DATE

5/29/26

PATIENT

Bugs Parslow

SPECIES

Canine

BREED

Shar Pei

SEX

Spayed female

AGE

10/11/13

WEIGHT

49.5 lbs

INTERPRETED BY

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

HOSPITAL NAME

Chadwell AH

REFERRING VET

Dr. Schaupp

INVOICE

78100

PRESENTING CLINICAL SIGNS

History: Echo done Aug 2025 revealed an arrhythmia with mild MR and trace TR regurg. Symptom then was pet lagging behind during walks. Started on Sotalol at 20 mg BID, arrhythmia resolved completely. Pet back to hiking normally. Recently, she is starting to fall behind again during walks. PE: Grade III systolic murmur, HR 122 BPM, 16 VPCs /minute (singles). Pea sized pigmented growth at anus (new finding). All else, wnl.
Pertinent abnormal PE/Chem/CBC/UA Results: Labwork attached, reported as: SDMA 15. All else wnl. HW test - neg
Current medications: Thyroxine 0.2 mg BID, Sotalol 40 mg BID (was increased on 05/12/2026)
Blood Pressure: N/A.
Sedation used: Not required to complete full diagnostic ultrasound.
Pertinent previous ultrasound results: 2025, 2024, 2021. See attached.
STAT: Declined at this time.
Imaging performed by: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

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 marginal 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 reveals a narrowing in the infundibulum with turbulent flow, with appropriate main pulmonary artery diameter and right pulmonary artery distensibility. The outflow tract velocity is marginally elevated. There is trivial 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.

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	22.5 kg	90	3.68	2.42	1.09	3.51	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	20	0.3	1.5	1.0	6.1	NM	NM

ECG:
The underlying rhythm is sinus in origin with a varying R-R interval and average heart rate of 90bpm. The majority of the QRS complexes are supraventricular in origin with consistent P-Q intervals. There are rare QRS complexes that are prolonged in duration (>70ms), suggesting a ventricular origin. No couplets or runs of ventricular tachycardia are identified. There is no evidence of atrioventricular block or atrial ectopy identified. This is most consistent with a respiratory sinus arrhythmia with rare 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. There is no progression in the structural aspects of the disease. The reduction in systolic function noted today, is likely due to the increased sotalol dose. This is also likely contributing to the bradycardia. At this point, these are unlikley to negatively impact the patient, but close monitoring is necessary for further progression. The ventricular ectopy is static to marginally improved since the previous study. The narrowing in the RVOT is also static from previous studies.

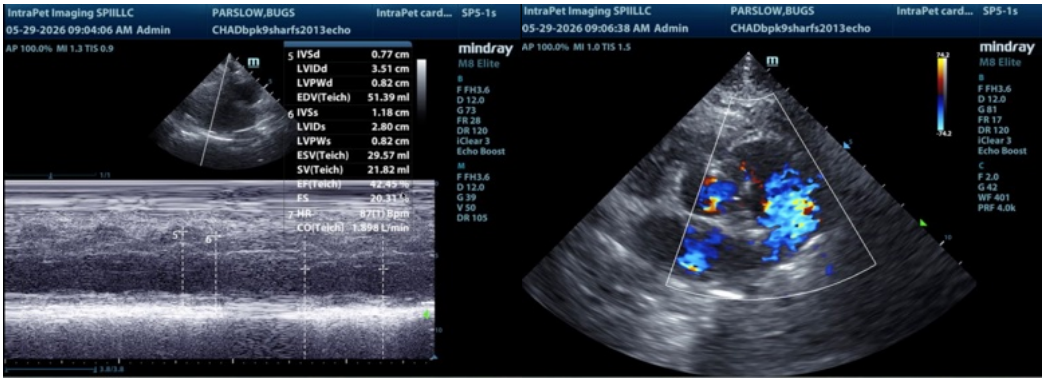
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

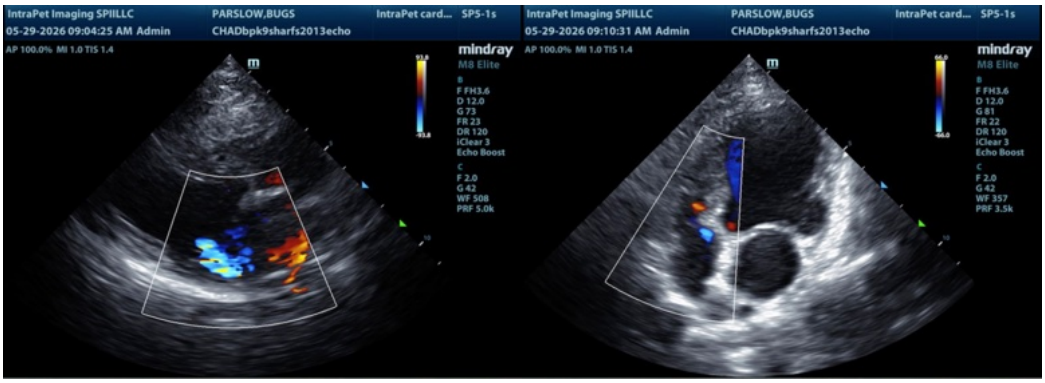
Given these findings, no changes to cardiac therapy are recommended. If there has been a progression of clinical signs after increasing the sotalol, then a reduction to the previous dose is recommended. A Holter monitor should be performed prior to further empiric adjustments of the medications. Additionally, other causes of exercise intolerance and ventricular ectopy should be investigated. There are no cardiac contraindications to anesthesia, fluid therapy, vasopressor therapy, or corticosteroids as indicated for further assessment and treatment. If not already performed, baseline thoracic radiographs and blood pressure are recommended. A recheck echocardiogram is recommended in 6 months.

Anesthesia considerations:
If anesthesia is necessary, alpha-2 agonists, ketamine, high dose acepromazine, and Telazol should be avoided. Do not give the sotalol the morning of anesthesia. 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:
No special considerations are necessary.





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.

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