



PATIENT PRESENTING CLINICAL SIGNS

Russel Taylor

Seen on 12/7/21 for oral mass, working up for surgical removal. No murmur or respiratory abnormalities on PE or associated clinical concerns from client. Presurgical ECG showed multiple abnormalities, thoracic radiographs taken and also show abnormalities. Has been on grain free diet long term. Heart Rate and Respiratory Rates HR - 110, 100 BPM. RR 28 and 30 Blood Pressure Measurements 144/76/96

SPECIES

Canine

Abnormal PE/Chem/CBC/UA Results: Is this a Pre-operative / pre-anesthetic ECG?: Yes Was the patient in right lateral recumbency for this ECG?: Yes Was this patient ausculted by a veterinarian prior to the ECG today?: Yes Was an arrhythmia noted on physical exam?: No Heart Murmur: None Is a gallop rhythm present?: No Is patient on an anti-arrhythmic (Sotalol, Atenolol, Diltiazem or Digoxin)?: No Was atropine or glycopyrrolate administered prior to this ECG?: No Was the patient sedated prior to this ECG?: Yes Anxiety/nervousness of this patient during this ECG transmission: Average Anxiety Was an alpha-2 agonist (Domitor or Xylazine) given prior to this ECG?: Yes HEART RATE AND RHYTHM: Heart Rate: 81 bpm Rhythm: Sinus ECG AND CLINICAL ASSESSMENT: The R wave amplitude is increased; this may suggest ventricular enlargement but can also be identified as a normal patient variant. Left axis deviation is noted. This could represent normal patient variation or indicate left heart enlargement.

BREED

Schnauzer

DIAGNOSTIC RECOMMENDATIONS: Multiple ECG criteria for structural heart disease are identified. Thoracic radiographs and echocardiography (if available) are recommended to evaluate cardiac size and determine if the ECG changes are secondary to cardiac enlargement or represent a benign variant of normal. OVERALL RECOMMENDATIONS: Without further workup, recommend avoiding alpha-2 agonists, ketamine, or Telazol in the anesthetic protocol. Consider premedication with an opioid/benzodiazepine and induction with propofol, etomidate, or alfaxalone (preferred, if available) Full BW WNL Thoracic radiograph findings : Three view thoracic radiographs: 3 images dated January 3, 2022 No prior imaging is listed for comparison. The cardiac silhouette measures large according to the VHS, 11.3. There is no evidence of specific chamber enlargement. The pulmonary vessels, structure of the lung, mediastinum and pleural space are unremarkable. There are no abnormalities visible within the portion of the abdomen included. There are no orthopedic abnormalities. Assessment: Enlarged cardiac silhouette without specific chamber enlargement, this could be related to DCM especially in a patient who is on a grain free diet. Consider follow-up with cardiology consult prior to any anesthetic event for baseline assessment

SEX

Neutered male

AGE

8 years

WEIGHT

18.4 lbs

INTERPRETED BY

Eric Lindquist, DMV, DABVP, Cert. IVUSS

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

IMAGING PERFORMED BY

Jenna Walsh, CVT

The echocardiogram in this patient demonstrated normal **left atrial** size based on 3 separate methods of LA evaluation. **Mitral** valve insufficiency was noted. Mitral insufficiency was centralized and minor. 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. Minor **tricuspid** insufficiency was noted and measured 1.9 m/sec. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. **Pulmonary outflow** 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. The cranial **mediastinum and pericardial and extra-cardiac regions** were free of masses in the visible window.

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Ark AH

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Dr. Jackson

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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	<1.6	28-40	40-100	<0.6
PATIENT	5.0	1.9	1.0	1.3	31	61	NM
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT	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	76	1.16		18.4 lbs	2.5	2.45	

ULTRASONOGRAPHIC FINDINGS

Mitral and tricuspid insufficiency.

Stage B1 valvular disease.

There is no evidence of volume overload.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

From a structural and functional standpoint there is no contraindication to anesthetic procedure.

B1: The heart is stable without clinical disease. No overt contraindication for anesthesia of brief to moderate duration. I suggest Torbutrol premed, Propofol induction, Isoflurane maintenance or similar protocol if anesthesia is desired. Blood pressure recommended if not already performed and target white coat negative systolic pressure of < 160 mmHg. If higher than this ACE-inhibitor is suggested to reach this level. Recheck echocardiogram is recommended in 6 months, earlier if murmur grade increases or clinical signs initiate.



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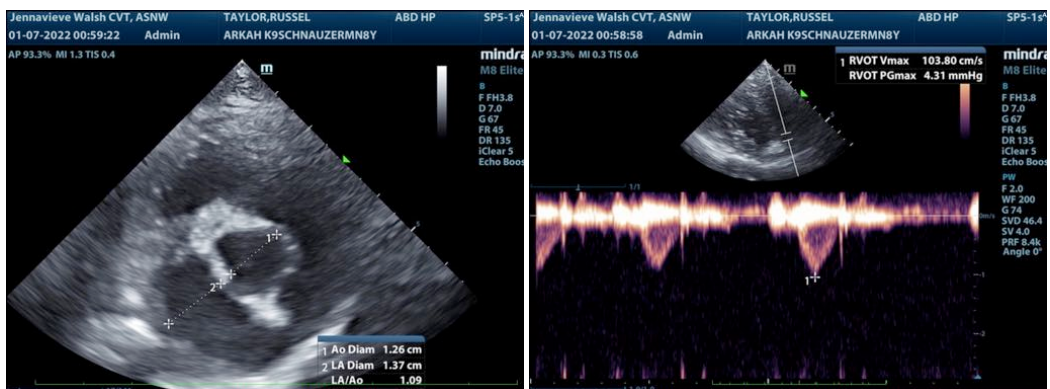
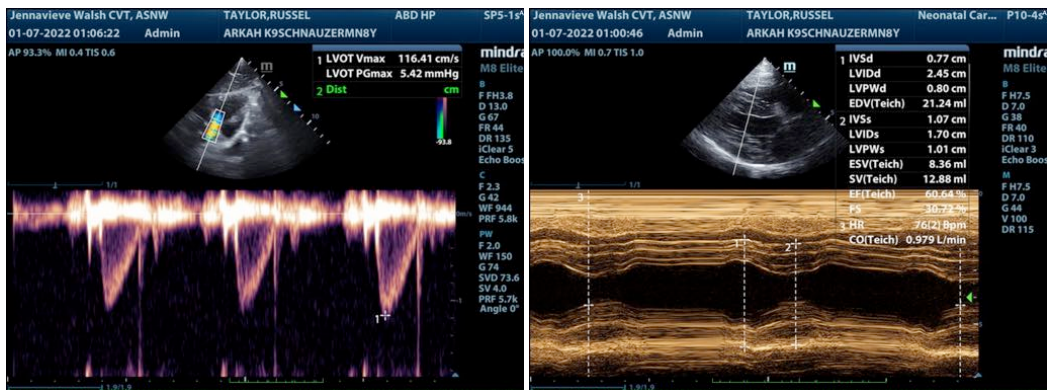
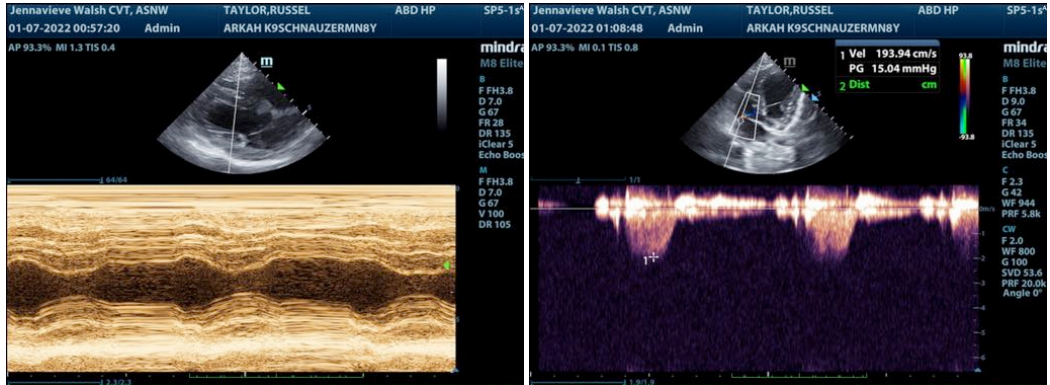
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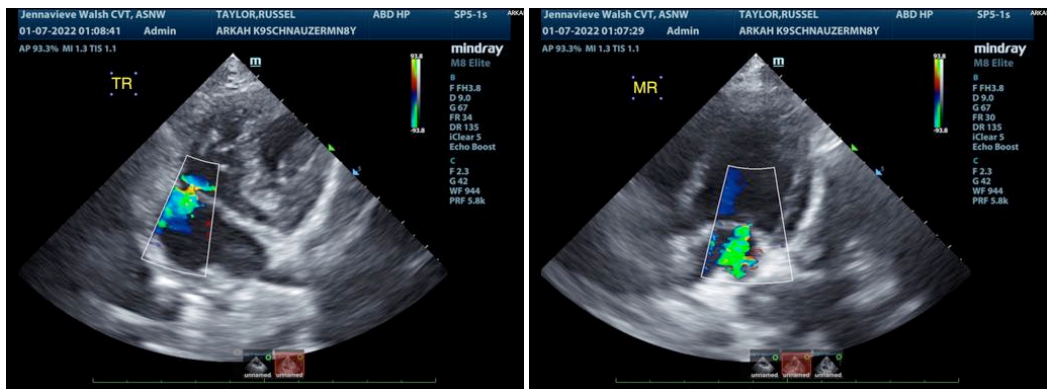
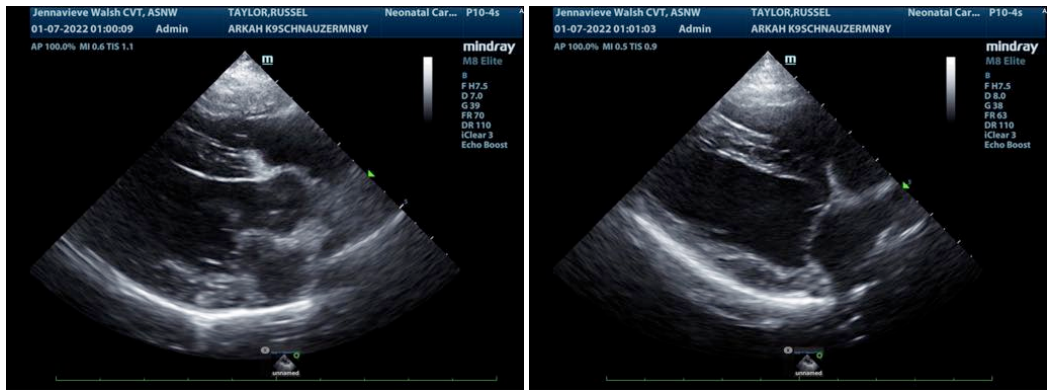
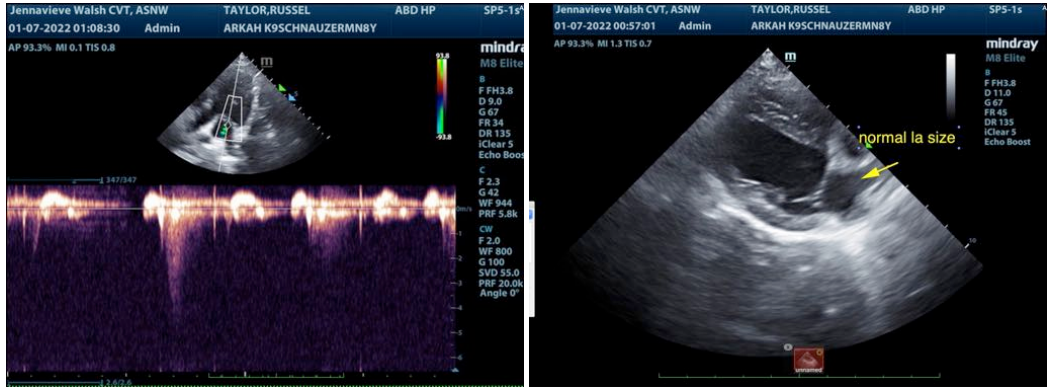
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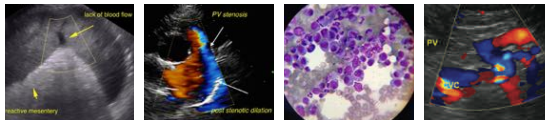


The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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



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Eric.Lindquist@SonoPath.com

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