



PATIENT

Tex Messer

SPECIES

Canine

BREED

Kelpie

SEX

Neutered Male

AGE

11 Years 8 Months

WEIGHT

60.1 Pounds

INTERPRETED BY

Bradley Harris, DVM,
DACVECC, DACVIM
(cardiology)

IMAGING PERFORMED BY

Dr. Jessie Evoniuk

HOSPITAL NAME

State Avenue VC

REFERRING VET

Dr. Jessie Evoniuk

INVOICE

37435

DATE

6/9/26

PRESENTING CLINICAL SIGNS

History: Presents for chronic cough with gagging/choking sounds, especially after drinking water (2–3 years; worsening recently). Gagging now also triggered by eating (last 2 weeks). Labored, wheezy breathing, more pronounced with exertion (last 2 weeks). One episode of vomiting after supper, re-ingested; no diarrhea. Eating, drinking, urinating, defecating, and activity level normal per client. Previous TPLO; biopsies of cutaneous masses performed at that time (benign per client). Cutaneous masses have increased in size; new small masses noted. No recent travel outside local area. No current supplements or analgesics; mild stiffness, ambulatory.

Abnormal PE/Chem/CBC/UA Results: Lenticular sclerosis, Increased upper airway noise in laryngeal area, labored breathing, wheezing, panting, Mild stiffness, occasional difficulty rising, Multiple subcutaneous masses, right thorax mass increased in size, additional masses noted bilaterally BP: 117/96 HR: 160; 168/108 HR:144; 173/108 HR: 141; 176/109 HR: 142 Chem wnl 6/8/26 IDEXX chest rad report: 1. Moderate generalized cardiomegaly. Differentials: cardiomyopathy, cardiac valvular degeneration, pericardial effusion. 2. If pulmonary arterial distention is a true finding, this may be secondary to chronic heartworm disease, pulmonary hypertension. 3. The marked patchy interstitial pulmonary pattern may represent pulmonary infiltrates, emerging bronchopneumonia, noncardiogenic pulmonary edema, fibrosis, or combination.

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	27.32	170	5.83	2.28	2.44	5.43	3.44
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	37	0.3	1.0	1.6	5.0	NM	NM

ECG Interpretation

There is a single-lead ECG available for review. The underlying rhythm is regular at an average rate of 170bpm. The rhythm appears to be sinus in origin with narrow QRS complexes. There is no atrial or ventricular ectopy and no atrioventricular block identified. This is most consistent with a sinus

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tachycardia.

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Cardiac Presentation**SPECIES**

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The left atrium is severely enlarged. The left ventricle is moderately enlarged, 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 mild prolapse. There is moderate to severe mitral regurgitation identified. The tricuspid valve leaflets are thickened and redundant, with mild 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.

ULTRASONOGRAPHIC FINDINGS

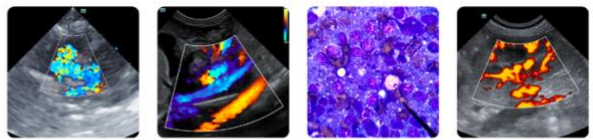
- These findings are consistent with degenerative mitral valve disease with significant hemodynamic effects. Given the degree of chamber enlargement and description of recent thoracic radiographs, congestive heart failure is a likely explanation for the clinical/radiographic signs, consistent with ACVIM Stage C. The mild systemic hypertension documented may be a stress induced response.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONSRecommendations/Treatment:

Therapy for CHF is recommended, with Lasix bolus (2-4 mg/kg IV PRN up to 10 mg/kg total dose) or a CRI (0.5-1 mg/kg/hr) as needed to resolve edema. Once oral therapy is started, therapy should include Lasix (2mg/kg BID), enalapril (0.5mg/kg BID assuming lack of renal insult), and Vetmedin (.25-.35mg/kg BID). 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 addition to the above treatments to improve the left ventricular function and blood pressure in patients that fail to respond adequately to diuretics, pimobendan, sedation, oxygen, and comfort care measures. A repeat chest X-rays, BP, and chemistry should be performed again in 1-2 weeks. A repeat echo is indicated in 3 months. 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:

Anesthesia should be avoided until manifestations of congestive heart failure (edema/effusion/respiratory distress) have resolved. Following that time, 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



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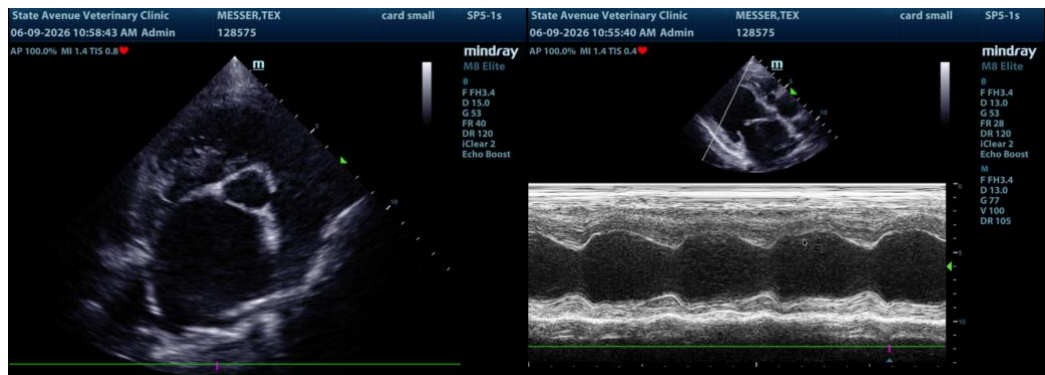
morning of general anesthesia. Other cardiac medications should be administered per the normal dosing schedule. Anesthetic IV fluid use should be limited to < 3 ml/kg/hr and, if IV fluid therapy is administered during the procedure, a 1 mg/kg dose of IM Lasix should be administered when the patient is awake and standing in recovery. 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 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 optimal body condition with mild dietary sodium restriction (<100 mg/100 kcal) 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.





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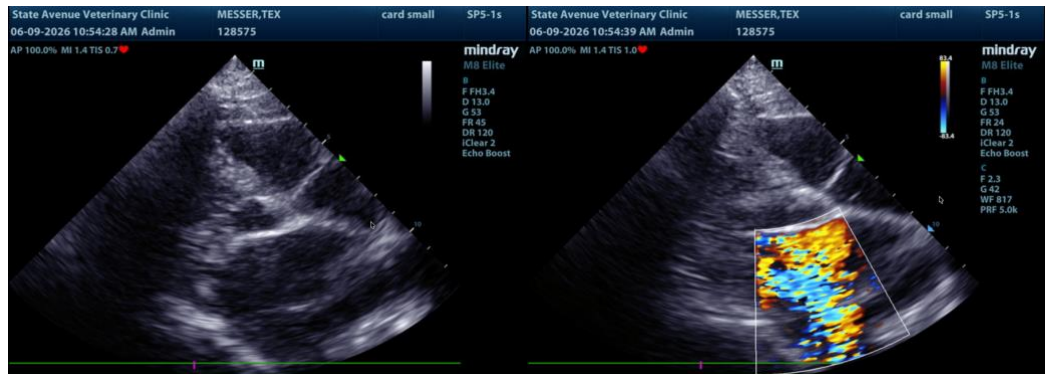
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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