

PATIENT

Lunara Macmillan

SPECIES

Canine

BREED

Rottweiler

SEX

Intact female

AGE

5 years

WEIGHT

106 lbs

INTERPRETED BY

Bradley Harris, DVM,
DACVECC, DACVIM
(cardiology)

IMAGING PERFORMED BY

Dr. Karen Ebersole,
DVM, DABVP

HOSPITAL NAME

Scanvet

REFERRING VET

Dr. Strickland

INVOICE

69772

DATE

1/1/26

PRESENTING CLINICAL SIGNS

History: New HM found last year. Unchanged this year. Planning anesthesia for a dental. No clinical signs.

Grade 2/6 systolic heart murmur. CBC/chem/TT4/UA/4Dx/fecal -- NSF

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

The left atrium is normal in dimension. The left ventricle is normal in dimension with marginal systolic function. The right atrium and ventricle are normal in dimension, and systolic function. The anterior and posterior mitral valve leaflets presented mild thickening with mild regurgitation, but no evidence of prolapse. The left ventricular outflow tract demonstrated normal turbulent flow with moderate aortic insufficiency, and a suspected sub valvular ridge. The visible aorta is unremarkable. Pulmonary outflow tract assessment revealed a laminar flow, with normal main pulmonary artery dimension, and distensibility. No pulmonic insufficiency is documented. There is no visible pericardial, pleural, or free peritoneal fluid noted. The cardiac chambers, pericardial and visible extra-cardiac regions were free of masses, spontaneous echo contrast, or thrombi.

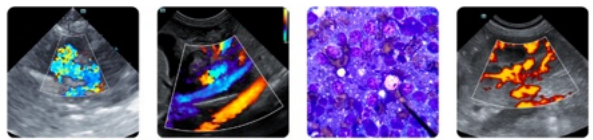
CANINE CARDIAC PARAMETERS	Body Weight kg	HR BPM	LAD 4 ch Long	RAD 4 ch Long	La/Ao Heart Base	LVIDd	LVIDs
NORMAL PARAMETER		50-100			<1.6		
PATIENT	48.18	120	4.95	3.08	1.13	5.33	3.92
CANINE CARDIAC PARAMETERS	FS	EPSS	PV V MAX (m/s)	AV V Max (m/sec)	MR Vmax	TR Vmax	RPA distensibility (normal >30%)
NORMAL PARAMETER	28-40	<0.6	0.7-1.6	0.7-1.7	4.5-5.5	< 2.7	
PATIENT	26	NM	1.3	4.6	5.9	Not present	29

ECG

There is a six-lead ECG with minimal baseline artifact is available for review. The underlying rhythm is regular at an average rate of 130bpm. The rhythm appears to be sinus in origin (PQ 80ms) with narrow QRS complexes (<70ms). There is no atrial or ventricular ectopy and no conduction delay or block identified. This is most consistent with a normal sinus rhythm.

ULTRASONOGRAPHIC FINDINGS

These findings are consistent with sub valvular aortic stenosis with concurrent mitral valve dysplasia (SAS and MVD). Given the severity of the SAS, and lack of any left atrial dilation, the SAS will be considered the more significant abnormality.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Cardiac therapy with atenolol (initial dose 1-2 mg/kg BID, starting with q24 for the first week to ensure tolerance) is recommended. Generally, interventional therapy (cutting balloon valvuloplasty) has not been terribly successful in improving long term outcomes. Otherwise, a repeat echo is recommended in another 6-12 months. As with all procedures or wounds, antibiotics should be used pre- and post-operatively given the risks of aortic endocarditis.

Anesthesia:

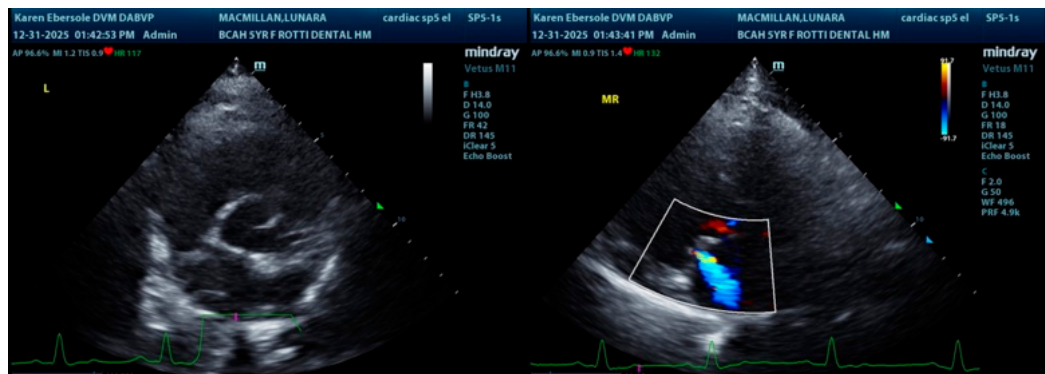
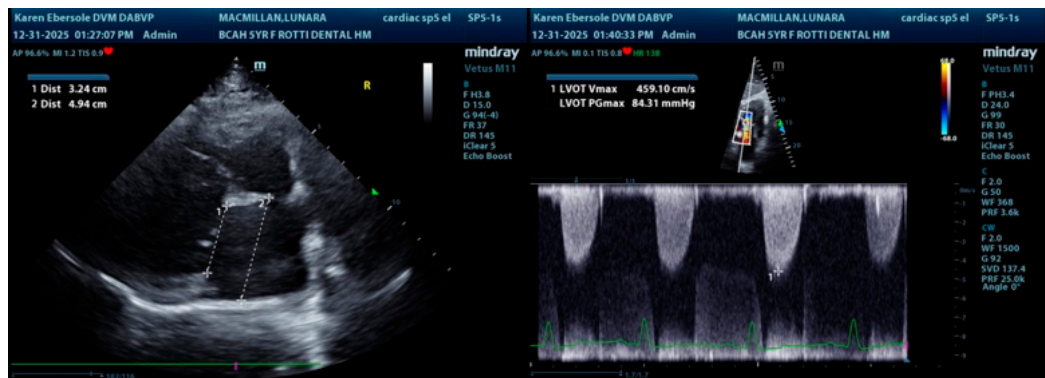
If anesthesia is necessary, then alpha-2 agonists, ketamine, high dose acepromazine, and Telazol should be avoided. Fluid therapy during anesthesia should be considered at a reduced rate (e.g., 5 ml/kg/hour) if possible. A shorter anesthetic duration will reduce the risk of complications. Pre-oxygenation is advised. Pre-medication with an opioid (i.e., butorphanol, hydromorphone, oxymorphone) with or without a benzodiazepine is generally the safest protocol. An induction agent such as Propofol, alfaxalone, or diazepam/etomidate can be used to effect. Maintenance of anesthesia with isoflurane or sevoflurane is reasonable.

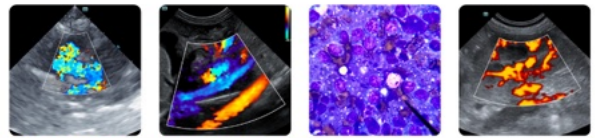
Diet:

A high-quality food from Hills, Royal Canin, Science Diet, Eukanuba, Iams, or Purina that is highly palatable with adequate protein and calories for maintaining optimal body condition is reasonable.

Activity:

Avoid overly strenuous activity.





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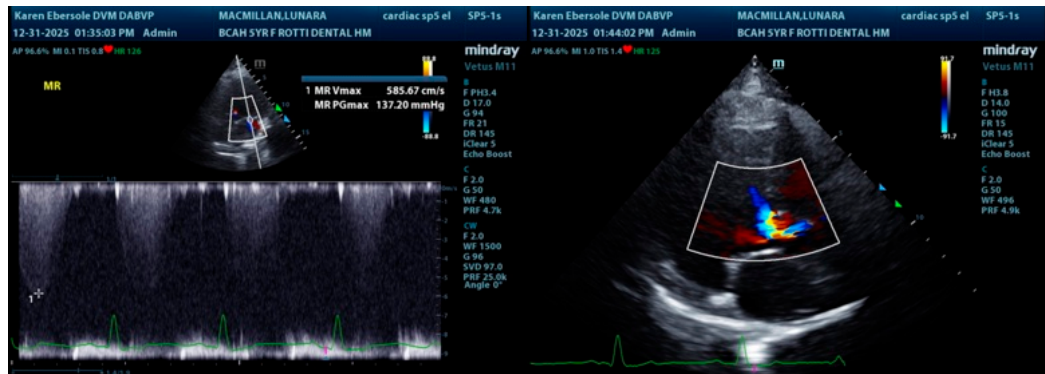
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com