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Clinical Sonography & Telecytology
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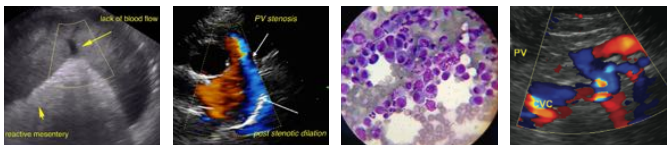

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Ruby Pellicani

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Spayed female

AGE

13 years

WEIGHT

11 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

Andover AH

REFERRING VET

Dr. Vanderbogart

INVOICE

32282

DATE

8/10/22

PRESENTING CLINICAL SIGNS

Grade III/VI L apical systolic heart murmur. P has coughed for years but recently cough worsened, tracheal sensitivity on palpation, slight tracheal dorsal deviation on rad.
Alt 260 (118H), Alp 216 (131H), Chol 364(329H), Trig 3089(291H), T4 <0.5 (0.8-3.5)

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

The echocardiogram in this patient demonstrated enlarged **left atrial** size based on LA max measurement. 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** was slightly enlarged likely owing to increased pulmonic pressures. No evidence of masses was noted or chamber overload. **Tricuspid** insufficiency was noted. 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. The hepatic veins were not dilated.

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	5.04	3.0	1.46	1.47	34	66	0.29
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	BELOW	BELOW	BELOW	BELOW
PATIENT	155		1.5	11 lbs	3.12 max	2.7	

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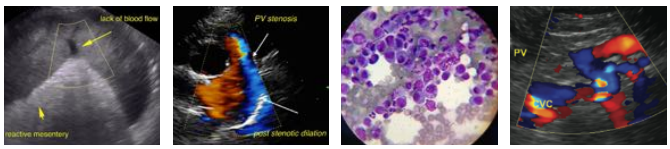

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ULTRASONOGRAPHIC FINDINGS

Mitral and tricuspid insufficiency.

Slight LA enlargement on LA max view.

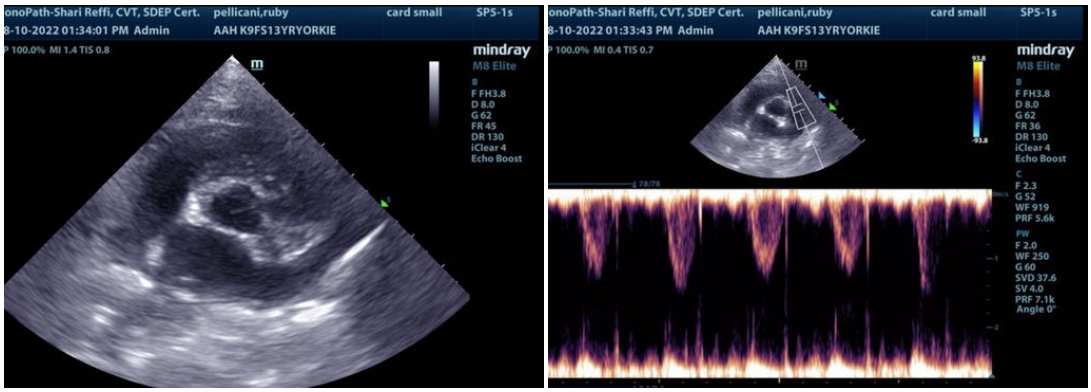
Mild cor pulmonale presentation.

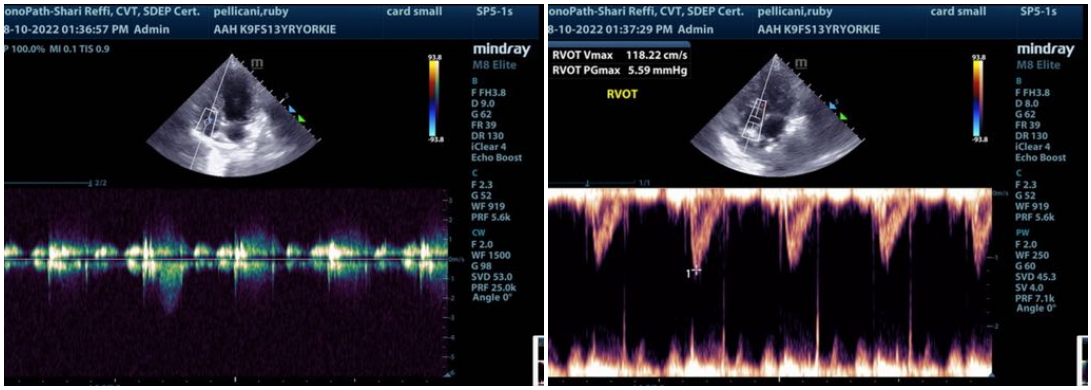
Early B2 valvular disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Primary respiratory cough is likely the underlying cause in this patient as the left atrial size is only slightly abnormal and not of typical size to cause a cardiac base cough. However, Pimobendan can be justified at 0.3 mg/kg b.i.d. if vertebral heart score is excessive. Primary respiratory protocol is warranted such as bronchodilator, antibiotic, and low-dose, non-injectable cortisone

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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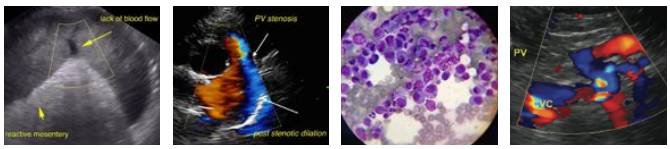

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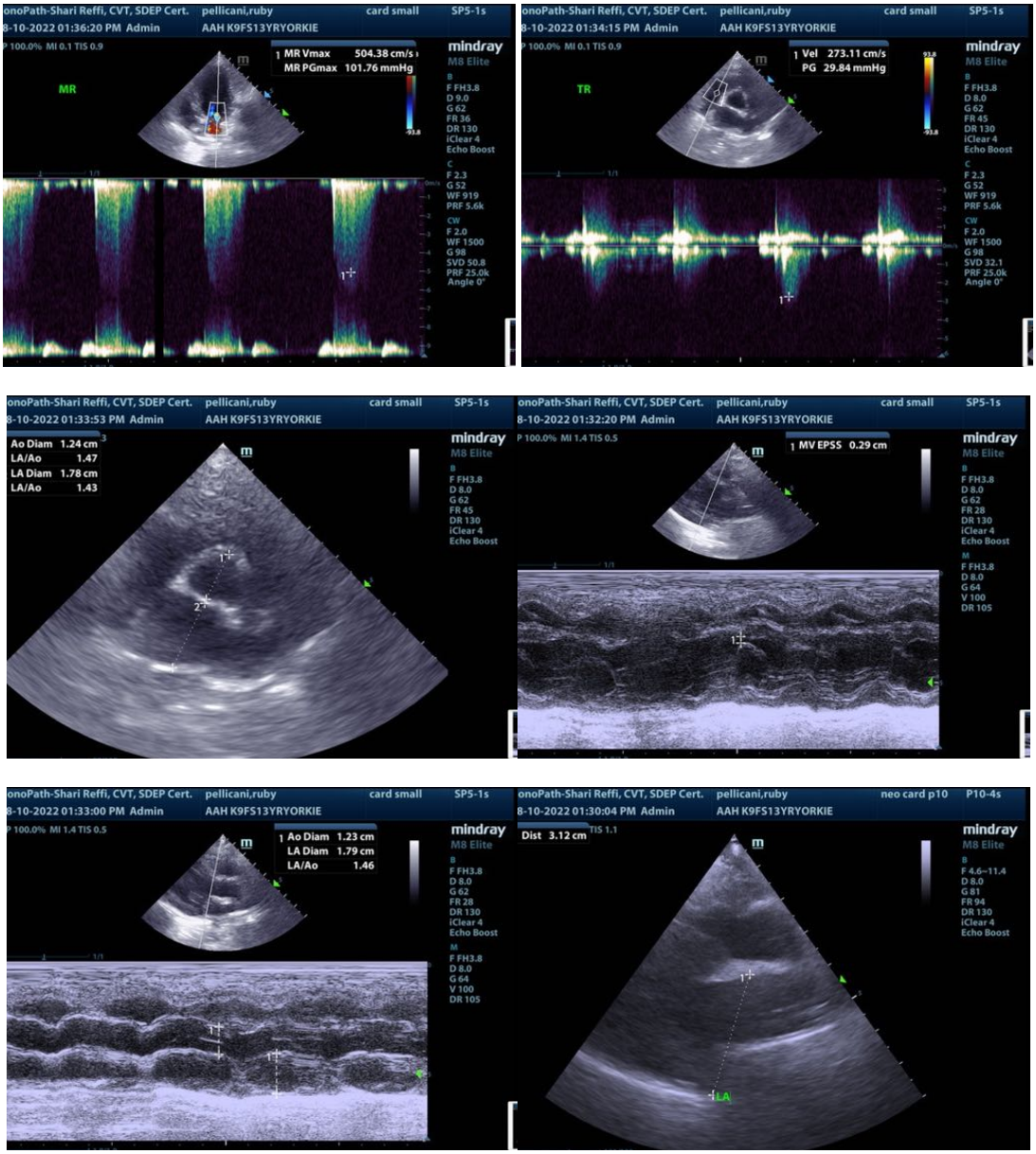

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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