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Clinical Sonography & Telecytology
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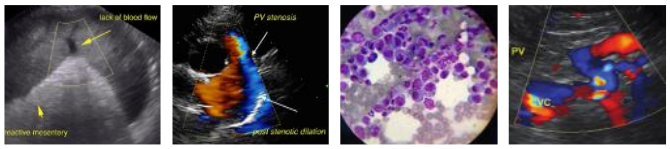

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Larry Halfway Home

SPECIES
Canine

BREED
Lhasa Apso

SEX
M

AGE
10

WEIGHT
20.4

INTERPRETED BY
Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Jenn

HOSPITAL NAME
Rockaway Animal Hospital

REFERRING VET
Dr. Ascot

INVOICE
12525ag

DATE
12/23/2022

PRESENTING CLINICAL SIGNS

rescue just obtained, Pt coughing abd breathing 5/6 systolic HM

Abnormal PE/Chem/CBC/UA Results: marked elevated ProBnp

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (Boon method)	LA/AO (Heart Base; Swe)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	<1.3	28-40	40-100	<0.6
PATIENT	5.8	2.0		2.0	58	89	0.1
CANINE CARDIAC PARAMETERS	**HR** (BPM)	**AV VMAX** (m/s)	**PV MAX** (m/s)	**BODY WEIGHT** (kg)	**LA** 2D short axis Base view (cm)	**LVIDd** Avg; 2D and m-mode short axis (cm)	**LVIDs** Avg; 2D and m-mode short axis (cm)
NORMAL PARAMETER	50-100	0.7-1.7	0.7-1.6				
PATIENT	131	1.2	0.90		4.3	3.22	

Cardiac Presentation

The echocardiogram for this patient presented excessive left atrial size expressed both in the LA/AO and LA max measurements. Chamber volumes and echogenicity were normal. The cranial and caudal mitral valve leaflets presented vegetative thickening consistent with endocardiosis. Doppler indicated measurable insufficiency. The left ventricle presented thicknesses with linear contour and was not dilated nor restricted. The myocardium presented normal echogenicity without subjective evidence of significant fibrotic or ischemic disease. Contractility of the ventricular walls was adequate and in normal range for this patient evidenced by the fractional shortening measurement and subjective evaluation of the different regions of the myocardium. The left ventricular outflow tract demonstrated normal laminar flow and subjective structural integrity. The right atrium and auricle revealed normal size, structure and content. No evidence of masses was noted or chamber overload. Tricuspid valvular assessment demonstrated adequate linear morphology. The right ventricle was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. Pulmonic tract assessment revealed normal valve structure, laminar flow, and diameter (approx.1:1 pa/ao ratio). No visible pericardial or free pleura fluid was noted. No echographically detectable evidence of infiltrative disease was visible. The cranial mediastinum and pericardial regions were free of masses in the visible window.

ULTRASONOGRAPHIC FINDINGS

- Advanced stage B2 valvular disease

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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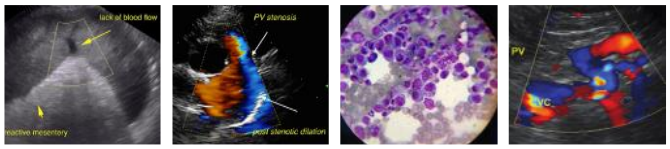

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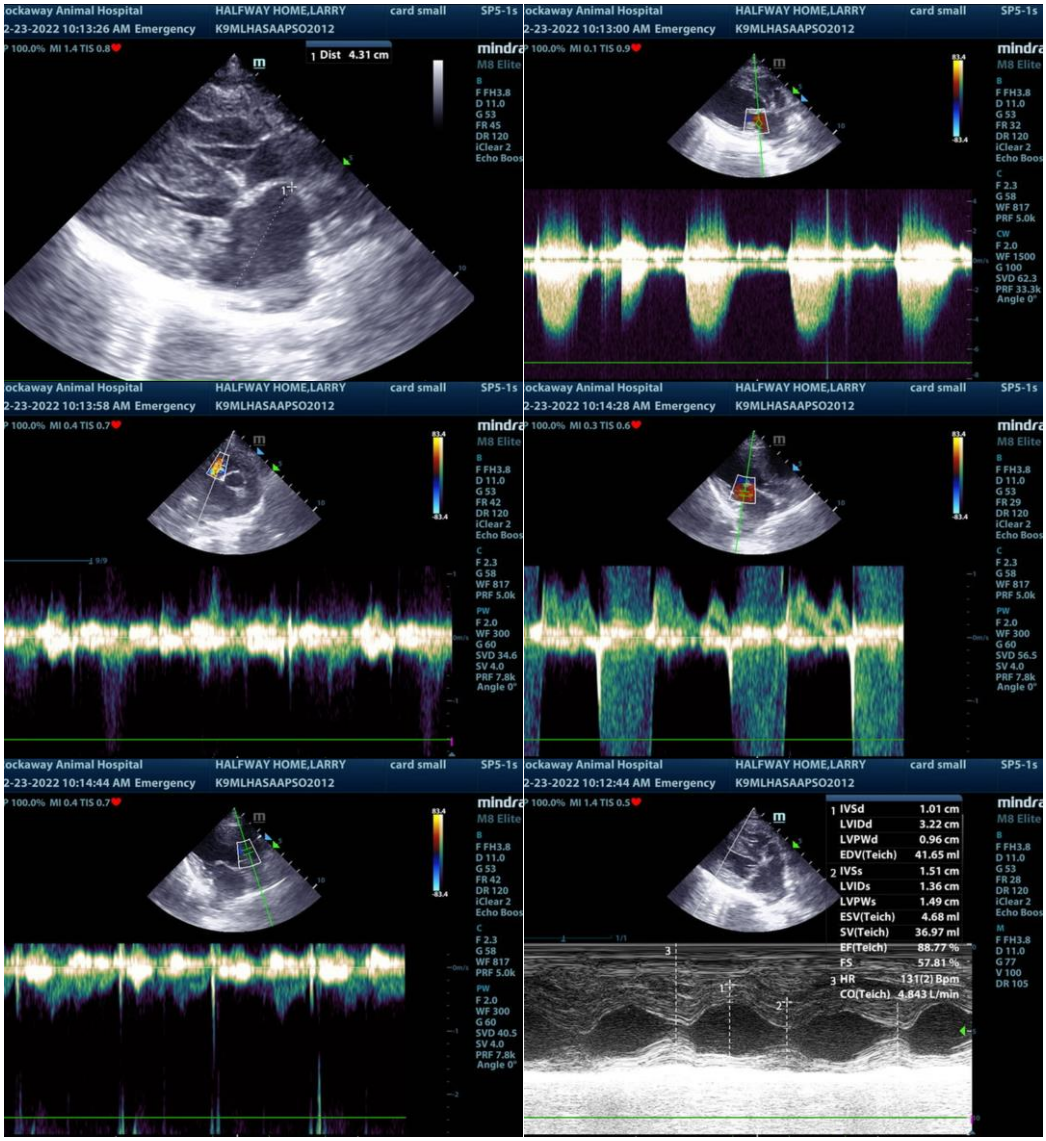
There may be a respiratory component as well as cardiac in this patient. The left atrial size is adequate to cause main stem bronchus impingement +/- early left sided CHF depending upon radiographic findings. Comet tail lung patterns noted in the peripheral lung field. Prolapsed anterior mitral valve leaflet is present. Recommend Pimobendan 0.3 mg/kg PO BID, ACE inhibitor 0.5 mg/kg PO SID progressing to BID and Lasix 1-2 mg/kg PO BID. Primary respiratory protocol such as a bronchodilator and broad spectrum antibiotic may be effective as well.

The heart has some volume overload and is working to compensate for the valvular insufficiency. Target respiratory rate is < 20 resp/minute after therapy. After initiating therapy, I recommend recheck on the clinical exam, BUN, Creatinine, USG, Chest radiographs & Blood pressure in 5-7 days. Recheck echo in 1 month. Earlier if clinical decompensation is occurring. I do not recommend anesthesia at this time until stabilization has occurred on the recommended medications. Repeat preanesthetic echo is ideal if anesthesia is eventually necessary



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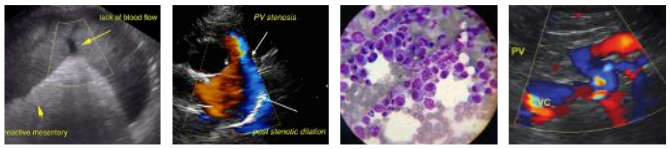

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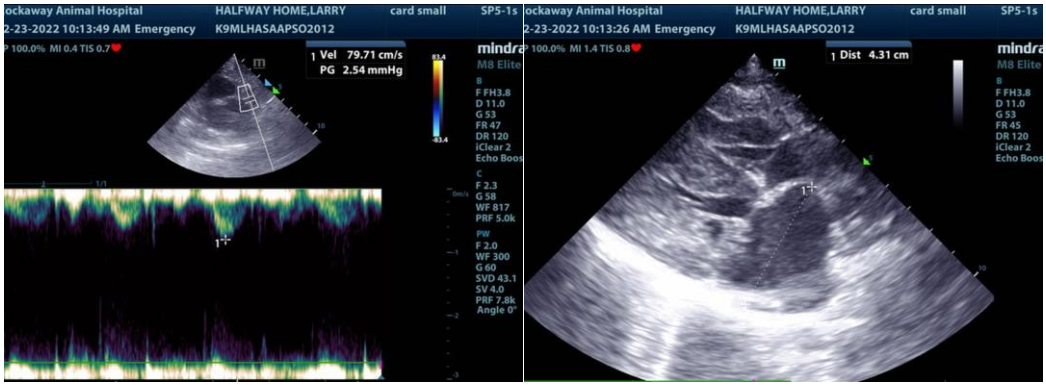

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
Eric.Lindquist@SonoPath.com