



PATIENT

Georgia Cretney

SPECIES

Canine

BREED

Bull Terrier

SEX

Intact female

AGE

7 ½ years

WEIGHT

21.6 kg

INTERPRETED BY

Bradley Harris, DVM,
DACVECC, DACVIM
(cardiology)

IMAGING PERFORMED BY

Dr. Mariusz
Chmielinski

HOSPITAL NAME

Apex VS

REFERRING VET

Alpine 24/7 ER Doctor

INVOICE

70194

DATE

1/15/26

PRESENTING CLINICAL SIGNS

History: o History of recurrent syncope/collapse episodes o Episodes are brief (seconds) with rapid recovery, followed by post-episode fatigue o First episode occurred after April 2025 and before December 27, 2025; additional episode possibly in January o Known Grade II/VI systolic heart murmur o Previously diagnosed with moderate-severe subaortic (aortic) stenosis on echocardiogram (06/07/2025) o On Atenolol 25 mg PO BID
Abnormal PE/Chem/CBC/UA Results: Vital Signs: Temperature: 38.2 °C, Heart Rate: 108 bpm, Pulse: 1:1, Respiratory Rate: Panting, Respiratory Effort: Normal, Mucous Membranes / CRT: Pink, moist / <2 sec, Mentation: BAR, Hydration: Adequate Blood Pressure (Doppler): • 124/75 (MAP 83) mmHg • 126/84 (MAP 92) mmHg • 143/74 (MAP 96) mmHg Physical Examination o Grade II/VI systolic murmur auscultated o Normal heart rate and rhythm at rest

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

The left atrium is normal in dimension. The left ventricle is normal in dimension, With mild hypertrophy and normal systolic function. The right atrium and ventricle are normal in dimension, with normal systolic function. The mitral valve is thickened and redundant consistent with myxomatous changes, and there is no significant prolapse. There is evidence of trivial mitral regurgitation. The tricuspid valve leaflets are subjectively normal with no tricuspid regurgitation and no evidence of pulmonary hypertension. The left ventricular outflow tract demonstrated turbulent, high velocity flow with a thickened aortic valve and suspected fibrous sub valvular ridge. The visible aorta is unremarkable. The right ventricular outflow tract assessment revealed normal laminar flow, and appropriate diameter and distensibility. There is no pulmonic and mild aortic valve insufficiency identified. There is no visible pericardial, pleural, or free peritoneal fluid documented. No evidence of hepatic venous congestion is 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	30.41 kg	NM	4.37	3.06	1.71	3.82	2.75
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	28	0.2	2.0	5.6	6.7	NM	NM



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ULTRASONOGRAPHIC FINDINGS

These findings identify static subvalvular vs aortic stenosis. The increased gradient today is not considered progression of disease, given the patients age, but rather dynamic changes in contractility, as well as differences in imaging planes between studies. The mitral valve disease remains static with no evidence of chamber dilation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the presence of episodes, and persistent severe gradient, an increase in beta blockade is recommended. Atenolol 37.5mg BID is indicated at this time. A repeat blood pressure and heart rate is recommended 1-2 weeks after increasing therapy. Additionally, a 24-48 hour ambulatory ECG (Holter) should be considered to rule out a concurrent dysrhythmia that may be precipitating episodes. A repeat echocardiogram is recommended in 6 months.

Diet recommendations:

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.

Anesthesia considerations:

If anesthesia is elected, then alpha-2 agonists, ketamine, high dose acepromazine, and Telazol should be avoided. If an ACE inhibitor or Spironolactone or beta blocker such as Atenolol is being given, it should not be administered the morning of general anesthesia. Other cardiac medications should be administered per the normal dosing schedule. Fluid therapy during anesthesia should be considered at a conservative rate (e.g., 5 ml/kg/hour) if possible. A shorter anesthetic duration will reduce the risk for complications. Preoxygenation is advised. Premedications with an opioid with or without a benzodiazepine is generally the safest protocol. An induction agent such as Propofol or Alfaxalone can be used to effect of anesthesia, with Isoflurane or Sevoflurane gas.

Activity:

Moderate physical activity is encouraged, but periods of strenuous aerobic activity should be avoided, especially during periods of high heat and humidity. Dogs with heart disease tend to tolerate cool/cold temperatures much better than high temperatures. Avoid sudden increases in activity, as this may be difficult for the cardiovascular system to deal with.



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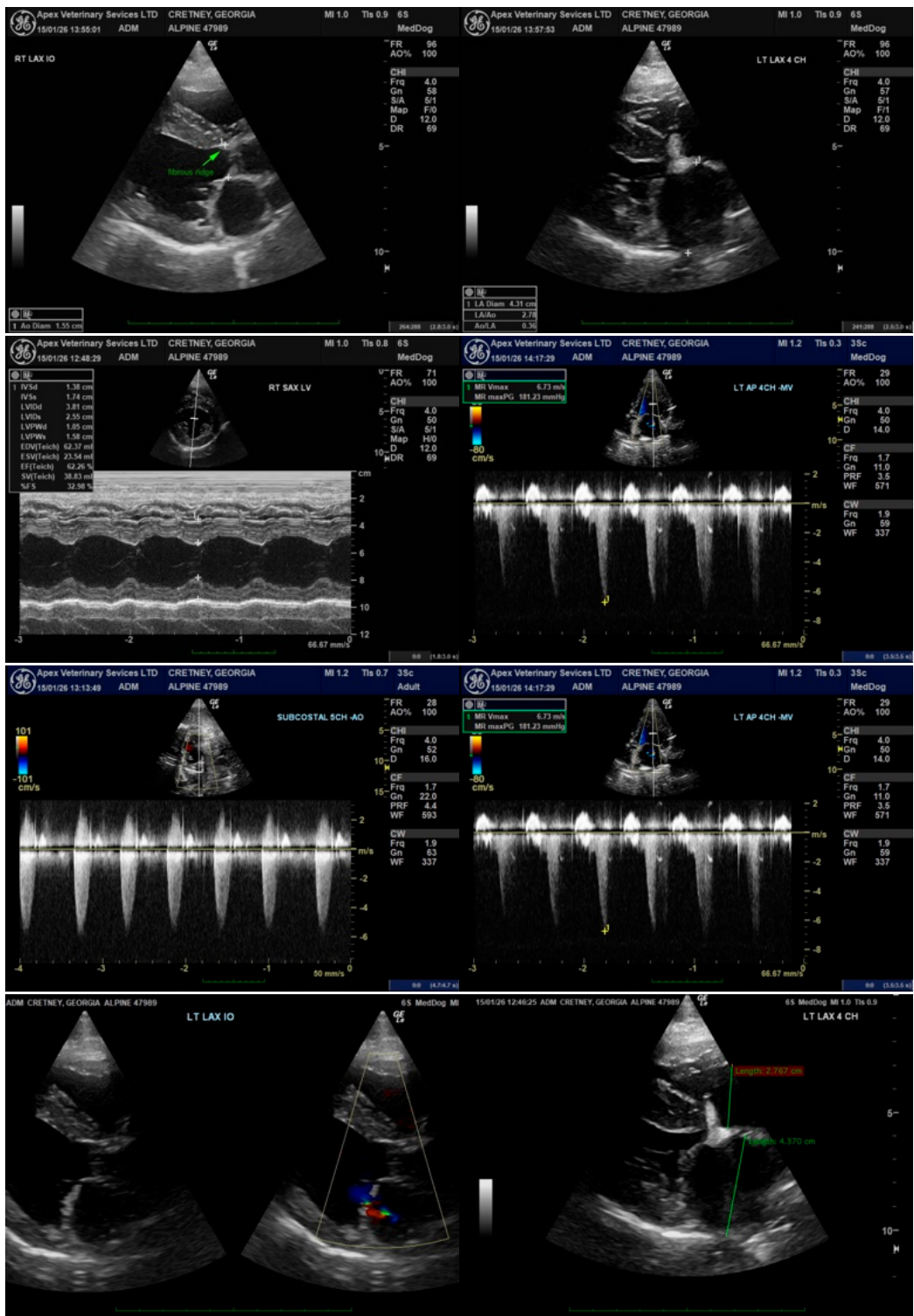
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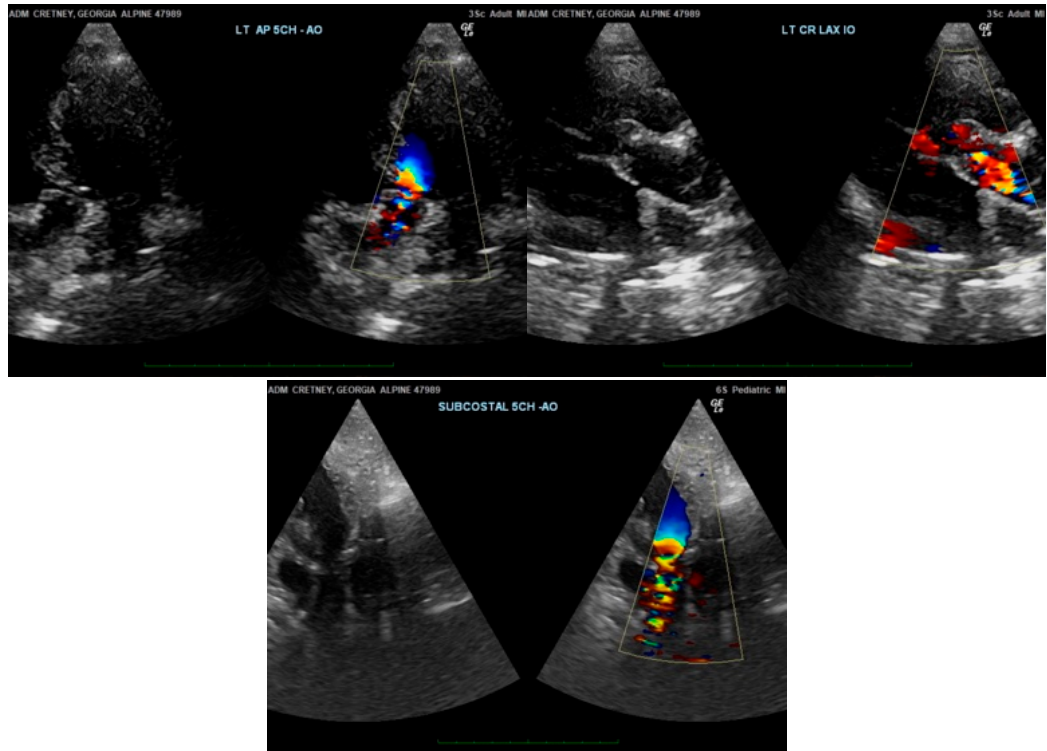
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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