



PATIENT

Rubble Pascucci

SPECIES

Canine

BREED

American Bulldog

SEX

Neutered Male

AGE

9 Years

WEIGHT

55 pounds

INTERPRETED BY

Bradley Harris, DVM,
DACVECC, DACVIM
(cardiology)

IMAGING PERFORMED BY

Karen Ebersole, DVM,
DABVP

HOSPITAL NAME

Scanvet

REFERRING VET

Dr. Van Binsbergen

INVOICE

12136

DATE

11/07/25

PRESENTING CLINICAL SIGNS

Presented for progressive cough, now with difficulty breathing. Rads showed pleural effusion and possible mediastinal mass (Attached). Referred to Specialty ER. Ddx DCM, hypertension and possible heart-based mass. Started medications. Cardiologist consult with echo strongly recommended, however the owner is unable to get cardiologist appt till December. Opted to do echo asap. Doing much better now on medications.

Current meds: Lasix 50 mg BID, Pimobendan 7.5 mg BID and Amlodipine 2.5 mg SID.

Abnormal PE/Chem/CBC/UA Results: 10/25 at ER: BP - systolic 220 mmHg. CBC/Chem - NSF K - 3.1 - rechecking today. FAST Scan - left ventricular enlargement with decreased contractile function (La:Ao 2.5-3:1) and mild B-lines, but no effusions.

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	25 kg	NM	3.48	3.38	--	4.33	2.45
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	43	NM	0.9	2.0	NM	NM	NM

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 subjectively normal in dimension and systolic function. The mitral valve is thickened and redundant consistent with myxomatous changes, and there is no significant

prolapse. There is evidence of mild mitral regurgitation. The tricuspid valve leaflets are subjectively normal with no significant tricuspid regurgitation and no evidence of 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 no overt semilunar valve insufficiency. There is no visible pericardial, and scant pleural fluid noted. There is a large heart-based mass at in the periaortic region that obscures visualization of the LA:AO at the heart base.



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ULTRASONOGRAPHIC FINDINGS

- These findings identify a large heart-based mass in the peri-aortic region most consistent with a chemodectoma. There appears to be compression of the main pulmonary artery and branch pulmonary artery, which is likely resulting in increased right ventricular pressure. This is considered the most likely etiology of the pleural effusion and suspected congestive heart failure. The presence of mild mitral regurgitation in the setting of a normal left side is consistent with degenerative/myxomatous mitral valve disease with minimal to mild hemodynamic effects (ACVIM Stage B1 disease).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Therapy for CHF is recommended, and should include Lasix (1-2 mg/kg BID), enalapril (0.5 mg/kg BID), Vetmedin (0.25-0.35 mg/kg BID), and spironolactone (1-2 mg/kg BID), in addition to the current amlodipine. The merits of a pericardiectomy should be considered for long term management, especially if pericardial effusion develops, as dogs with chemodectomas can do well for some time (as opposed to hemangiosarcoma). An abdominal ultrasound should be performed to make sure no concurrent intra-abdominal neoplasia is identified, especially if surgery is being contemplated. A repeat blood pressure, chemistry panel, and free fluid evaluation is recommended in 1-2 weeks to monitor for renal effects of the medication, and ensure no further effusion has developed. If the combination of amlodipine and enalapril results in systemic hypotension, then amlodipine should be discontinued at that time as well. If the systemic hypertension persists, increase in the amlodipine dose will be indicated. A repeat echo is indicated in 3-6 months.

Anesthesia considerations:

Anesthesia should be avoided if possible. If anesthesia is necessary, then alpha-2 agonists, ketamine, 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 (5 ml/kg/hour) if possible (i.e., if not hypotensive). A shorter anesthetic duration will reduce the risk of complications. Pre-oxygenation is mandatory. Premedication with an opioid (e.g., 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:

Ensure feeding a grain-inclusive diet if possible. 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. I would avoid any grain-free diets and ensure the patient is not currently receiving a grain-free diet.

Note that these recommendations are guidelines, and must be correlated with the history, physical examination findings, and diagnostic test results. The recommendations may need to be altered as the clinical status of the patient changes.

Activity:

Avoid strenuous activity.



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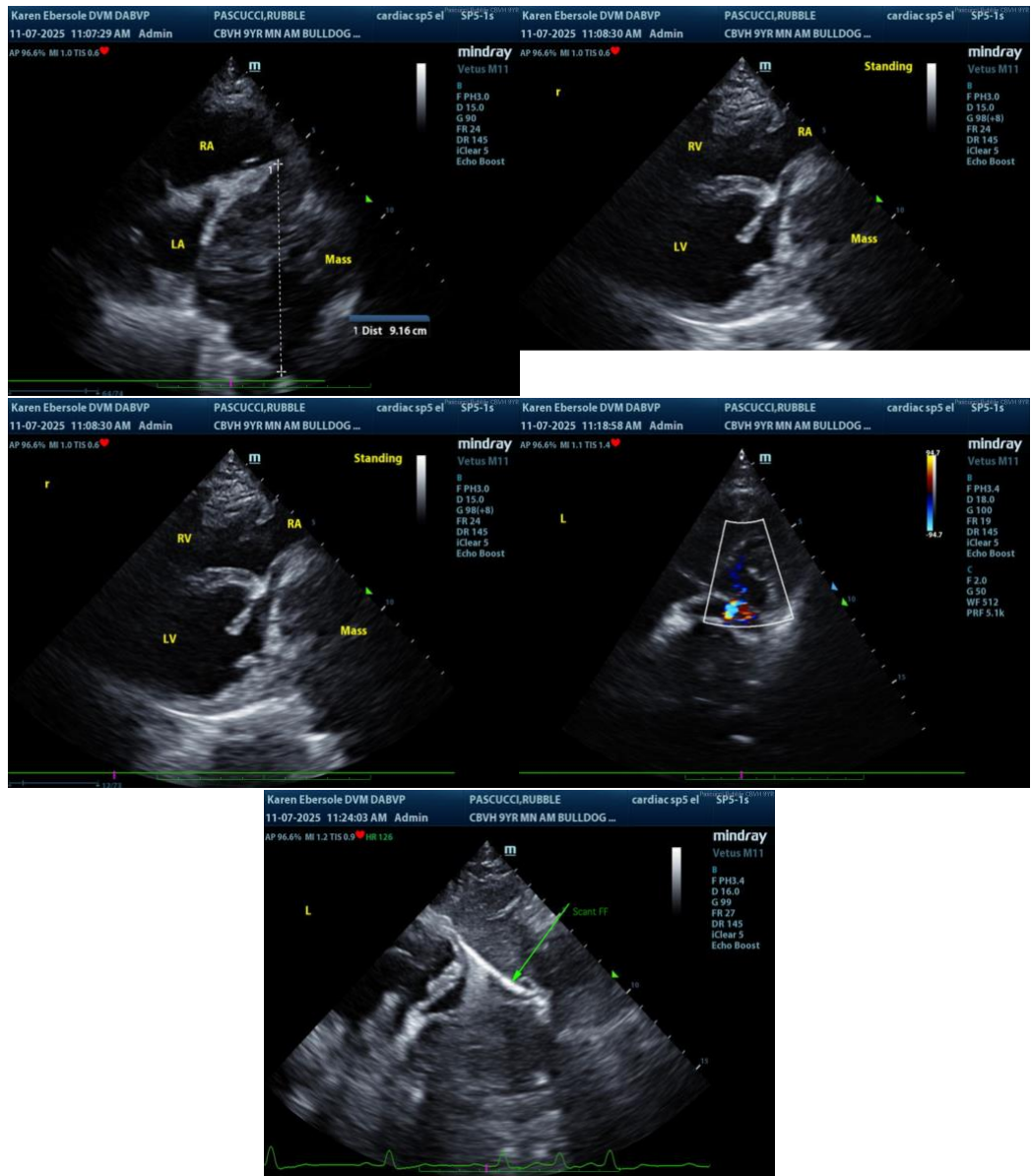
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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