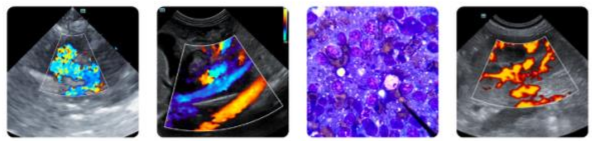

PATIENT

Taco Senior Dog Haven

SPECIES

Canine

BREED

Chihuahua

SEX

Neutered Male

AGE

16 Years 5 Months

WEIGHT

2.27 kg

INTERPRETED BY

Laurent Locquet, DVM, MRCVS, GPCert, (VC) Diplomate, ECVIM-CA (Cardiology)

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

East Bradford VH

REFERRING VET

Meghan McGrath, DVM

INVOICE

35117

DATE

12/29/25

PRESENTING CLINICAL SIGNS

History: Recheck echo in a senior dog with known DVD, Stage B-2, now presenting with suspected syncopal episodes and concern for pulmonary hypertension (vs true seizure). On 12/26, presented for a 3-day history of falling over and shaking, no loss of bowel/bladder, no vomiting. Episodes last about 1 min then dog gets up. Occurs 4-5 times/day. (Foster showed rDVM Videos). PE - HR 124, RR 18, Grade 5-6/6 left apical HM, grade 4/6 right HM, lungs clear on auscultation. Concern for PHT and started on Sildenafil. Meds: Sildenafil 5 mg Q 12 (recent), Pimobendan 1.25 mg BID (Chronic), Midazolam (for poss seizures, PRN).

Abnormal PE/Chem/CBC/UA Results: Doppler BP: 100, 105, 110 mmHg 7/28/25 Prev Echo (Sonopath): DVD, stage B-2, moderate to severe LA enlargement, mild TR without evidence of pulmonary hypertension 12/25 BW: - CBC: Hct 44.7%, mild neutrophilia and lymphopenia, remainder NSF - CHEM: normal LES and renal values, remainder NSF.

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (M-Mode)	LA/AO (Heart Base; Swe)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	Up to 1.6	28-40	40-100	<0.6
PATIENT	5.46	1.16	1.49	1.84	48	83	NM
CANINE CARDIAC PARAMETERS	**HR** (BPM)	**AV VMAX** (m/s)	**PV MAX** (m/s)	**BODY WEIGHT** (kg)	**LAD** LA MAX 4 Chamber	**LVIDd** Avg; 2D and m-mode short axis (cm)	**LVIDs** Avg; 2D and m-mode short axis (cm)
NORMAL PARAMETER	50-100	0.7-1.7	0.7-1.6				
PATIENT	168	1.44	1.62	2.27	2.02	1.15	0.59

Cardiac Presentation

The left atrial size is enlarged based on the LA/AO Swedish method. The mitral valve shows degenerative changes, compatible with myxomatous mitral valve disease and severe mitral valve regurgitation. The left ventricle is within normal limits but is partially compressed by the concentric hypertrophy of the right ventricle. The myocardium presented normal echogenicity without subjective evidence of significant fibrotic or ischemic disease. Contractility of the ventricular walls was adequate and in normal range for this patient, evidenced by the fractional shortening measurement and subjective evaluation of the divergent regions of the myocardium. The left ventricular outflow tract demonstrated normal laminar flow and subjective structural integrity, though there was a suspicion of

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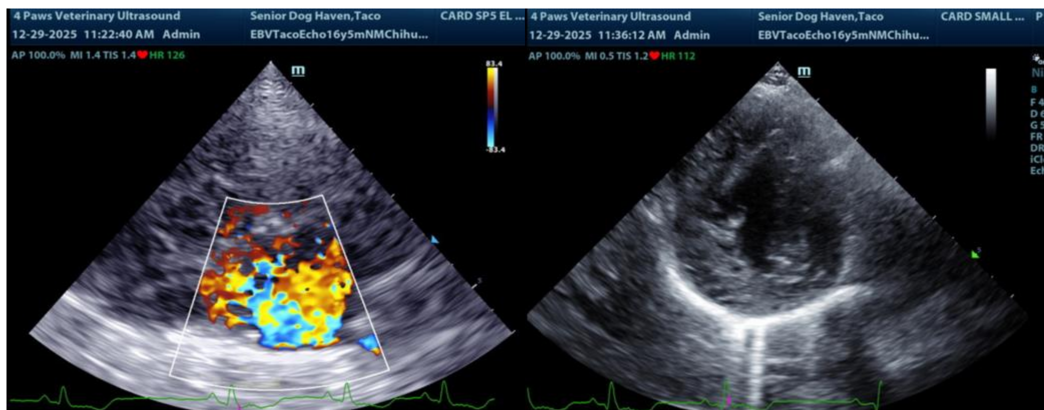
a shunt between the left ventricle and the right atrium. The right atrium and auricle revealed normal size, structure, and content. No evidence of masses or chamber overload was noted. There was mild tricuspid valve regurgitation with myxomatous changes at the level of the tricuspid valve disease, compatible with myxomatous tricuspid valve regurgitation. The right ventricle showed moderate to severe concentric hypertrophy with partial compression of the left ventricle. The pulmonic tract was dilated with severe pulmonic insufficiency. There was no visible pericardial disease or pericardial or pleural effusion, but there were B-lines noted in the lungs. The cranial mediastinum and pericardial regions were free of masses in the visible windows.

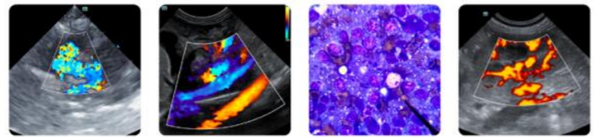
ULTRASONOGRAPHIC FINDINGS

- Myxomatous mitral valve disease with secondary left atrial enlargement
- Concomitant tricuspid valve regurgitation and pulmonic valve regurgitation
- Concentric hypertrophy of the right ventricle with dilation of the pulmonary artery, potentially secondary to pulmonary hypertension
- Suspected shunt (which would be very rare) between the left ventricle and the right atrium, which would be compatible with a Gerbode defect.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I would continue the medication (sildenafil and Vetmedin) unchanged. I would stop the midazolam, for potential seizures, as the complaints are most likely secondary to a cardiogenic cause. Recheck echo in 3 months. In the meantime, I would consider thoracic radiographs and a heartworm test to look for pulmonary causes of pulmonary hypertension.





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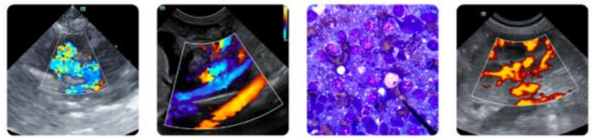
The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Laurent Locquet, DVM MRCVS GPCert (VC) Diplomate ECVIM-CA



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