



**PATIENT**

Aska Harrison

**SPECIES**

Canine

**BREED**

Icelandic Sheepdog

**SEX**

Spayed Female

**AGE**

8 Years

**WEIGHT**

14 kg

**INTERPRETED BY**

James Wood, DVM,  
DACVIM (Cardiology)

**IMAGING PERFORMED BY**

Dr. Iacovides

**HOSPITAL NAME**

Tuxedo AH

**REFERRING VET**

Dr. Fredette

**INVOICE**

37293

**DATE**

6/2/26

**PRESENTING CLINICAL SIGNS**

History: Started having occasional "old lady cough" inconsistently ~2 weeks ago, seems to be increasing in frequency from 1 episode per week to at most 1-2 short self-limiting episodes per day where she coughs 3-5 times then stops. Is a dry, short cough, not a hacking cough. No exercise intolerance noted. RRR not yet completed.

Abnormal PE/Chem/CBC/UA Results: BCS 6/9 Radiographs attached. VHS = 10.9

**ULTRASONOGRAPHIC EXAMINATION OF THE HEART**

CANINE CARDIAC PARAMETERS	LA long axis	LAmxN	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	3.44	1.53	1.2	1.69	2.8	3.6	1.56
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	14	1.38	0.82	5.12	2.3	30.6	0.89
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	78	--	--	--	--	0.28	0.31

**Radiographic Interpretation**

Three view thoracic radiographs are reviewed. The cardiac silhouette is normal on lateral projections. An equivocal right-sided enlargement pattern is present on the DV projection. This is not corroborated on the echocardiogram. The pulmonary vasculature is within normal limits. There's a mild diffuse broncho-interstitial pulmonary pattern. An age-related change versus lower airway inflammatory disease are differentials.

**Cardiac Presentation**



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The mitral valve leaflets are mildly thickened with mild central mitral valve insufficiency. There is no prolapse of the mitral valve leaflets. The left atrium is equivocally dilated. Left ventricular internal dimensions during diastole are within normal limits and the global left ventricular systolic function is normal. There is normal right atrial size with trace tricuspid regurgitation. There is no prolapse of the tricuspid valve leaflets and no evidence of pulmonary hypertension based upon tricuspid regurgitant velocities. The right ventricle subjectively appears normal in structure and function. The aortic and pulmonary valves have normal appearance and motion, and the corresponding outflow velocities are within normal limits. There is no evidence of pulmonary or aortic valve insufficiency. The aorta appears normal. The pulmonary artery and associated branches appear normal. There is no evidence of pleural effusion, pericardial effusion, or intracardiac masses.

## ULTRASONOGRAPHIC FINDINGS

- Myxomatous mitral valve disease- ACVIM stage B1 (equivocal LA enlargement, normal LV)
- Chronic cough- suspect noncardiogenic

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The echocardiogram showed evidence of myxomatous mitral valve disease. Based on this echocardiogram, the left atrial and left ventricular chamber sizes do not meet the criteria for the initiation of pimobendan. No medications are recommended at this time. The overall risk of adverse cardiovascular outcomes is considered very low in the near future. This is, however, a progressive disease, and as such repeat echocardiogram in ~9-12 months is recommended to screen for progression. Recheck sooner if there is a new cough, increase in the resting RR, or other concern for progressive cardiac disease. Recheck for an echocardiogram in 9-12 months or sooner if concerns arise.

Given the lack of significant left-sided chamber remodeling and the mild nature of the mitral regurgitation, congestive heart failure is not suspected to be the cause of the clinical signs supported by the radiographic findings. Treatment of an underlying airway disease is recommended.

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



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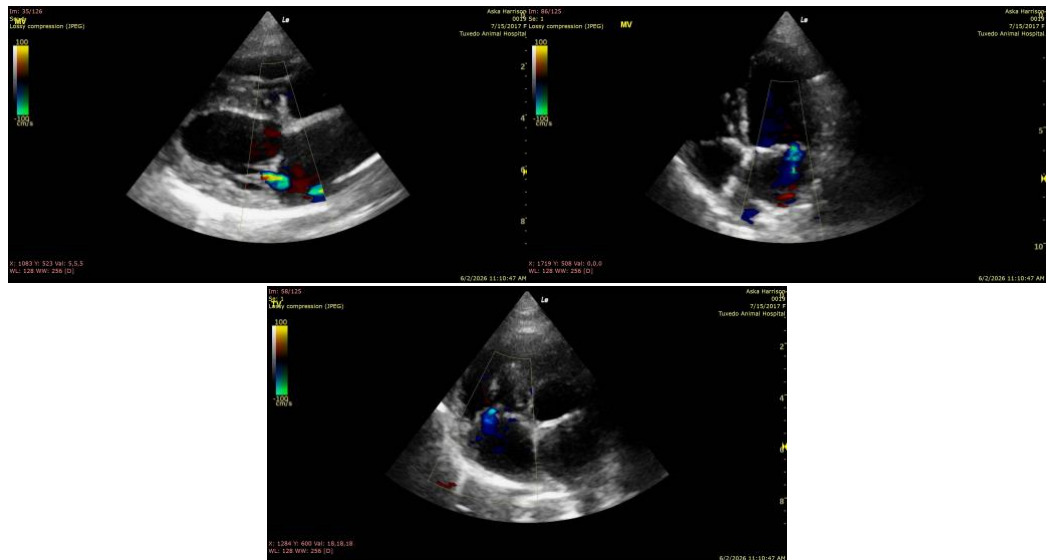
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

[info@SonoPath.com](mailto:info@SonoPath.com)