



**PATIENT**

Jessie Weston

**SPECIES**

Canine

**BREED**

Border Collie x

**SEX**

Spayed Female

**AGE**

11 Years

**WEIGHT**

36 lbs

**INTERPRETED BY**

Brad Harris, DVM,  
DACVECC, DACVIM  
(cardiology)

**IMAGING PERFORMED BY**

Gudrun Gunther

**HOSPITAL NAME**

New Frontier Animal  
Medical Center

**REFERRING VET**

Dr. Weston

**INVOICE**

75214

**DATE**

5/17/26

**PRESENTING CLINICAL SIGNS**

Patient was diagnosed with pericardial effusion and tamponade on 5/12/26. The pericardial effusion was drained via pericardiocentesis, and patient has returned to normal energy, etc. Cardiac hemangiosarcoma is suspected. The client wishes to pursue an oncology consult and cardiac radiation therapy.

Abnormal PE/Chem/CBC/UA Results: WNL Thoracic rads unremarkable

**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	16.36	80	3.91	2.81	1.43	3.66	2.84
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	22	0.7	0.6	1.2	5.0	NM	44

**Cardiac Presentation**

The left atrium is upper limits of normal in dimension. The left ventricle is normal in dimension, with marginal systolic function. The right atrium and ventricle are normal in dimension, with normal systolic function. The anterior and posterior mitral valve leaflets are thickened and redundant consistent with myxomatous changes, and there is no significant prolapse. There is mild mitral regurgitation identified. The tricuspid valve leaflets are minimally thickened, with trivial 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 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. There are several fleeting views of a possible mass lesion in near the right auricular appendage at the heart base. However, this may also represent an artifactual change. A definitive mass lesions is not identified.



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## ULTRASONOGRAPHIC FINDINGS

These findings do not identify an overt heart base mass lesion in the setting of historic pericardial effusion. Given the absence of any identifiable neoplasia, idiopathic disease or coagulopathy is a possibility. However, the inability to document a mass does not exclude the potential for neoplastic effusion. The presence of mild mitral regurgitation in the setting of a normal left side are consistent with degenerative/myxomatous mitral valve disease with minimal to mild hemodynamic effects (ACVIM Stage B1 disease). The marginal systolic function is likely to be secondary to myocardial stunning from the previous pericardial effusion, however intrinsic myocardial disease (dilated cardiomyopathy), secondary nutritional cardiomyopathy (grain free diet), or the myocardial effects of other systemic disease cannot be completely excluded.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given these findings, no specific cardiac therapy will be recommended at this time. Options include further evaluation for a possible occult mass lesion (CT with angiography) or considering a pericardiectomy for long term management. If not yet done, the fluid should ideally be submitted for cytology to help identify the presence of neoplasia. If the effusion is idiopathic in origin, surgery may be curative. However, the added value of CT/surgery is to better evaluate the heart base to identify mass lesions that can be missed by ultrasound. If this is being considered, an abdominal ultrasound is recommended to evaluate for potential mass lesions. . If the owners are feeding a grain free diet, an immediate diet change would be necessary, and the addition of taurine (50 mg/kg BID) would be appropriate.

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 until any signs of CHF and/or pericardial effusion have resolved. If anesthesia is necessary after that time, 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., 2-3 ml/kg/hour) if possible (i.e., if not hypotensive). A shorter anesthetic duration will reduce the risk of complications. Pre-oxygenation is advised. Pre-medication 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



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clinical status of the patient changes.

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Activity:

Avoid strenuous activity.

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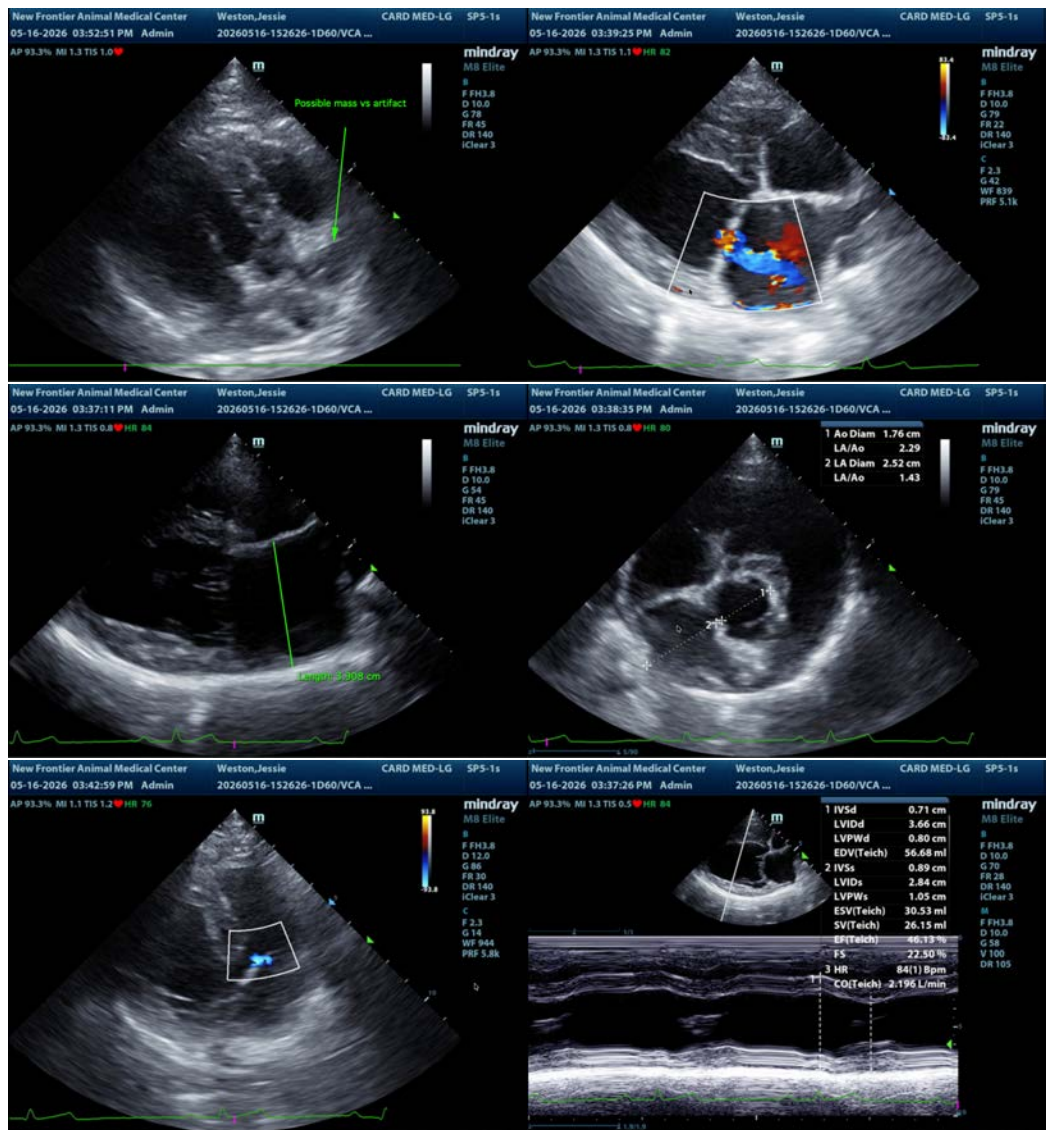
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Brad Harris, DVM, DACVECC, DACVIM (cardiology) [info@SonoPath.com](mailto:info@SonoPath.com)