



PATIENT PRESENTING CLINICAL SIGNS

Coco Singh History: Coughing with congested sounds and audible wheezes
 Chest rads showed severely enlarged heart with right ventricle resting on sternum, left atrium enlarged pushing trachea upwards, bronchial pattern with white dots throughout lungs. No meds.

SPECIES

Canine

BREED

Morkie

SEX

Spayed female

AGE

5 years

WEIGHT

5.7 kg

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

The left atrium is normal in dimension. The left ventricle is normal in dimension with normal systolic function, and the right atrium and right ventricle are at the upper limits of normal in dimension with normal systolic function. The anterior and posterior mitral valve leaflets are appropriately thin with adequate apposition and intact chordae, with no significant prolapse identified, and no significant mitral regurgitation is present. The tricuspid valve leaflets are appropriately thin with adequate apposition and intact chordae, with no significant tricuspid regurgitation and no evidence of elevated right ventricular pressures. The left ventricular outflow tract demonstrates normal laminar flow, and the visible aorta is unremarkable. The right ventricular outflow tract demonstrates normal laminar flow with a mildly distended main pulmonary artery diameter and reduced right pulmonary artery distensibility. There is no pulmonic or aortic valve insufficiency identified. There is no visible pericardial, pleural, or free peritoneal fluid documented, and no evidence of hepatic venous congestion is noted. The cardiac chambers, pericardium, and visible extracardiac regions are free of masses, spontaneous echo contrast, or thrombi.

INTERPRETED BY

Bradley Harris, DVM,
 DACVECC, DACVIM
 (cardiology)

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

The Collegeway AH

REFERRING VET

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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	5.7 kg	140	2.44	2.03	1.58	2.0	1.13
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	44	0.2	1.5	1.8	None	1.3	20

ULTRASONOGRAPHIC FINDINGS

These findings identify changes that may represent at least mild pulmonary hypertension, in the absence of any significant left sided disease. Despite the inability to document elevated right ventricular pressures, the changes to the pulmonary arteries, accompanied by the clinical signs, make any potential PH more likely related to primary respiratory disease or other etiology (non-type 2 PH). Pulmonary hypertension in dogs is most commonly secondary to primary respiratory disease (chronic bronchitis, pulmonary fibrosis, or other forms of pulmonary interstitial disease). Pulmonary hypertension can also develop in dogs with severe heartworm disease or secondary to pulmonary thromboembolism (PTE). Less commonly, pulmonary hypertension is identified in dogs as an idiopathic condition.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given these findings, no cardiac therapy is recommended. There are no cardiac contraindications to fluid therapy or corticosteroid therapy, as indicated for further assessment and treatment. No specific cardiac recheck is recommended unless a murmur or clinical signs of heart disease develop.

Anesthesia considerations:

No special considerations are necessary.

Diet:

No special considerations are necessary. Any high-quality food from Hills, Royal Canin, Science Diet, Eukanuba, Iams, or Purina is reasonable.

Activity:

No special considerations are necessary.



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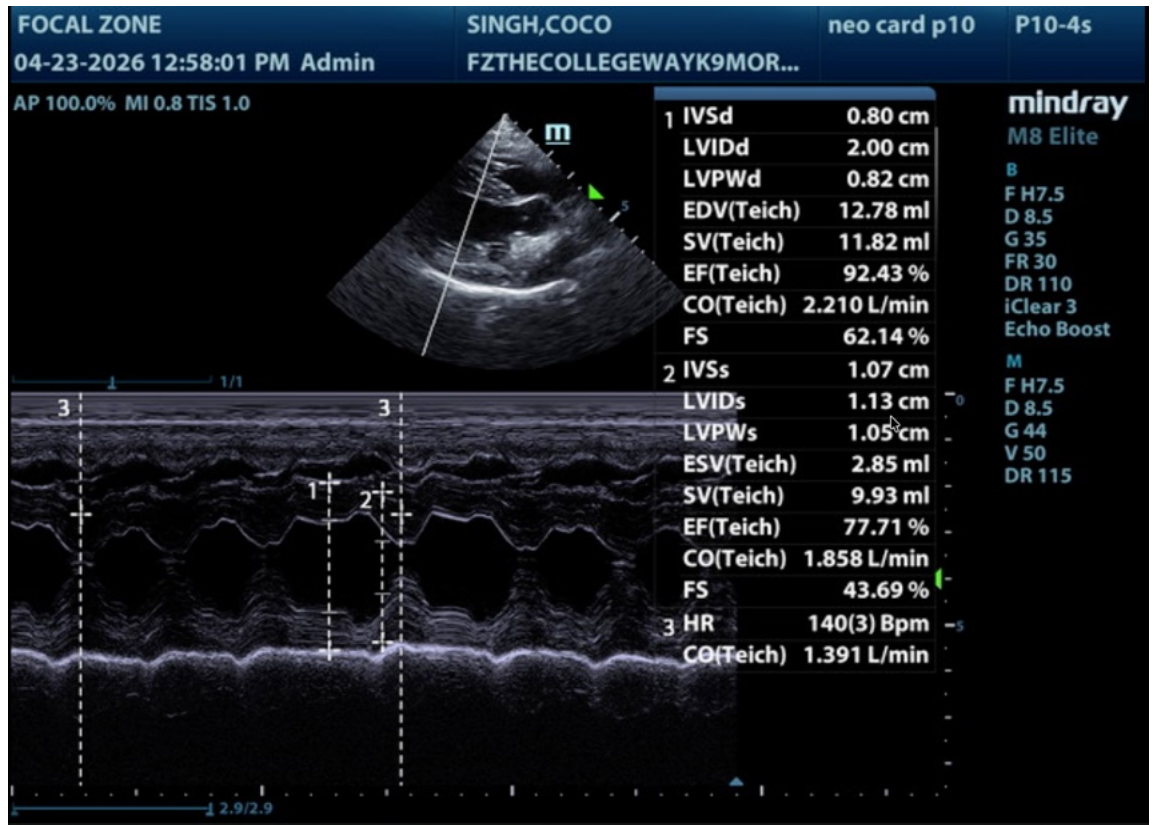
Dr. Hanna

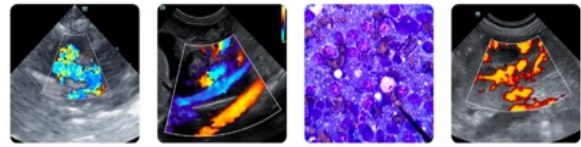
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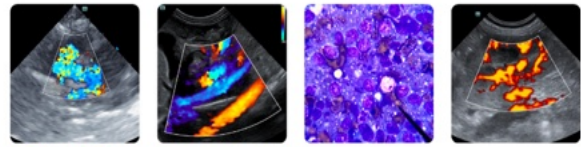
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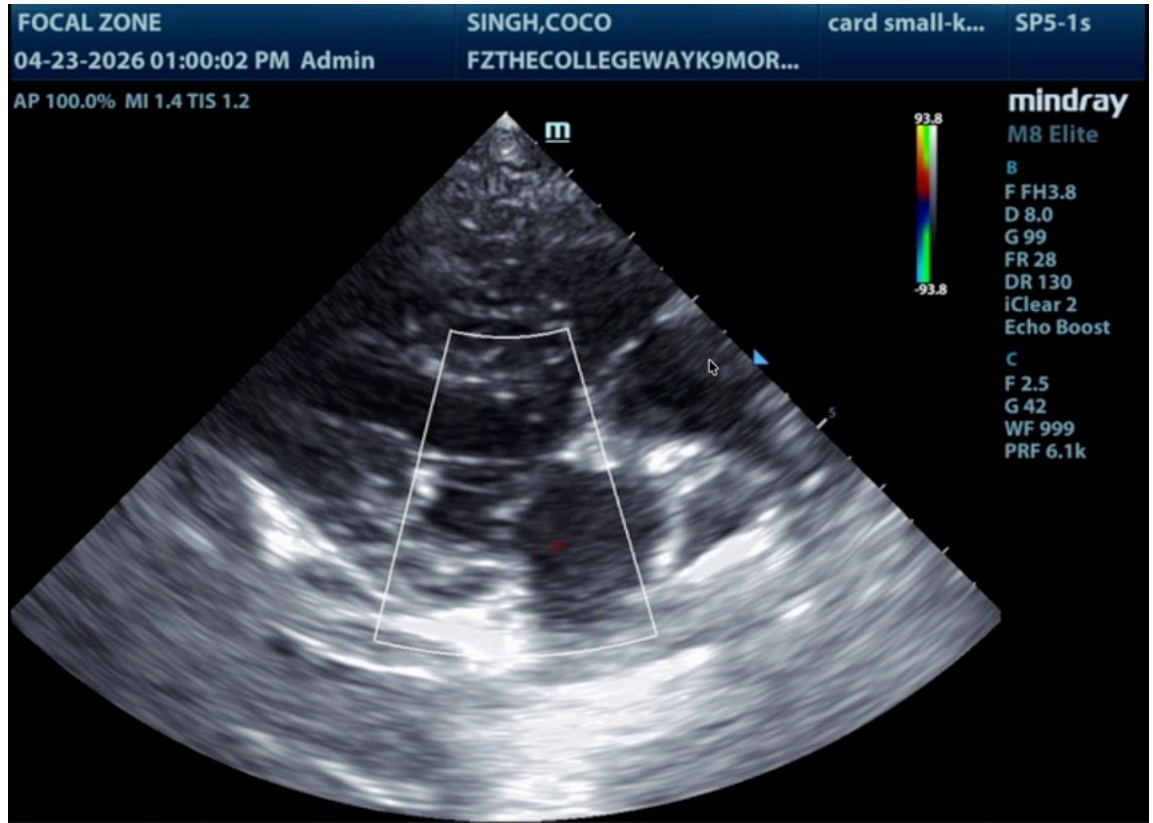
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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