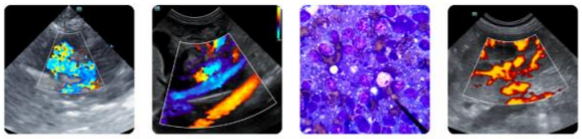


PATIENT

Bruiser Gionfriddo

SPECIES

Canine

BREED

Boxer

SEX

Intact Male

AGE

3/18/18

WEIGHT

30.45 kg

INTERPRETED BY

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

BestFriends Animal Clinic

REFERRING VET

Natalie Sundstrom, DVM

INVOICE

16498

DATE

05/22/26

PRESENTING CLINICAL SIGNS

Recent heart murmur, radiographs taken at another clinic suggestive of cardiomegaly. VPCs under anesthesia (mass removal) performed about 3 weeks ago, controlled with Lidocaine bolus and CRI 3/6, not symptomatic. Working diagnosis. MMVD vs CHF vs other

Increased: ALT 134 (0- 120) ALP 197 (0-140) TP 8.6 (5.5- 7.6)

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

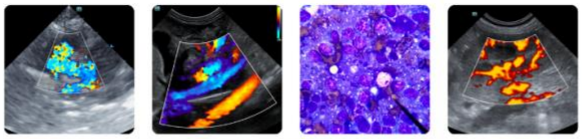
CANINE CARDIAC PARAMETERS	BW	HR BPM	LAD 4 ch Long	RAD 4 ch Long	La/Ao Heart Base	LVIDd	LVIDs
NORMAL PARAMETER		50-100			<1.6		
PATIENT	30.45	90	4.36	2.42	1.3	4.26	2.8
CANINE CARDIAC PARAMETERS	**FS**	**EPSS**	**PV V MAX (m/s)**	**AV V Max (m/sec)**	**MR Vmax**	**TR Vmax**	**RPA distensibility (normal >30%)**
NORMAL PARAMETER	28-40	<0.6	0.7-1.6	0.7-1.7	4.5-5.5	< 2.7	
PATIENT	34	0.6	1.1	1.5	6.2	NM	23

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 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 minimal prolapse. There is mild mitral regurgitation identified. The tricuspid valve leaflets are minimally thickened, 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, 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. The cardiac chambers, pericardial and visible extra-cardiac regions were free of masses, spontaneous echo contrast, or thrombi.

ECG

The underlying rhythm is sinus in origin with a varying R-R interval and average heart rate of 90 bpm. The majority of the QRS complexes are supraventricular in origin with consistent P-Q intervals. P wave amplitude fluctuates with the R-R interval, including occasional negative P waves in lead II. There are occasional single QRS complexes that are prolonged in duration (>70ms), suggesting a ventricular



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origin, as well as several fusion complexes identified. There is no evidence of atrioventricular block or atrial ectopy identified. This is most consistent with a respiratory sinus arrhythmia with ventricular ectopy.

ULTRASONOGRAPHIC FINDINGS

These findings are consistent with degenerative/myxomatous mitral valve disease with minimal to mild hemodynamic effects consistent with ACVIM Stage B1 disease. Given the breed, a concurrent arrhythmogenic right ventricular cardiomyopathy is also suspected based on the history and the ECG provided. Non-cardiac causes of ventricular ectopy are also common and include splenic disease, metabolic disease, electrolyte disturbances, tick-borne disease, fever, anemia, trauma, GDV, hepatic disease, GI disease, pancreatitis, DIC, and sepsis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

At this time, there are several options, to include (1) do nothing now, and simply monitor for progressive changes, especially as the dog is asymptomatic, (2) consider the merits of having a Holter performed to determine if the severity of the arrhythmia warrants therapy, or (3) go ahead and start therapy with sotalol (1-2 mg/kg orally every twelve hours), recognizing the reality that there is no current evidence documenting the ability of antiarrhythmics to reduce the risk of sudden death. If therapy is started (either with or without a Holter), a repeat echo, ECG and BP would be recommended to in 2-4 weeks to monitor for benefit/adverse effects of therapy. Otherwise, a repeat evaluation should be performed in another 3-6 months to determine if the arrhythmia has worsened.

Anesthesia considerations:

If anesthesia is necessary, alpha-2 agonists, ketamine, high dose acepromazine, and Telazol should be avoided. Fluid therapy during anesthesia should be considered at a conservative rate (e.g., 5 ml/kg/hour) if possible.

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.

Imaging performed by
pawsonography@gmail.com
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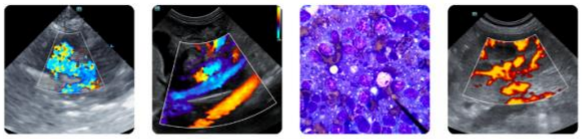

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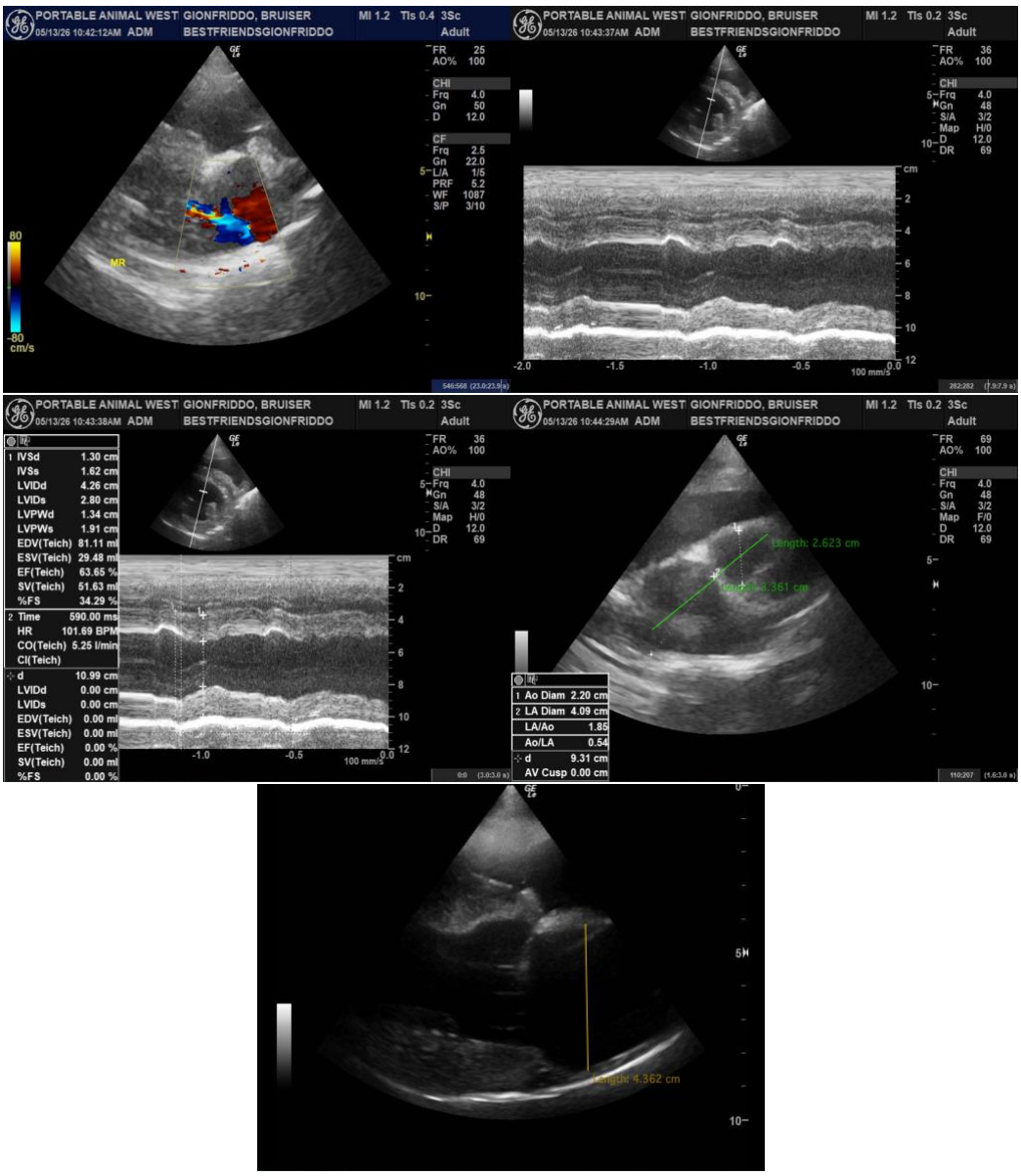

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@SonoPath.com