PATIENT

Joey Scarlet

SPECIES

Canine

BREED

Golden Retriever

SEX

Neutered Male

AGE

4 Years

WEIGHT

25 kg

INTERPRETED BY

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Gagemount Animal Hospital

REFERRING VET

Dr. Irene

INVOICE

14236

DATE

03/11/26

PRESENTING CLINICAL SIGNS

- - Has not been seen here for 2 years but recently came from 2 clinics, comprehensive bloodwork done 4 days ago with severe azotemia,
- advanced kidney failure, non-regenerative anemia; no appetite, lethargic, as per O, less likely to be exposed to toxins, one vomit 12 days ago;
- tested negative for lepto and lyme; BP readings elevated (taken 4 days ago)
- 203/171 (182)
- 212/183 (193)
- 230/181 (197)
- PE: very emaciated, depressed, tachycardic, HR - 152/min for a large dog, Heart Murmur 5/6
- mm - pale, collapsed abdomen, empty on palpation, no signs of acute pain,
- Current Medications
- Given Cerenia 4 days ago, Enalapril

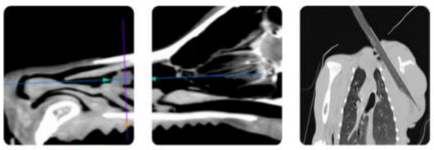
Abnormal PE/Chem/CBC/UA Results: labs attached from emerg clinic

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	100	3.76	2.13	1.04	2.97	1.79
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	40	0.4	2.0	6.5	5.8	NM	NM

Cardiac Presentation

The left atrium is normal in dimension. The left ventricle is normal in dimension as well as systolic function. There is mild to moderate remodeling and hypertrophy of the left ventricular wall. The right atrium and ventricle are subjectively normal in dimension, with normal systolic function. The mitral valve is thickened and irregular with mild to moderate mitral regurgitation. The tricuspid valve leaflets are also thickened with mild regurgitation. The left ventricular outflow tract demonstrated turbulent flow, a sub-valvular ridge, and mild to moderate aortic insufficiency. The visible aorta is unremarkable. Pulmonary outflow tract assessment revealed normal laminar flow and normal valve structure and integrity. There is no visible pericardial, pleural, or free peritoneal fluid noted. The cardiac chambers,



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pericardial and visible extra-cardiac regions were free of masses, spontaneous echo contrast, or thrombi.

ULTRASONOGRAPHIC FINDINGS

- These findings are consistent severe sub valvular stenosis, with moderate left ventricular hypertrophy, but no significant chamber enlargement. The presence of concurrent AV valve regurgitation is confounding due to this patient's age. This may represent early degenerative change, however, given the presence of another congenital abnormality, concurrent mitral and/or tricuspid valve dysplasia must also be considered. Regardless, there is no current evidence of hemodynamically significant disease at this time.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Cardiac therapy with atenolol (initial dose 1-2 mg/kg BID, higher doses may be needed especially as the patient grows) is typically recommended, however given the concurrent azotemia and renal disease, it may be prudent to hold on additional therapy until the azotemia is resolved. Given the severity of disease, the merits of a balloon valvuloplasty could be discussed with the owner, especially if there are clinical signs associated, although evidence for balloon valvuloplasty (cutting and/or high pressure) is equivocal in cases of subvalvular aortic stenosis. If an intervention is being considered, a re-evaluation by a cardiologist would be appropriate. Otherwise, a repeat echo is recommended in another 6-12 months. At this time, there is no overt contraindication to IV fluid therapy.

Anesthesia:
If anesthesia is necessary, then alpha-2 agonists, ketamine, high dose acepromazine, and Telazol should be avoided. Skip any ACE-inhibitor (if receiving) on morning of anesthesia. 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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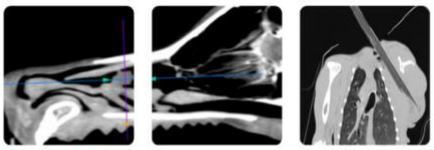

Teleradiology
Educational Teleconsultation Services™

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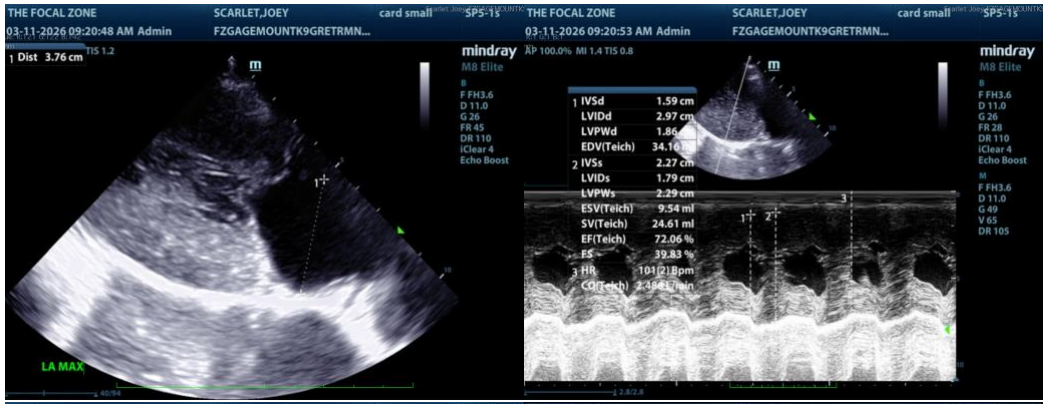

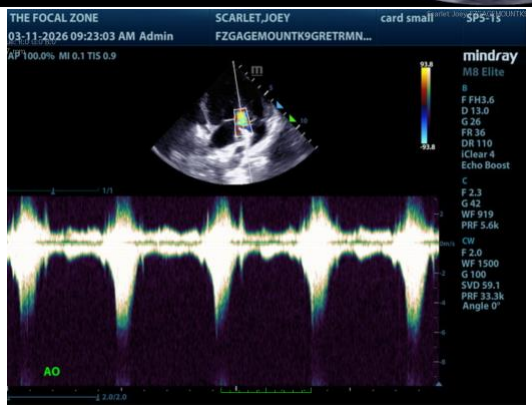

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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