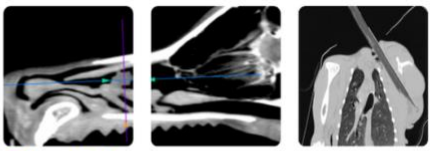


PATIENT

Saylor Keeley

SPECIES

Canine

BREED

Cane Corso X

SEX

Intact Female

AGE

9 Months

WEIGHT

22 kg

INTERPRETED BY

James Wood, DVM, DACVIM (Cardiology)

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

New Hamburg VC

REFERRING VET

Dr. Von Hausen

INVOICE

37229

DATE

5/27/26

PRESENTING CLINICAL SIGNS

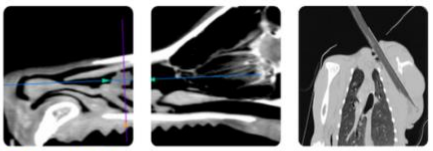
History: PE WNL except grade 4 heart murmur 1st identified 04/23/2026. PMI Previously noted as L base but readily audible on both sides of chest. 4dx negative. No concerns on history, normal activity levels, no changes with breathing or coughing observed. Current Medications: GABA / traz and torb for scan only.

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

CANINE CARDIAC PARAMETERS	LA long axis	LAmaxN	Ao long axis	LA/AO (Heart Base; Swe, short axis)	LA/AO long axis	LVIDd	LVIDdN
NORMAL PARAMETER		<1.57		<1.6	<2.5		<1.7
PATIENT	2.44	0.94	1.48	1.54	1.65	3.01	1.13
CARDIAC PARAMETERS	**Body Weight (kg)**	**AV VMAX (m/s)**	**PV MAX (m/s)**	**MR VMAX (m/s)**	**TR VMAX (m/s)**	**FS (%)**	**LVIDsN**
NORMAL PARAMETER		0.7-1.7	0.7-1.6			22 - 49%	<0.9
PATIENT	22	2.5	4.95	--	--	47.5	0.47
CARDIAC PARAMETERS	**HR (bpm)**	**MV E (m/s)**	**MV A (m/s)**	**MV E/A (m/s)**	**EF (%)**	**IVSdN**	**LVFWdN**
NORMAL PARAMETER						<0.6	<0.6
PATIENT	116	--	--	--	76.5	0.5	0.49

Cardiac Presentation

The mitral valve leaflets are normal and there is no mitral regurgitation. Leaflet prolapse is not identified. The left atrial size is normal. Left ventricular systolic and diastolic function is within normal limits. The left ventricular outflow tract and aortic valve morphologies are incompletely visualized on this study. The transaortic flow velocity is mild increased. The aortic valve is competent. The right atrium is normal in size. There is trace central tricuspid valve insufficiency. The estimated RV systolic pressure is severely elevated. There is severe right ventricular wall thickening with systolic flattening of the interventricular septum, consistent with an RV pressure overload. The pulmonary valve leaflets are also not well visualized, however, suspected to be mildly thickened with some commissural fusion and systolic doming. There is a severe RVOT obstruction at the level of the valve based on CW



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doppler with a maximum instantaneous pressure gradient of ~98mmHg. There is moderate to severe pulmonary valve insufficiency. The pulmonary trunk and proximal PA branches are mildly dilated. The pulmonary trunk and proximal branch PAs are not completely visualized. And as such, shunting lesions such as a PDA cannot be fully excluded.

ULTRASONOGRAPHIC FINDINGS

- Pulmonary valve stenosis (severe), pressure gradient 98mmHg- moderate to severe pulmonary valve insufficiency.
- Equivocal subaortic stenosis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Saylor has severe pulmonary valve stenosis with severe RV concentric hypertrophy, but normal RA size. Patients with severe PS generally have a reduced lifespan with anticipated survival times of ~4-6 years with medical management on a beta blocker. Outcomes include progressive right atrial enlargement culminating in right sided CHF, clinical signs of exercise intolerance/syncope and arrhythmias, with sudden death being a possible outcome of ventricular arrhythmias. Intervention with a balloon valvuloplasty is generally recommended in these patients to prolong survival.

Atenolol should be considered for this patient, starting at ~0.5mg/kg q12, titrating up to a target dose of 1mg/kg PO q12hr.

Referral to a cardiologist for consultation regarding balloon valvuloplasty is recommended. If this is not pursued, a recheck echocardiogram at approximately 1 year of age is recommended to evaluate the right heart remodeling and response to beta blockade. Monitor for abdominal distention, difficulty breathing, lethargy, exercise intolerance, or syncope. Recheck immediately if any concerns arise. Anesthesia would optimally be delayed until ballon valvuloplasty is performed.

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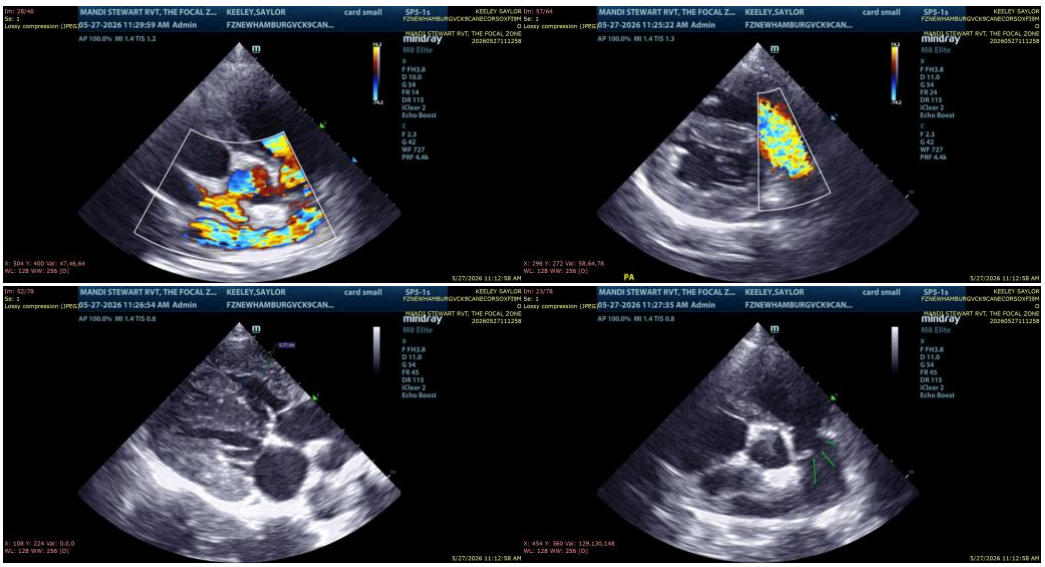

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@SonoPath.com