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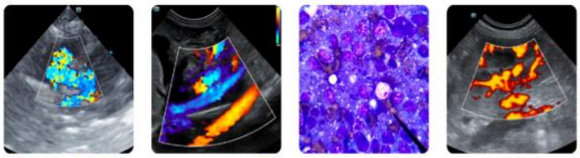

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath
FOSTERING THE ART OF VETERINARY MEDICINE™
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PATIENT

Tango Touch

SPECIES

Canine

BREED

Pitbull

SEX

Spayed Female

AGE

13 Years

WEIGHT

48.6 Pounds

INTERPRETED BY

James Wood, DVM, DACVIM (Cardiology)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT, RVT

HOSPITAL NAME

VCA Baring Blvd Vet

REFERRING VET

Dr. Kimberly Clark

INVOICE

37310

DATE

6/3/26

PRESENTING CLINICAL SIGNS

History: Heart murmur both sides 5/6- DCM, compensated CHF, Diagnosed 1/2025-
MEDS: Vetmedin 5mg BID, Enalapril 10mg SID, Furosemide 50mg BID. Attached prev echo report.

Abnormal PE/Chem/CBC/UA Results: BP- 151 mmHg systolic.

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

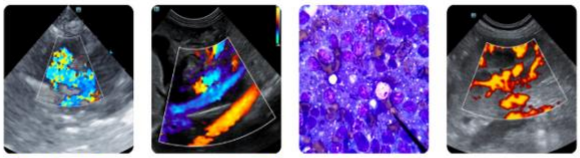
CANINE CARDIAC PARAMETERS	LA long axis	LAmaxN	Ao long axis	LA/AO (Heart Base; Swe, short axis)	LA/AO long axis	LVIDd	LVIDdN
NORMAL PARAMETER		<1.57		<1.6	<2.5		<1.7
PATIENT	4.1	1.58	1.52	1.62	2.7	5.17	1.94
CARDIAC PARAMETERS	**Body Weight (kg)**	**AV VMAX (m/s)**	**PV MAX (m/s)**	**MR VMAX (m/s)**	**TR VMAX (m/s)**	**FS (%)**	**LVIDsN**
NORMAL PARAMETER		0.7-1.7	0.7-1.6			22 - 49%	<0.9
PATIENT	22.1	2.4	1.36	5.35	2.7	23.6	1.17
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	1.20	0.74	0.63	1.17	--	0.48	0.5

ECG Interpretation

A six lead ECG is reviewed. The underlying rhythm is a sinus rhythm with a rate of 120bpm. No supraventricular or ventricular ectopy is identified. No AV block is present. The R-wave amplitude is increased consistent with the pattern of LV enlargement.

Cardiac Presentation

The mitral valve leaflets are mildly thickened with mild eccentric and posteriorly directed mitral valve insufficiency. Leaflet prolapse is not identified. The left atrium is equivocally to mildly dilated. The left ventricle is moderately dilated, and there is mild to moderate left ventricular systolic dysfunction based



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on minor axis fractional shortening and end-systolic chamber dimension. There is normal right atrial size, with mild tricuspid regurgitation. The tricuspid valve leaflets are normal. There is no evidence of clinically significant pulmonary hypertension on this evaluation. Subjectively normal RV systolic function. The aortic valve is normal in thickness with mild aortic valve insufficiency. The pulmonary valve is competent. The transaortic velocity is mildly increased. 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

- DCM phenotype – improved
- MMVD
- Left-sided congestive heart failure - reportedly compensated

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The echocardiogram shows left ventricular systolic dysfunction, evidence of myxomatous mitral valve disease, and mild to moderate left atrial and left ventricular enlargement. Given the previous echocardiogram report, there is suspected to be improvement in the left-sided chamber dimensions. This may reflect chamber size reduction on pimobendan and furosemide, however, if a secondary cause of a dilated cardiomyopathy phenotype, such as nutritionally mediated causes, was adjusted clinically, this may reflect improvement with treatment of any secondary conditions. Regardless, there are no reported clinical signs of decompensated heart failure. Radiographs are recommended every 3-4 months to evaluate for pulmonary edema, along with a renal panel with electrolytes to assess kidney function. These should be performed if not already done. Otherwise, no adjustment to the current medications is recommended. Recheck in 3-4 months. Spironolactone is also typically added at this stage. It was not reported in the history. Spironolactone is recommended at a dose of between 1-3 mg/kg PO once daily.

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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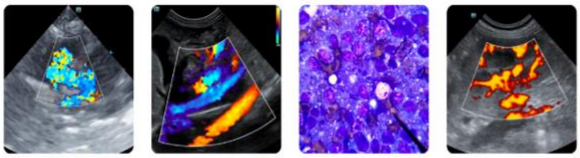

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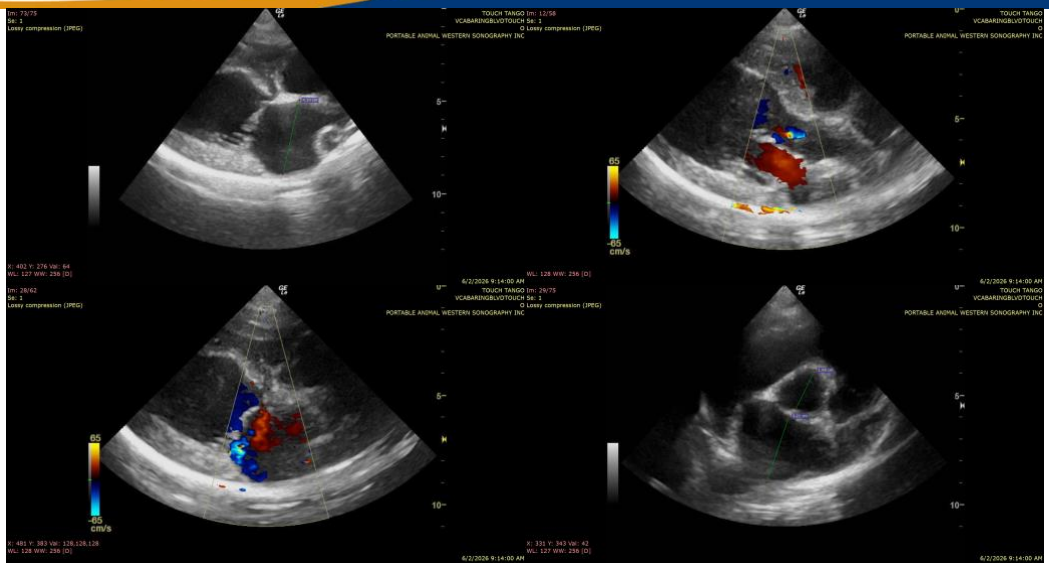

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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