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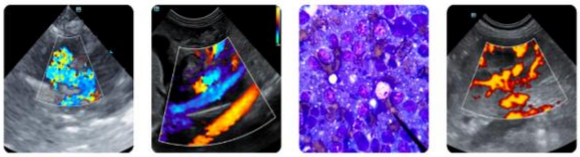

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath
FOSTERING THE ART OF VETERINARY MEDICINE™
SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

Lucy Stafford

SPECIES

Canine

BREED

Mixed Breed

SEX

Spayed Female

AGE

10/2/12

WEIGHT

23.04 kg

INTERPRETED BY

James Wood, DVM, DACVIM (Cardiology)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT, RVT

HOSPITAL NAME

Pinion Veterinary Hospital

REFERRING VET

Dr. Jennifer Jackson

INVOICE

37306

DATE

6/3/26

PRESENTING CLINICAL SIGNS

History: 3/6 heart murmur. Vet Medin (pimobendan) 5 mg - Give 1 1/2 tablets by mouth in am and 1 tablet by mouth in pm. Butorphanol sedation.

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	4.98	1.89	1.72	1.66	2.9	4.89	1.81
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	23.04	1.8	1.15	6.24	2.5	55.8	0.63
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	85	0.95	0.67	1.42	--	0.55	0.55

ECG Interpretation

A six lead ECG is reviewed. The underlying rhythm is a sinus arrhythmia with an average heart rate of 85bpm. There are occasional single ventricular ectopic beats. These occur occasionally at a similar sinus rate and are idioventricular. Others are premature. No couplets, triplets, runs, or other complexity is identified.

Cardiac Presentation

The mitral valve leaflets are moderately thickened with mild eccentric and posteriorly directed mitral valve insufficiency. There is mild anterior leaflet prolapse. The left atrium is mildly dilated. The left ventricle is mildly dilated. Normal global left ventricular systolic function. There is normal right atrial

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size with mild tricuspid regurgitation. There is mild thickening of the septal leaflet of the tricuspid valve with mild prolapse and no evidence of pulmonary hypertension based upon tricuspid regurgitant velocities. The right ventricle subjectively appears normal in structure and function. The aortic valve leaflets are diffusely moderately thickened and there is mild aortic valve insufficiency based on color doppler and subjective pressure half time. The pulmonary valve is normal in appearance with no evidence of pulmonary 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 B2
- Aortic valve insufficiency - r/o endocardiosis
- Degenerative tricuspid valve disease – mild
- Ventricular ectopy

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The echocardiogram showed evidence of degenerative valve disease affecting the mitral, aortic, and tricuspid valves. There is mild to moderate left heart enlargement, and continued therapy with pimobendan is recommended. A slight dose increase to 7.5 mg PO Q12 is reasonable, given the chamber remodeling. There are no reported clinical signs of congestive heart failure, however, baseline thoracic radiographs are reasonable if not performed already.

The aortic valve thickening and insufficiency are most likely secondary to degenerative valve disease, however, given the concurrent ventricular ectopy, if there is a clinical suspicion for endocarditis, this cannot be fully excluded. Full lab work and a troponin should be considered along with blood cultures if this is suspected.

The ventricular ectopy appears infrequent with a lack of significant complexity. No therapy is necessarily recommended based on what is observed here, however, a Holter monitor is strongly recommended for assessment of the arrhythmia burden and to determine if antiarrhythmic therapy is necessary to reduce the risk of sudden death.

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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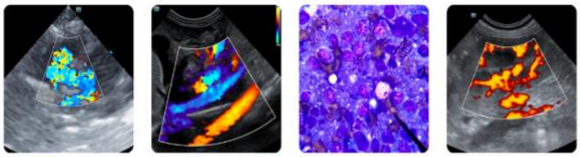

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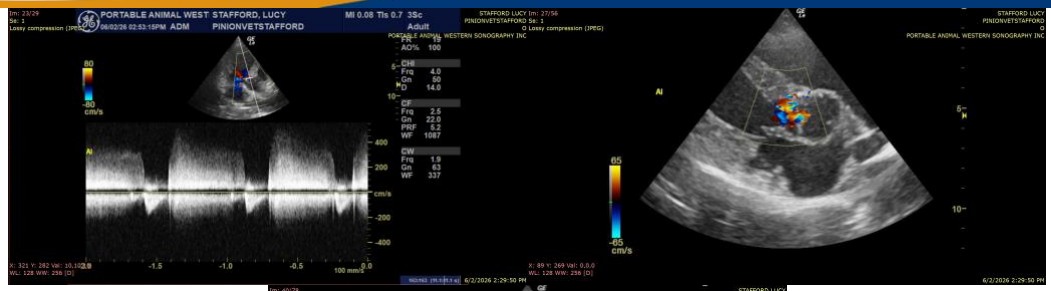

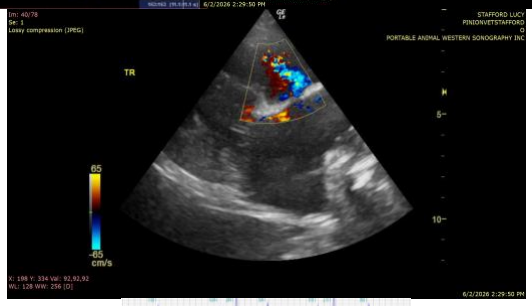

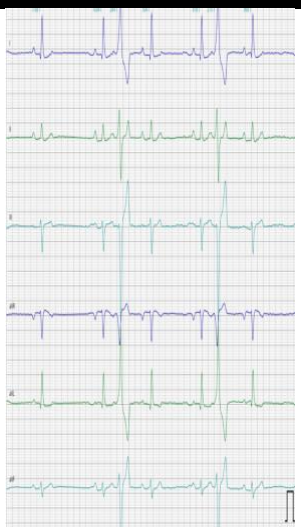

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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