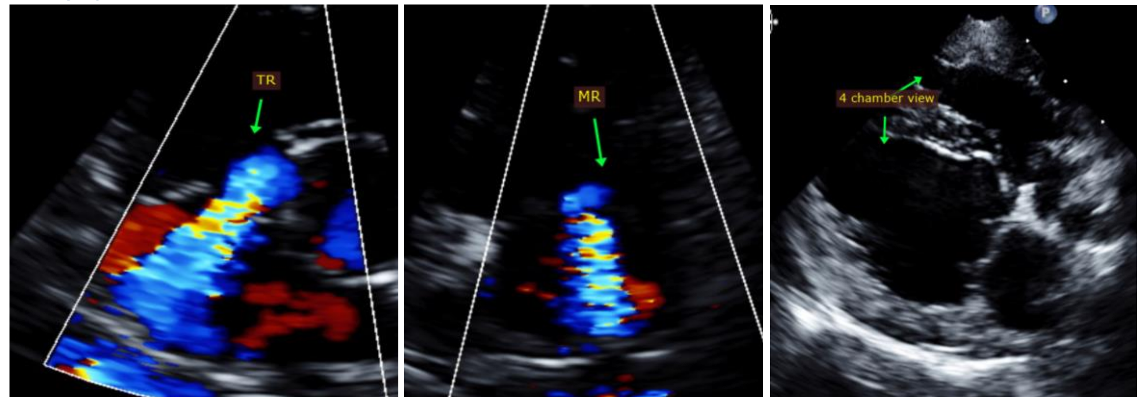
RECOMMENDATIONS

- No cardiac medications are clearly indicated.
- Consider further respiratory evaluation/treatment as discussed.
- Monitor for signs progressive PAH (exertional dyspnea/collapse).
- 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 1 year, sooner if clinical signs arise.

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)