

PATIENT PRESENTING CLINICAL SIGNS

Milo McKinnon
 History: Auscultation of the lungs revealed crackles over the left lung field. No wheezing was noted. The patient was eupneic but panting due to anxiety.
 Current Medications
 - Hydrocodone 2.5mg/mL oral Suspension, P will be on PVP (gabapentin and Trazodone) day of echo. O was instructed not give Hydrocodone day before and day of echo
Canine
 Radiographic Findings Tracheal and Bronchial Collapse: There is confirmed tracheal narrowing and bronchial collapse. I explained that while radiographs are a static image, they confirm the presence of collapse, which contributes significantly to her coughing and breathing difficulty. - Lower Airway Inflammation: There is inflammation present in the lungs. The specialist's report suggests this is likely a secondary consequence of her previous heartworm disease. An allergic or environmental component cannot be ruled out but is considered less likely. - Mild Cardiomegaly and Pulmonary Hypertension: The radiographs show a mildly enlarged heart and pulmonary artery.
BREED
 Terrier Cross
SEX
 Spayed female

AGE ULTRASONOGRAPHIC EXAMINATION OF THE HEART

12 years
 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 normal 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 trivial 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 revealed normal laminar flow, with appropriate main pulmonary artery diameter and right pulmonary artery distensibility. There is no pulmonary 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.

INTERPRETED BY

Bradley Harris, DVM,
 DACVECC, DACVIM
 (cardiology)

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

St Catharines AH

REFERRING VET

Dr. Sotto-Fortes

INVOICE

74343

DATE

4/9/26

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	9.4 kg	100	2.76	1.99	1.07	2.64	1.38
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	48	0.3	1.2	0.9	6.0	1.3	19



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ECG:

There is a six-lead ECG available for review. The underlying rhythm is regular at an average rate of 130bpm. The rhythm appears to be sinus in origin with narrow QRS complexes (<70ms). There is no atrial or ventricular ectopy and no conduction delay or block identified. This is most consistent with a normal sinus rhythm.

ULTRASONOGRAPHIC FINDINGS

These findings identify degenerative mitral valve disease with minimal to no hemodynamic effects with evidence of possible pulmonary hypertension (PH). While not demonstrated by the RV pressure gradient, there is mild dilation of the main and right pulmonary artery, which can be suggestive of PH. In the absence of more convincing left sided enlargement, the PH is 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given these findings, no cardiac therapy is recommended. 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:

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, and Telazol should be avoided. Fluid therapy during anesthesia does not necessarily need to be adjusted. A shorter anesthetic duration will reduce the risk of complications. Pre-oxygenation is mandatory. Premedication with an opioid (e.g., 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:

No special considerations are necessary.



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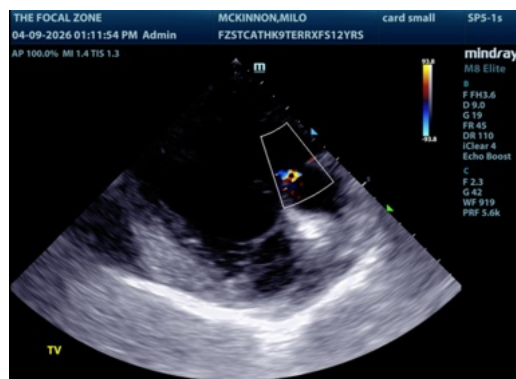
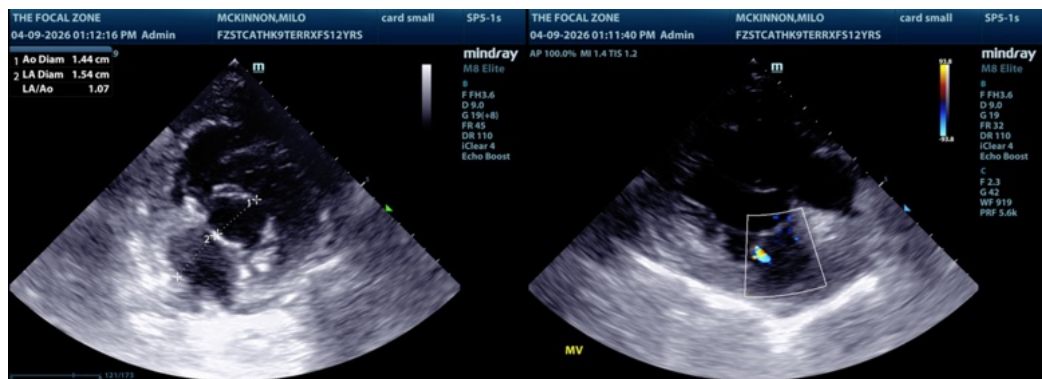
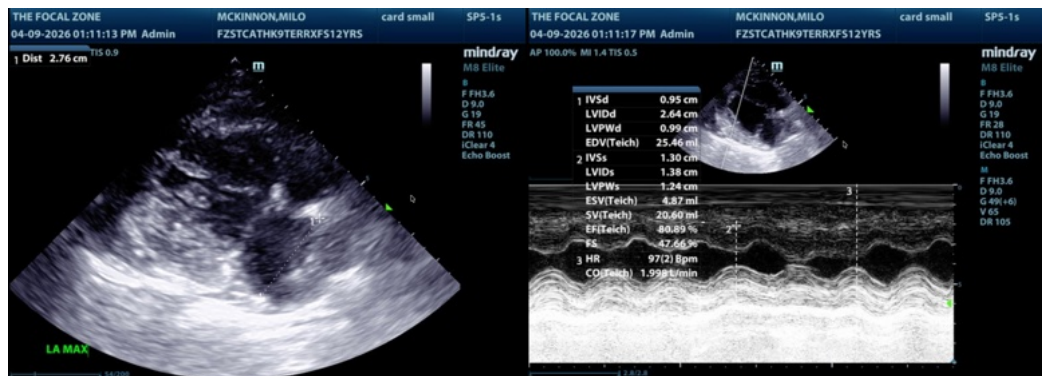
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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