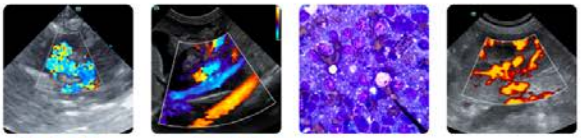

PATIENT

Teddy Seder

SPECIES

Canine

BREED

Pit Bull x

SEX

Neutered Male

AGE

12 Years 5 Months

WEIGHT

74.6 lbs

INTERPRETED BY

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

Shohola Veterinary Hospital

REFERRING VET

Dr. Wright

INVOICE

72997

DATE

1/6/26

PRESENTING CLINICAL SIGNS

Grade IV/VI L sided systolic murmur. Coughing, significantly elevated ProBNP. Current Medications: Vetmedin 7.5mg bid; Furosemide 80mg sid; Galliprant 60mg sid; Gabapentin 600mg bid.

Abnormal PE/Chem/CBC/UA Results: AST 70; ALT 158; Na 155; ProBNP 5,188. UA: 2+protein; 4-10 wbc/hpf; USG 1.029

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

CANINE CARDIAC PARAMETERS	BW	HR BPM	LAD 4 ch Long	RAD 4 ch Long	La/Ao Heart Base	LVIDd	LVIDs
NORMAL PARAMETER		50-100			<1.6		
PATIENT	33.91	160	3.32	4.98	1.34	2.86	1.94
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	32	0.3	0.7	1.2	NM	4.7	17

Cardiac Presentation

The left atrium is normal in dimension. The left ventricle is normal in dimension, with normal systolic function. The right atrium and ventricle are moderately enlarged, with marginal systolic function, and mild intraventricular septal flattening. 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 thickened and redundant with mild tricuspid regurgitation and evidence of severe pulmonary hypertension. The left ventricular outflow tract demonstrated normal laminar flow and the visible aorta is unremarkable. The right ventricular outflow tract assessment revealed normal laminar flow, and appropriate diameter and distensibility. There is mild pulmonic and no aortic valve insufficiency identified. There is no visible pericardial, pleural, or free peritoneal fluid documented. Mild hepatic venous congestion is noted. The cardiac chambers, pericardial and visible extra-cardiac regions were free of masses, spontaneous echo contrast, or thrombi.

ULTRASONOGRAPHIC FINDINGS

- These findings identify significant pulmonary hypertension in conjunction with degenerative mitral disease. The lack of chamber enlargement is consistent with ACVIM stage B1, making the PH more likely related to primary respiratory disease or other etiology (non-type 2 PH). Pulmonary hypertension in dogs is most commonly secondary to primary respiratory disease

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(chronic bronchitis, pulmonary fibrosis, or other forms of pulmonary interstitial disease). Pulmonary hypertension can also develop in dogs with severe heartworm disease or secondary to pulmonary thromboembolism (PTE). Less commonly, pulmonary hypertension is identified in dogs as an idiopathic condition. Pulmonary hypertension commonly causes syncope, and a patient's signs may be attributable to this condition.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the degree of right sided cardiac enlargement, cardiac therapy is reasonable at this time. Treatment for the PH/presumed respiratory disease is also warranted, as clinical signs are present. Therapy should include Vetmedin (0.25-0.35 mg/kg BID), sildenafil (2 mg/kg BID), and enalapril (0.5 mg/kg BID assuming normotension and lack of renal insult). In the absence of pulmonary infiltrate or cavitary effusions, the diuretics can be discontinued at this time. A cough suppressant could be considered for a clinically significant cough. Baseline thoracic radiographs, blood pressure and chemistry panel should be performed now, and again in 1-2 weeks. A repeat echocardiogram, thoracic radiographs, blood pressure, and chemistry panel is indicated in another 3-6 months, or sooner if progression is suspected, clinical signs develop/worsen, or additional cardiac therapy is being contemplated.

Anesthesia considerations:
While there is no CHF present, there is likely an increased anesthetic risk which must be considered prior to any anesthetic procedure. If anesthesia is necessary, then alpha-2 agonists, ketamine, high dose acepromazine, and Telazol should be avoided. If an ACE inhibitor (enalapril, benazepril) or spironolactone is being given, it should not be administered on 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 reduced rate (e.g., 5 ml/kg/hour) if possible. A shorter anesthetic duration will reduce the risk of complications. Pre-oxygenation is advised. Premedication 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 with mild dietary sodium restriction (<100 mg/100 kcal) is recommended. Consider omega-3 fatty acid supplementation. Ensure the patient is not currently receiving a boutique, exotic, or grain-free diet.

Activity:
Moderate physical activity (meandering walks, exploring the backyard, playing with toys inside, getting excited when family gets home, etc.) is encouraged, but periods of strenuous aerobic activity (jogging, strenuous outdoor ball play, prolonged play at the dog park, etc.) should be avoided, especially during periods of high heat (> 80 F) and humidity. Dogs with heart disease tend to tolerate cool and cold temperatures much better than high temperatures. Avoid sudden increases in activity (e.g. 2 block walks during the week but 2 mile walks followed by 30 minutes at the dog park on the weekends) as this may be difficult for the cardiovascular system to deal with.

New Jersey Mobile
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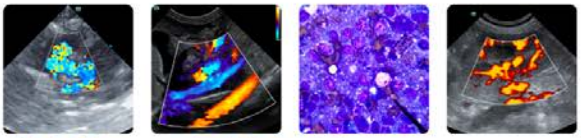

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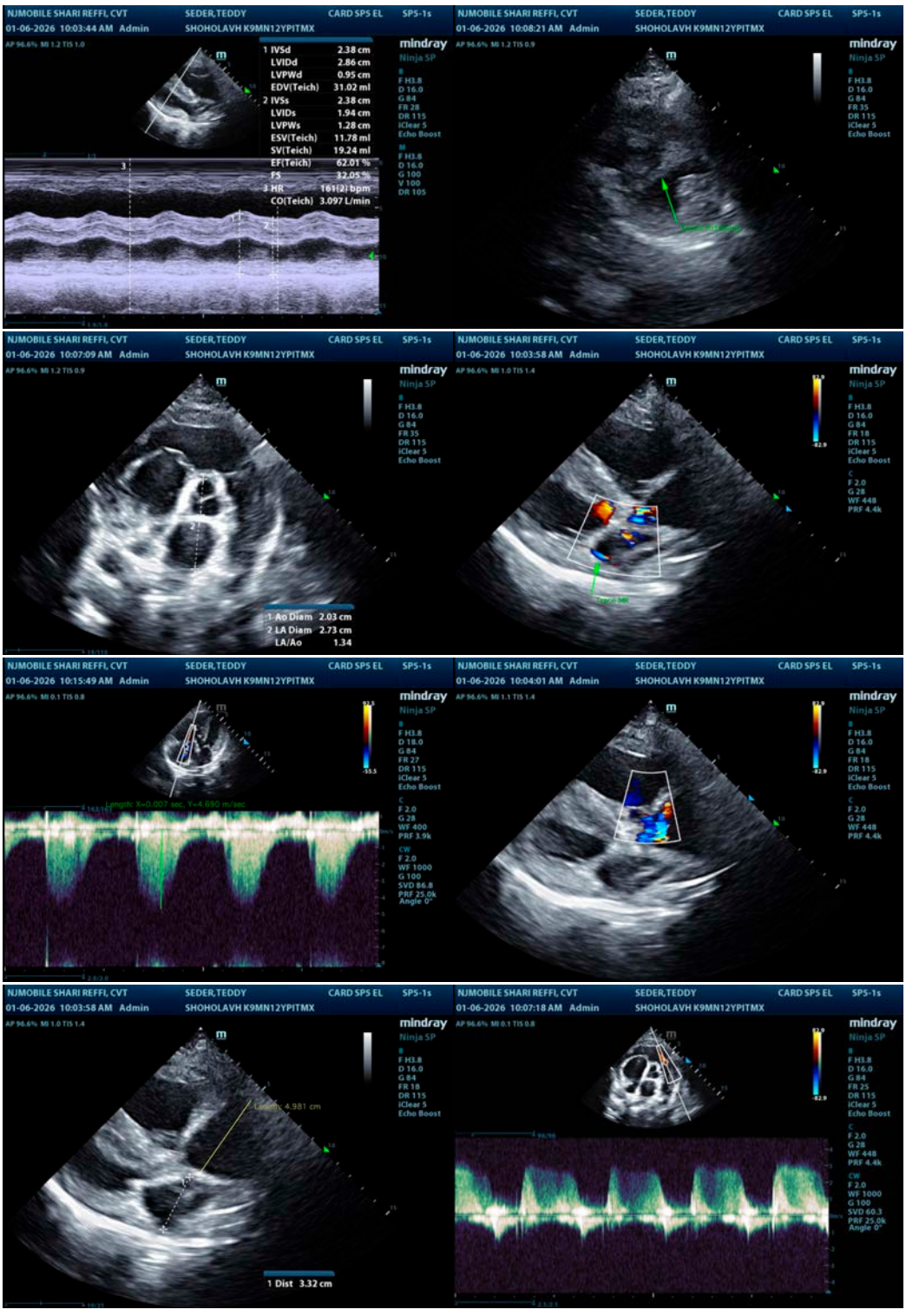

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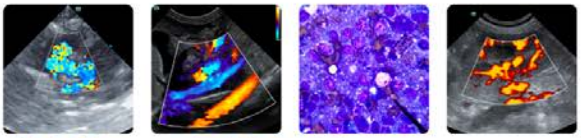

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com