

PATIENT

Winston Arnold

SPECIES

Canine

BREED

English Golden Retriever

SEX

Neutered Male

AGE

7.5

WEIGHT

68.5

INTERPRETED BY

Bradley Harris, DVM,
 DACVECC, DACVIM
 (cardiology)

IMAGING PERFORMED BY

Ginny Dodd, DVM, D,
 ABVP-CFP

HOSPITAL NAME

Miller Animal Hospital

REFERRING VET

Dr. Jack Miller

INVOICE

16017

DATE

05/09/26

PRESENTING CLINICAL SIGNS

Recent heart murmur noted. Winston's sister died recently - HSA- - owner and vet concerned heart murmur may be due to HSA in heart. Extremely anxious dog at vet. Owner has noticed Winston not as active in past 2 weeks- grief, heat, or heart issues. Vet began Pimobendan for murmur recently. Winston has had Gabapentin and Buprenorphine prior to visit but still very anxious, panting

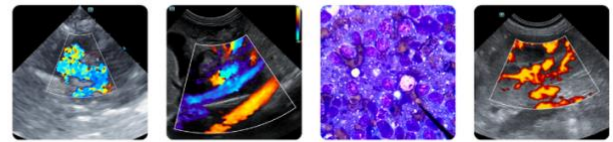
PE: Panting, anxious, grade 4/6 systolic murmur, PMI L heart base, HR 110, no pulse deficits, Normal sinus rhythm CBC- WNL CHEM- WNL pro BNP > 4000

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	31.14	110	4.55	NM	1.33	3.84	2.17
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	43	0.4	1.4	6.9	4.9	2.5	NM

Cardiac Presentation

The left atrium is normal in dimension. The left ventricle is normal in dimension, with normal systolic function. There is mild concentric left ventricular hypertrophy. The right atrium and ventricle are normal in dimension, with normal systolic function. The anterior and posterior mitral valve leaflets are mildly thickened and redundant, with apparently intact chordae, and there is no significant prolapse. There is mild mitral regurgitation identified. The tricuspid valve leaflets are appropriately thin with adequate apposition, intact chordae, trace tricuspid regurgitation and no evidence of pulmonary hypertension. The left ventricular outflow tract demonstrated turbulent flow and the visible aorta is mildly dilated. 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 moderate aortic valve insufficiency identified. There is dropout at the level of the perimembranous intraventricular septum with apparent left to right color doppler flow, but no spectral doppler interrogation. 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.



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ULTRASONOGRAPHIC FINDINGS

- These findings identify a severe left ventricular outflow tract obstruction, most consistent with subvalvular aortic stenosis (given the breed). Additionally, there is mild mitral valve regurgitation, which may represent concurrent congenital mitral valve dysplasia, but given the patient's age, degenerative mitral valve disease is also considered likely. There is one image loop that identifies concern for a possible left to right ventricular septal defect. This would also likely be considered a congenital anomaly, however in the absence of any left sided chamber dilation, it is of minimal to no hemodynamic significance.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are multiple levels of uncertainty regarding this case. Given the patient's age and the presence of several congenital defects, cardiac therapy at this is not clearly indicated. However, due to the severe nature of the outflow tract obstruction, and risk for the development of dysrhythmias, cardiac therapy with atenolol (initial dose 1-2 mg/kg BID) will be recommended. The Pimobendan should be discontinued at this time. In the absence of overt clinical signs (syncope), interventional procedures are typically not recommended for SAS. Due to the risks for infective endocarditis, antibiotics should be administered prior to any surgeries, dentals, or in the case of even minor wounds/lacerations. Ideally, an evaluation by a cardiologist is recommended. Otherwise, a repeat echo is recommended in another 6-12 months.

Anesthesia:

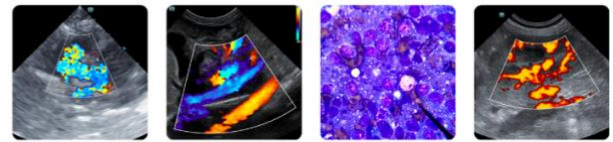
If anesthesia is necessary, then alpha-2 agonists, ketamine, high dose acepromazine, and Telazol should be avoided. Skip any ACE-inhibitor (if receiving) on morning of anesthesia. Fluid therapy during anesthesia should be considered at a reduced rate (e.g., 5 ml/kg/hour) if possible. A shorter anesthetic duration will reduce the risk of complications. Pre-oxygenation is advised. Pre-medication 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.

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.



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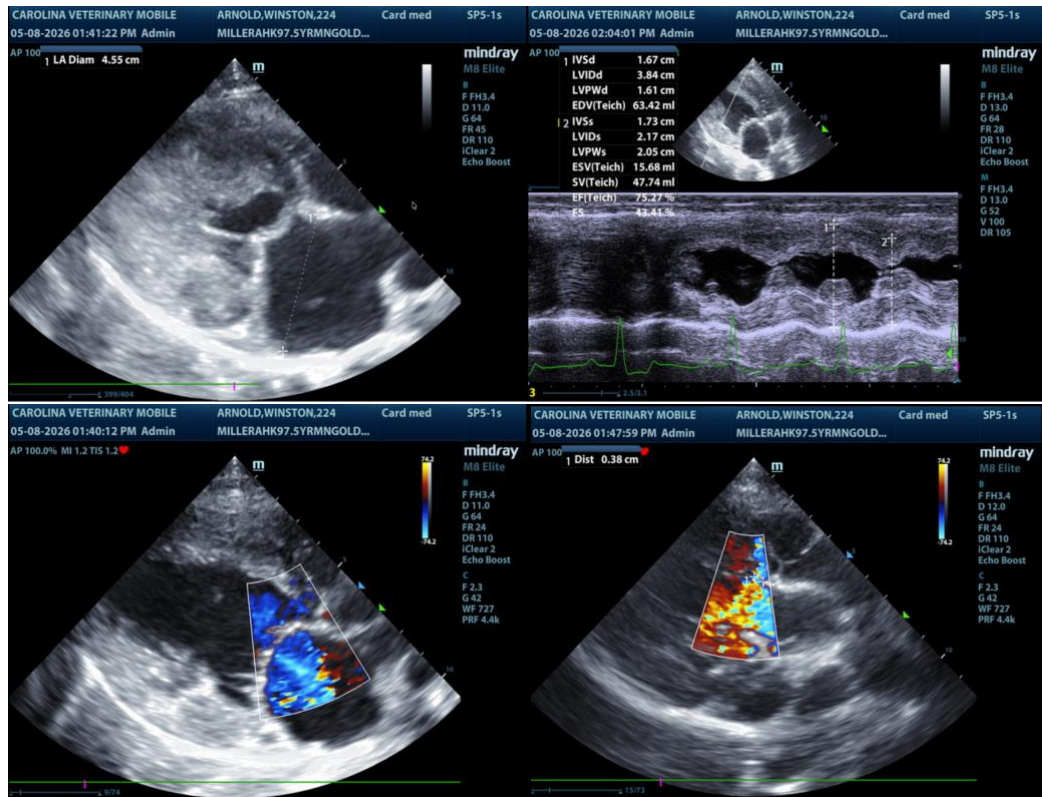
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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