



PATIENT

Rufus Sharma

SPECIES

Canine

BREED

Maltese

SEX

Neutered male

AGE

12 years

WEIGHT

4.5 kg

INTERPRETED BY

Bradley Harris, DVM,
 DACVECC, DACVIM
 (cardiology)

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

West Brant AH

REFERRING VET

Dr. Balaraju

INVOICE

73930

DATE

3/31/26

PRESENTING CLINICAL SIGNS

- History of heart murmur, started on Vetmedin in May 2025 and Furosemide October 2025.
- Seen for appointment Mar 26/26 for eye issue and owner noted that cough improved with increased dosing of Furosemide though still some coughing in the morning. Grade 4/6 murmur, no cough on tracheal palpation.
- Has been on Vetmedin 1.25mgBID, Furosemide 20mg AM and 10mg PM, bravecto, metacam SID as needed for limping.

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

The left atrium is severely enlarged. The left ventricle is moderately enlarged, 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 mild prolapse. There is mild to moderate 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. No gross pulmonary pathology is identified on thoracic radiographs.

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	4.5 kg	180	4.1	1.8	2.27	3.51	1.56
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	56	NM	0.7	1.5	5.8	2.6	NM

ULTRASONOGRAPHIC FINDINGS

These findings are consistent with degenerative/myxomatous mitral valve disease with moderate hemodynamic effects consistent with at least ACVIM Stage B2. The distinction between ACVIM stage B2 and ACVIM Stage C (congestive heart failure) is made via evidence of pulmonary edema (traditionally via thoracic radiographs).



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the degree of chamber dilation, cardiac therapy with enalapril (0.5 mg/kg BID assuming normotension and lack of renal insult) and Vetmedin (0.25-0.35 mg/kg BID) is recommended. If there is evidence of pulmonary edema on thoracic radiographs, additional diuretics (spironolactone 1-2mg/kg BID or furosemide TID) is recommended. In the absence of pulmonary edema, a cough suppressant may help alleviate the cough associated with mainstem bronchi compression secondary to the left atrial dilation. While there is an increased risk of IV fluids, corticosteroids, or anesthesia, there is no overt objection, as the need likely outweighs the risks. Repeat chest X-rays, BP, and a chemistry should be performed again in 1-2 weeks. A repeat echo is indicated in 3-6 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:

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 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.



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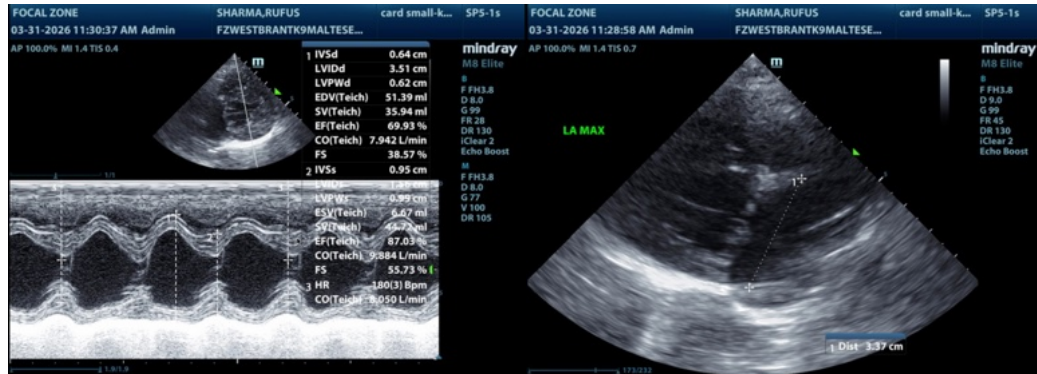
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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