

**PATIENT**

Leia Durkot

**SPECIES**

Canine

**BREED**

Toy Poodle

**SEX**

Spayed Female

**AGE**

14 Years

**WEIGHT**

4.95 kg

**INTERPRETED BY**

James Wood, DVM,  
 DACVIM (Cardiology)

**IMAGING PERFORMED BY**

Crystal Hill

**HOSPITAL NAME**

East Credit VH

**REFERRING VET**

Dr. Webster

**INVOICE**

37206

**DATE**

5/25/26

**PRESENTING CLINICAL SIGNS**

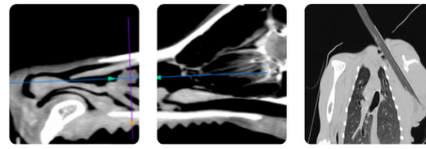
History: Previous Echo Jan 26, see attached. Episode of collapse May 21st where Leia fell to her side, started vocalizing and paddling though did not lose consciousness. Owner picked her up and took her outside where she promptly walked and positioned and passed a very large BM, urinated normally 2X then seemed slightly quieter but otherwise normal and normal since. BP is WNL. Has been on Enalapril 5mg - 1/2 tab BID, Vetmedin 1.25mg BID, Spironolactone 25mg - 1/4 tab BID, Zentonil Advanced, Omega Fatty Acids, Nexgard Spectra and Hydrocortisone into both ears every 1-2 weeks. Abnormal PE/Chem/CBC/UA Results: Please see attached previous echo report, blood results and attached current ECG.

**ULTRASONOGRAPHIC EXAMINATION OF THE HEART**

<b>CANINE CARDIAC PARAMETERS</b>	<b>LA long axis</b>	<b>LAmxN</b>	<b>Ao long axis</b>	<b>LA/AO (Heart Base; Swe, short axis)</b>	<b>LA/AO long axis</b>	<b>LVIDd</b>	<b>LVIDdN</b>
<b>NORMAL PARAMETER</b>		<1.57		<1.6	<2.5		<1.7
<b>PATIENT</b>	3.77	2.3	--	2.38	--	3.31	2.0
<b>CARDIAC PARAMETERS</b>	<b>Body Weight (kg)</b>	<b>AV VMAX (m/s)</b>	<b>PV MAX (m/s)</b>	<b>MR VMAX (m/s)</b>	<b>TR VMAX (m/s)</b>	<b>FS (%)</b>	<b>LVIDsN</b>
<b>NORMAL PARAMETER</b>		0.7-1.7	0.7-1.6			22 - 49%	<0.9
<b>PATIENT</b>	4.9	2.4	1.43	6.07	3.7	70	0.53
<b>CARDIAC PARAMETERS</b>	<b>HR (bpm)</b>	<b>MV E (m/s)</b>	<b>MV A (m/s)</b>	<b>MV E/A (m/s)</b>	<b>EF (%)</b>	<b>IVSdN</b>	<b>LVFWdN</b>
<b>NORMAL PARAMETER</b>						<0.6	<0.6
<b>PATIENT</b>	125	1.6	1.18	1.38	95.5	0.5	0.5

**ECG Interpretation**

A six lead ECG showed an underlying sinus arrhythmia. The average heart rate is 114bpm. There was a single APC observed (saved in images below). No SVT, ventricular ectopy, AV block or evidence of sinus node dysfunction is present on the provided strips. If an arrhythmic cause of the episodes is suspected, a holter monitor should be considered to provide rhythm-symptom correlation.



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**Cardiac Presentation**

The mitral valve leaflets are moderately thickened with mild eccentric and posteriorly directed mitral valve insufficiency. There is severe anterior leaflet prolapse with a suspected chordae tendineae rupture. The left atrium is severely enlarged; this is mildly progressive. The left ventricle is severely enlarged; this is mildly progressive to the prior echo. Normal global left ventricular systolic function. There is normal right atrial size. The tricuspid regurgitant velocities suggest an elevated RV systolic pressure. There is no prolapse of the tricuspid valve leaflets. The right ventricle subjectively appears normal in structure and function. The aortic and pulmonary valves have normal appearance and motion. The pulmonic corresponding outflow velocity is within normal limits. The transaortic flow velocity is mildly increased. There is no evidence of pulmonary or aortic valve insufficiency. The aorta appears normal. The pulmonary artery and associated branches appear normal with normal distensibility. There is no evidence of pleural effusion, pericardial effusion, or intracardiac masses.

**ULTRASONOGRAPHIC FINDINGS**

- Atrial ectopy - single APC on ECG
- Myxomatous mitral valve, ACVIM stage B2 (severe left atrial and left ventricular enlargement)
- Suspected chordae tendineae rupture
- Pulmonary hypertension – mild to moderate (suspect post-capillary)
- Syncopal episode- open

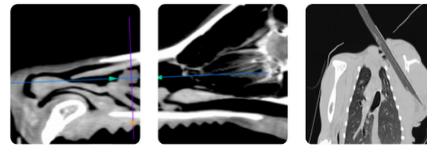
**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The echocardiogram shows mildly progressive and severe myxomatous mitral valve disease with severe left-sided chamber enlargement. The new finding is a suspected chordae tendineae rupture, which might explain the reported episode of syncope. Thoracic radiographs are recommended, particularly if there are any respiratory symptoms that are new or progressive to screen for the development of congestive heart failure. Otherwise, continue pimobendan, enalapril, and spironolactone. The pimobendan dose may be increased slightly given the severity of chamber enlargement. Give 1 1/4 of the 1.25 mg tablets twice daily. Other doses, no change recommended.

The pulmonary hypertension appears mild to moderate, but given the severity of left heart enlargement, no specific treatment for the pulmonary hypertension is recommended, as this is due in large part to post capillary causes. If the syncopal episodes persist or progress, consider a holter monitor and recheck echocardiogram to determine if an intermittent arrhythmia or progression of the pulmonary hypertension are possible causes.

**Monitoring**

It is very important to catch any clinical signs concerning for emerging CHF as early as possible. The client should be closely monitoring and ideally tracking the sleeping respiratory rate. The sleeping RR should be between 10-30 breaths per minute or less (ideally in the teens or low 20s). **If the resting RR is trending upward**, consistently >35/min while resting/sleeping AND/OR there is a new or progressive cough, the patient should be seen urgent for evaluation to determine if CHF is developing. \*RECHECK ASAP for thoracic radiographs if there is a new cough or increase in RR to



**PATIENT** detect early CHF and avoid ER presentation\*\*

Leia Durkot **Sodium Restriction**

**SPECIES** Moderate sodium restriction may be beneficial in managing this stage of cardiac disease. High-salt treats or diets should be avoided. If interested, further information on moderate sodium restricted diets for dogs with advanced cardiac disease can be found at:

**BREED** <https://heartsmart.vet.tufts.edu/nutrition/>.

Toy Poodle **Anesthesia**

**SEX** There is a severely increased risk to anesthesia given the underlying cardiac disease. Anesthesia should only be pursued for medically necessary procedures with client understanding of the risks.

Spayed Female

**AGE** On top of the increased intraoperative risks (hypotension, hypoventilation, hypothermia) with cardiac disease, there is an increased risk of precipitating CHF. With this understanding, anesthesia can be pursued pending normal labwork, with appropriate precautions for strictly necessary procedures.

14 Years

**WEIGHT** Baseline thoracic radiographs are recommended within 1-2 months of anesthesia, not only to rule out CHF, but to serve as a baseline for comparison if a new cough or other respiratory signs develop after anesthesia. Pimobendan can be given three times daily for 2-3 days prior to and following anesthesia to support cardiac function. The morning dose of any ACEi should be skipped the day of anesthesia.

4.95 kg

**INTERPRETED BY** Recommendations for pre-operative sedation include an opiate (such as butorphanol) combined with a benzodiazepine (such as midazolam or diazepam). It is recommended to avoid alpha 2 agonists, as these agents can cause vasoconstriction and worsen MR, exacerbating left atrial hypertension. These effects persist for hours even after reversal. Etomidate or alfaxalone are preferred induction agents. Propofol can be considered for induction; however, is less preferred to alfaxalone or etomidate. Ketamine should ideally be avoided. Atropine should be used as needed for blood pressure support when bradycardia is present during periods of hypotension.

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**HOSPITAL NAME** Full cardiac precautions should be taken with regards to monitoring (ideally CO2, SpO2, ECG, and BP monitoring) and judicious IV fluid administration (avoid volume overload or underload/hypotension – 1-2 mL/kg/hr surgical fluid rate is recommended). All other methods of blood pressure support should be utilized **instead of fluid boluses** (i.e. reduce inhalant/use MAC reducing agents, consider anticholinergics if bradycardia + hypotension), and the use of parenteral inotropes should be considered (i.e. dobutamine or dopamine).

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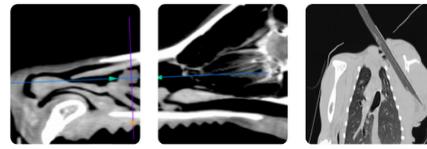
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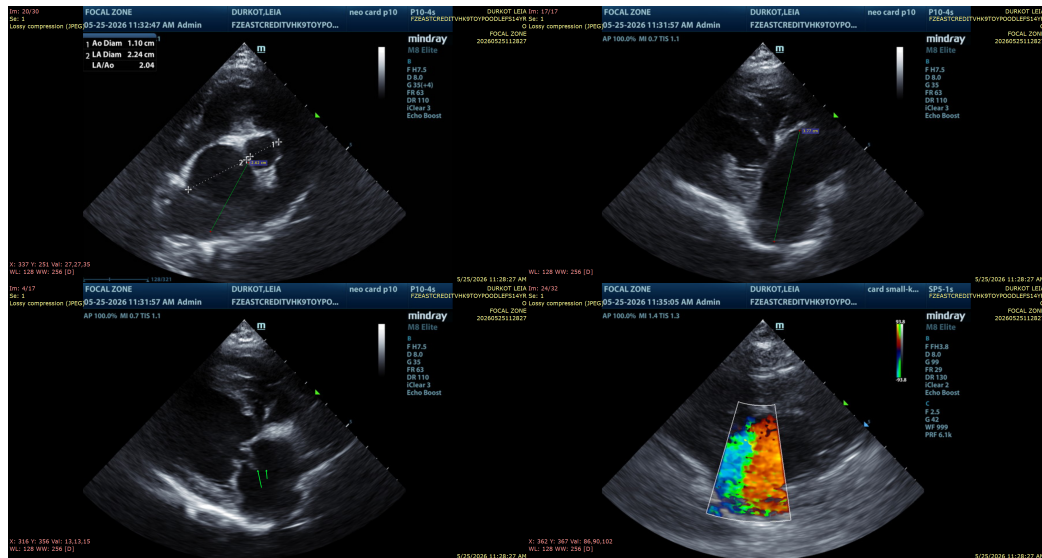
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

James Wood, DVM, DACVIM (Cardiology)

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