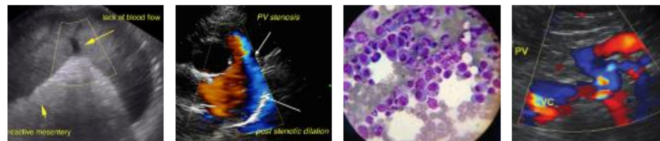
SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Simone Gillman

SPECIES

Canine

BREED

Chihuahua

SEX

Spayed Female

AGE

11 Years

WEIGHT

6.3 Pounds

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Diane McFadden

HOSPITAL NAME

Wantage AH

REFERRING VET

Dr. Bullock

INVOICE

16668

DATE

8/2/22

PRESENTING CLINICAL SIGNS

History: coughing; 5/6 systolic murmur, lethargic. Rads show VHS 11.5 with tracheal elevation and sternal contact

Abnormal PE/Chem/CBC/UA Results: cbc/chem nsf; UA: small amount of blood, USPG 1.044

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

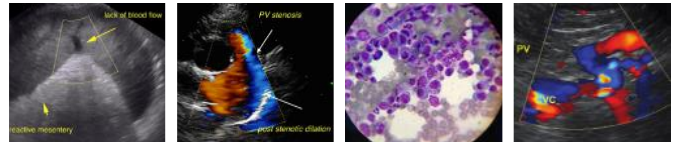
CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (Boon method)	LA/AO (Heart Base; Swe)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	<1.3	28-40	40-100	<0.6
PATIENT	5.09	3.9	1.7	>2.3	52	85	0.12
CANINE CARDIAC PARAMETERS	**HR** (BPM)	**AV VMAX** (m/s)	**PV MAX** (m/s)	**BODY WEIGHT** (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	210	1.30	1.08	--	2.7	2.5	--

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. Prolapse of the anterior mitral valve leaflet noted. 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. . The **right ventricle** was of normal size (1/3 diameter LV), chordae structure, myocardial echogenicity and thickness. Moderate tricuspid insufficiency was noted. **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. B-lines were noted in the peripheral lung field. The hepatic veins were not dilated.

ULTRASONOGRAPHIC FINDINGS

- Mitral valve prolapse
- Advanced stage C-1 valvular disease, given the tachycardia



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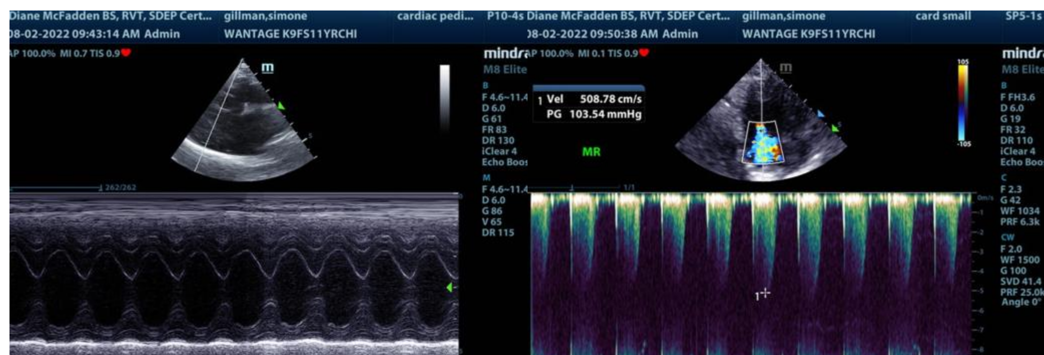
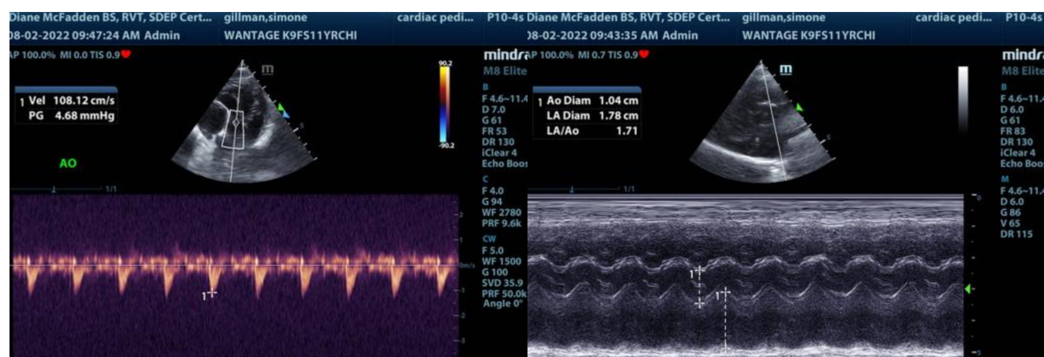
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Radiographic assessment for early pulmonary edema is warranted. I recommend triple therapy in this patient, as I feel this patient is in C-1 valvular disease with the cough, main stem bronchus elevation, tracheal elevation and generalized cardiomegaly. I recommend Pimobendan at 0.3 mg/kg BID, Ace-inhibitor at 0.5 mg/kg SID (progressing to BID), Spironolactone at 1-2 mg/kg BID and Lasix at 2 mg/kg BID. Sleeping respiratory rate should be monitored. SRR should be <25 p/m. Hycodan may be utilized for cough.

The heart is in a somewhat precarious state with volume overload and a heart that 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 7-10 days. 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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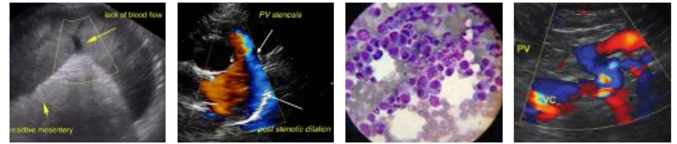

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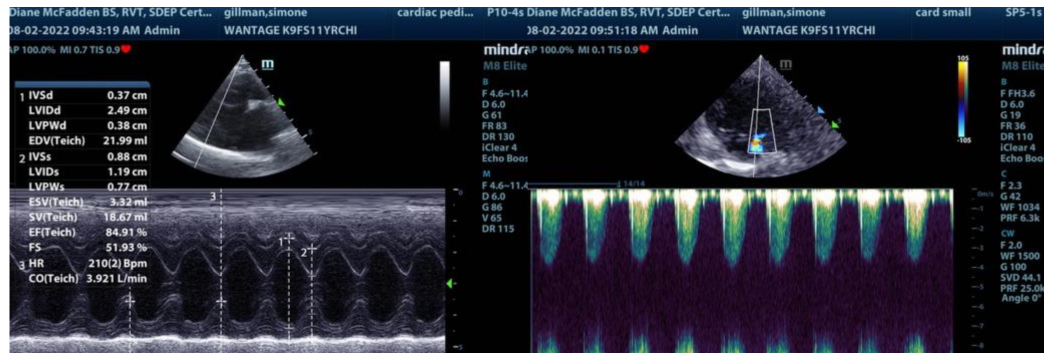

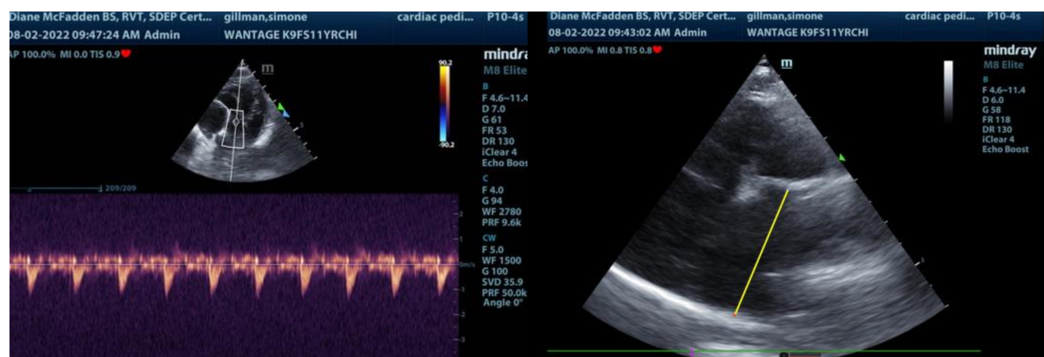

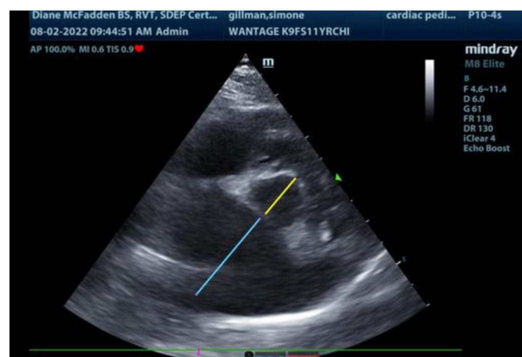

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@SonoPath.com