

PATIENT

Charlie Patitucci

SPECIES

Canine

BREED

Viszla X

SEX

Spayed Female

AGE

6 Years

WEIGHT

23.2 kg

INTERPRETED BY

Bradley Harris, DVM,
 DACVECC, DACVIM
 (cardiology)

IMAGING

PERFORMED BY

Kelly Reschny

HOSPITAL NAME

BPH Ancaster

REFERRING VET

Dr. Davis

INVOICE

36529

DATE

4/10/26

PRESENTING CLINICAL SIGNS

History: Follow-up Echo and ECG for consistent Grade 3/6 heart murmur
 Current Medications: Fortekor 5mg SID, Vetmedin 5mg BID, Taurine 1000mg BID
 Abnormal PE/Chem/CBC/UA Results: Prev US report attached.

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

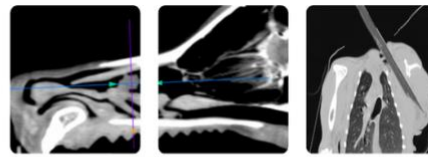
CANINE CARDIAC PARAMETERS	BW	HR BPM	LAD 4 ch Long	RAD 4 ch Long	La/Ao Heart Base	LVIDd	LVIDs
NORMAL PARAMETER		50-100			<1.6		
PATIENT	23.2	80	4.28	2.64	1.56	5.85	4.94
CANINE CARDIAC PARAMETERS	FS	EPSS	PV V MAX (m/s)	AV V Max (m/sec)	MR Vmax	TR Vmax	RPA distensibility (normal >30%)
NORMAL PARAMETER	28-40	<0.6	0.7-1.6	0.7-1.7	4.5-5.5	< 2.7	
PATIENT	16	0.3	0.9	1.3	4.9	NM	NM

ECG Interpretation

A six-lead ECG is available for review. The average heart rate is approximately 100bpm, with a normal mean electrical axis. The QRS complexes are sinus in origin (<70ms), with appropriate P-Q intervals. There are irregular R-R intervals, consistent with respiratory variation. There is no evidence of atrial or ventricular ectopy, nor any atrioventricular block. The underlying rhythm is most consistent with a respiratory sinus arrhythmia (normal physiologic change).

Cardiac Presentation

The left atrium is upper limits of normal to mildly enlarged. The left ventricle is severely enlarged with severely reduced systolic function. The right atrium and ventricle are normal in dimension with normal systolic function. The anterior and posterior mitral valve leaflets are appropriately thin but do not completely appose during systole due to annular dilation, and there is no significant prolapse. There is mild mitral regurgitation identified. The tricuspid valve leaflets are appropriately thin with adequate apposition and intact chordae, with mild 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, with appropriate main pulmonary artery diameter and right pulmonary artery distensibility. There is no



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pulmonic and no 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.

ULTRASONOGRAPHIC FINDINGS

- These findings identify significantly improved but still reduced left ventricular function in the setting of an enlarged left ventricle. A secondary nutritional cardiomyopathy is considered most likely, given the degree of improvement since the previous study.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations/Treatment:

At this time, continued therapy for the myocardial dysfunction can be recommended, to include Vetmedin (0.25-0.35 mg/kg BID) and enalapril (0.5 mg/kg BID, assuming normotension and lack of renal insult) and taurine (50 mg/kg BID). A follow-up echocardiogram, thoracic radiographs, blood pressure, and chemistry panel is recommended in 3 months to assess for either static, improved, or progressive changes. Owners should continue monitoring resting respiratory rate at home. Values above 30 breaths/minute or an increase in respiratory rate 10% above baseline should prompt veterinary re-evaluation.

The following sources for supplemental taurine are recommended:

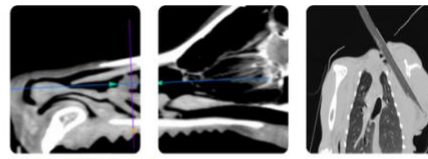
- Mega taurine caps by Twinlab (1000mg capsule)
- Taurine by Swanson Health Products (500mg capsule)
- Taurine by NOW foods (500mg capsule)
- Taurine 500 by GNC (500mg tablet)

Anesthesia considerations:

Anesthesia should be avoided if possible. 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 (i.e., if not hypotensive). 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. Dobutamine (2.5-10 µg/kg/min as a CRI, starting at 2.5 µg/kg/min and increasing the dosage incrementally) may be used in lieu of fluid boluses to augment systemic blood pressure.

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. Consider



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omega-3 fatty acid supplementation. Ensure the patient is not currently receiving a boutique, exotic, or grain-free diet.

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Activity:

Canine

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.

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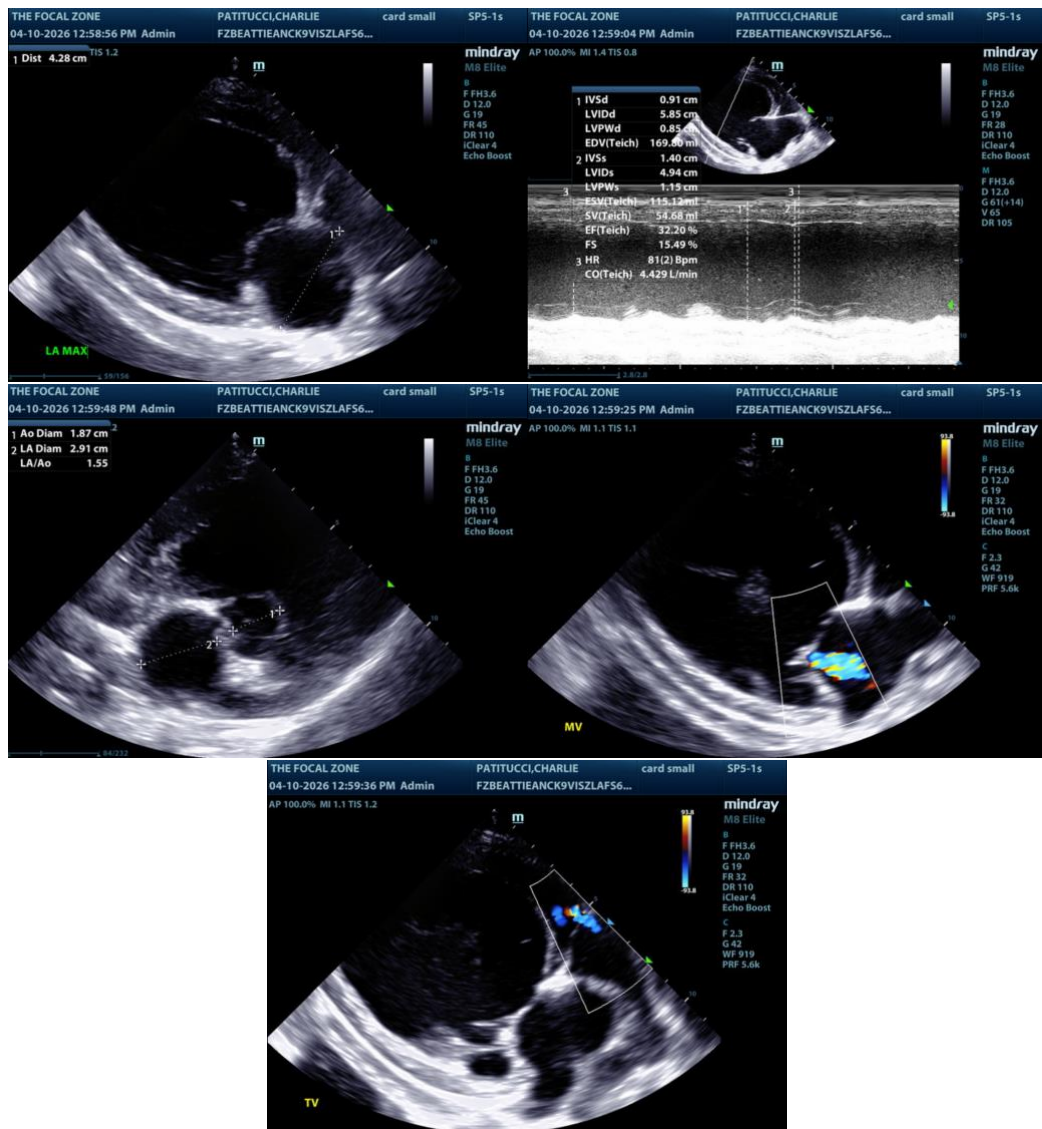
Dr. Davis

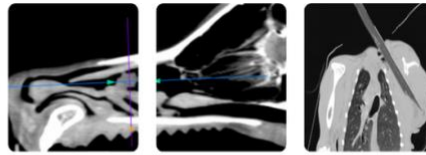
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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