

PATIENT

Bodie Sullivan

SPECIES

Canine

BREED

West Highland White
Terrier

SEX

Neutered male

AGE

11 years

WEIGHT

30.2 lbs

INTERPRETED BY

Bradley Harris, DVM,
DACVECC, DACVIM
(cardiology)

IMAGING PERFORMED BY

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

MountainView AH

REFERRING VET

Dr. Bridget Landon

INVOICE

78092

DATE

5/29/26

PRESENTING CLINICAL SIGNS

History: prev echo and abdominal Sonopath reports- Gabapentin sedation- patient presented for UTI 5/23 and a possible mass was observed on ultrasound for cystocentesis not seen in prev scans- UTI clinical signs responded to medical management. No current stranguria, pollakiuria, hematuria

Blood Pressure- BP: 140,150,159, 154

ECG- atropine response test results 12/25/2025-consistent with a sinus arrhythmia.

REPEATED ATROPINE TEST TODAY AND ATTACHED BOTH PRE AND POST ATROPINE ECG TESTS FOR REVIEW

MEDS- Amoxi/Clav, Cytopoint, Galliprant, Trazadone, Vetmedin

hx cardiomegaly, bradycardia

last echo performed 11/10/2025 (attached report as from another company)

Degenerative Valve Disease (DVD)- mild LAE, mild MR, normal LV, normal systolic function, trace TR, normal right heart. (Sonopath Echo report); 11/21/24. Mild LAE, moderate MR, normal LV, normal systolic function, trace TR, normal right heart. (Sonopath Echo report); 3/13//25.

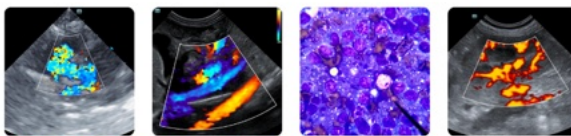
Arrhythmia auscultated; 10/30/25. Mild LVEH, moderate LAE, moderate MR, trace TR, normal RA/RV;

11/10/25. Sinus arrhythmia with frequent periods of sinus arrest; suspect early sick sinus syndrome

Cadet BRAF pending bacteruria 5/23 bw 5/23 mild ALP elevation - consistent w/ prev findings non-azotemic otherwise unremarkable findings. RADS- chest radiographs show cardiomegaly, no evidence of chest metastasis

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

The left atrium is upper limits of normal to mildly enlarged. 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 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. The cardiac chambers, pericardial and visible extra-cardiac regions were free of masses, spontaneous echo contrast, or thrombi. No gross pulmonary pathology or cardiomegaly are identified on thoracic radiographs.



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CANINE CARDIAC PARAMETERS	Body Weight kg	HR BPM	LAD 4 ch Long	RAD 4 ch Long	La/Ao Heart Base	LVIDd	LVIDs
NORMAL PARAMETER		50-100			<1.6		
PATIENT	13.73 kg	60	3.68	2.45	1.6	3.58	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	50	0.2	1.0	2.0	5.7	2.7	34

ECG:

A six-lead ECG is available for review. Prior to the atropine administration, the average heart rate is approximately 60bpm, with a normal mean electrical axis. The QRS complexes are sinus in origin, 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). The atropine administration abolishes this rhythm and a normal sinus rhythm is documented.

ULTRASONOGRAPHIC FINDINGS

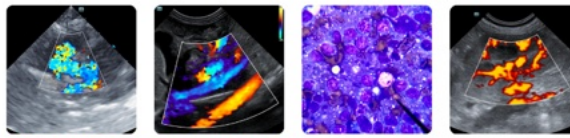
These findings are consistent with degenerative/myxomatous mitral valve disease with mild hemodynamic effects consistent with the history of ACVIM Stage B2. There has been no apparent progression since the previous evaluation. The sinus arrhythmia continues to respond to atropine. With the history of periods of sinus arrest, an early sick sinus syndrome remains a likelihood.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the degree of chamber dilation, continued cardiac therapy with Vetmedin (0.25-0.35 mg/kg BID) is recommended. In the absence of syncope or other clinical signs, no therapy for the arrhythmia is indicated. While there is an increased risk of IV fluids, corticosteroids, or anesthesia, there is no overt objection, as the need likely outweighs the risks. A repeat echo is indicated in 6 months. Consideration could be given to mitral valve repair (open heart surgery or transcatheter edge to edge repair). Owners should monitor resting respiratory rate at home. Values above 30 breaths/minute or an increase in respiratory rate 10% above baseline should prompt veterinary re-evaluation.

Anesthesia considerations:

While there is no CHF present, there is likely an increased anesthetic risk which must be considered prior to any anesthetic procedure. 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. 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



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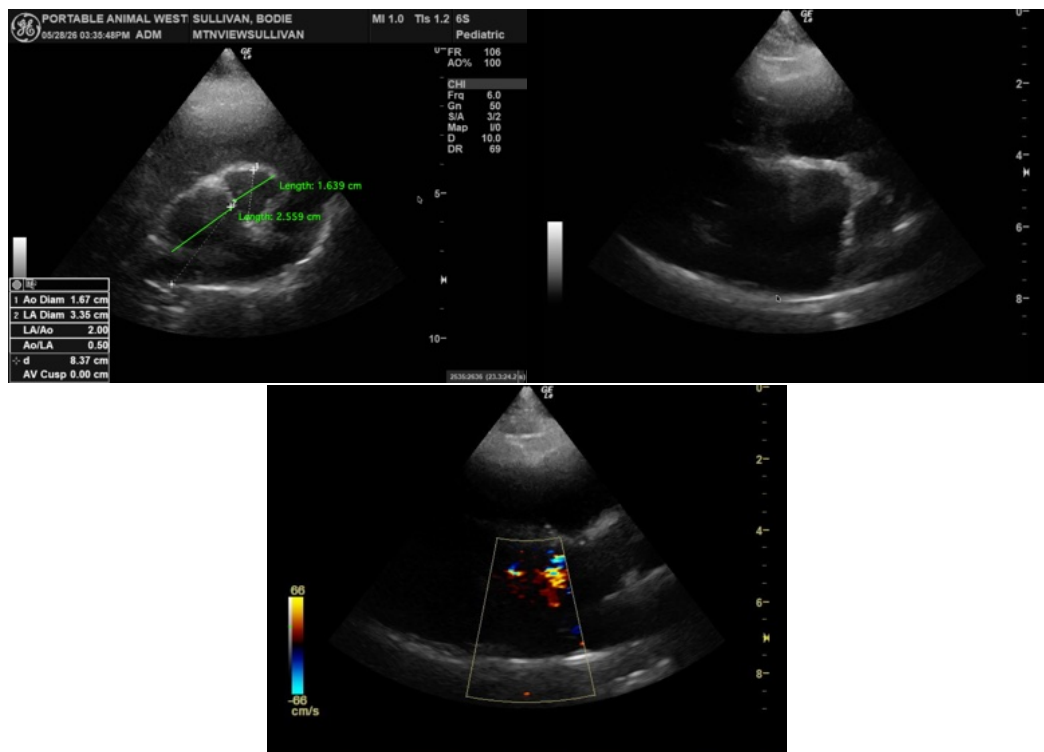
the safest protocol. An induction agent such as Propofol, alfaxalone, or diazepam/etomidate can be used to effect. Maintenance of anesthesia with isoflurane or sevoflurane is reasonable. Dobutamine (2.5-10 µg/kg/min as a CRI, starting at 2.5 µg/kg/min and increasing the dosage incrementally) may be used 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 an optimal body condition is recommended. Consider omega-3 fatty acid supplementation. Avoid any boutique, exotic, or grain-free diets.

Activity:

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.



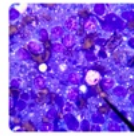
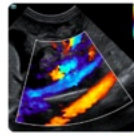
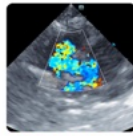
The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Imaging
performed by



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