



PATIENT

Toby Prechitko

SPECIES

Canine

BREED

Miniature Poodle

SEX

Intact Male

AGE

13 years

WEIGHT

9.7 lbs.

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP
(Canine and Feline)

IMAGING PERFORMED BY

Kelly Vazquez

HOSPITAL NAME

Ramapo Valley AH

REFERRING VET

Dr. Katara

INVOICE

15908

DATE

1/24/23

PRESENTING CLINICAL SIGNS

PU/PD, grade 4-5/6 systolic heart murmur; syncopal episodes. No current meds.

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (Boon method)	LA/AO (Heart Base; Swe)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	<1.3	28-40	40-100	<0.6
PATIENT	5.7	<2.0		1.46	36	68	0.18
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT (kg)	LA 2D short axis Base view (cm)	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	113	1.5	1.0		2.6	2.5	

Cardiac Presentation

The echocardiogram in this patient demonstrated mildly enlarged **left atrial** size based on 3 different LA measurement methods. The cranial and caudal **mitral** valve leaflets presented mild to moderate thickening consistent with endocardiosis. Subjective minor septal leaflet prolapse was noted. Doppler indicated measurable moderate eccentric insufficiency. The **left ventricle** presented normal thicknesses with linear contour without evidence of overt or significant increased LV volume. 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 different regions of the myocardium. The **left ventricular outflow** tract demonstrated normal laminar flow and subjective structural integrity. The **right atrium** and auricle revealed normal size, structure and content. No evidence of masses was noted or chamber overload. **Tricuspid** valvular assessment demonstrated adequate linear morphology. Mild TR was present on Doppler. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. **Pulmonic** tract assessment revealed normal valve structure, laminar flow, and diameter (approx. 1:1 pa/ao ratio). No visible **pericardial** or free pleura fluid was noted. No echographically detectable evidence of infiltrative disease was visible. The cranial **mediastinum and pericardial regions** were free of masses in the visible window. No arrhythmia was noted.

ULTRASONOGRAPHIC FINDINGS

- Chronic mitral valve disease (ACVIM mild B2)



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The mild increased LA size indicates that the current and future risk secondary to MR is mildly elevated, yet overall the heart appears to be compensated at this stage. Without overt arrhythmogenic disease and without clinical issues such as significant left or right chamber enlargement, evidence of clinical pulmonary hypertension, or LV systolic dysfunction, the reported syncopal episodes are not obviously cardiogenic in origin.

ECG or a potential Holter monitor could be considered, if continued syncopal episodes, to rule out paroxysmal arrhythmia. Likewise, abdominal ultrasound could be considered to assess for intraabdominal pathology as a contributing factor to the PU/PD and syncopal episodes.

Although no definitive indication for cardiac medications at this stage, Pimobendan 0.3 mg/kg PO BID is suggested as this medication may help prolong cardiac changes associated with MR in light of mild LA enlargement.

Prognosis is highly variable and sonographic monitoring is recommended. Recheck echocardiogram is suggested in 6 months, sooner if progressive syncopal episodes or clinical signs consistent with heart disease are noted.

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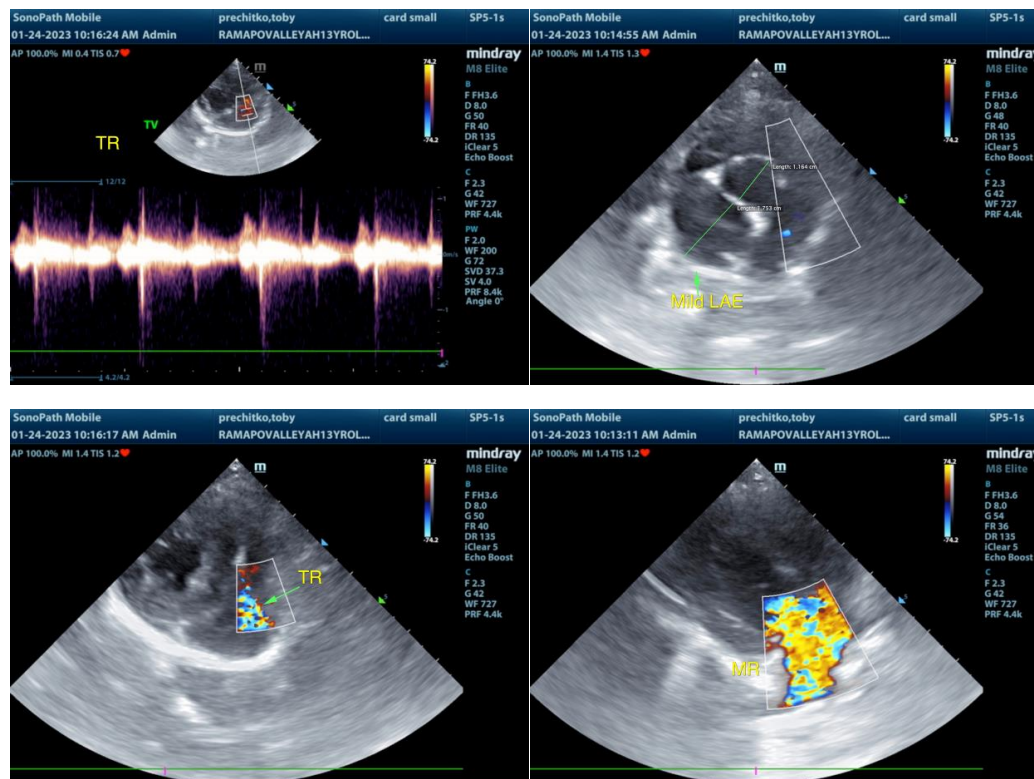
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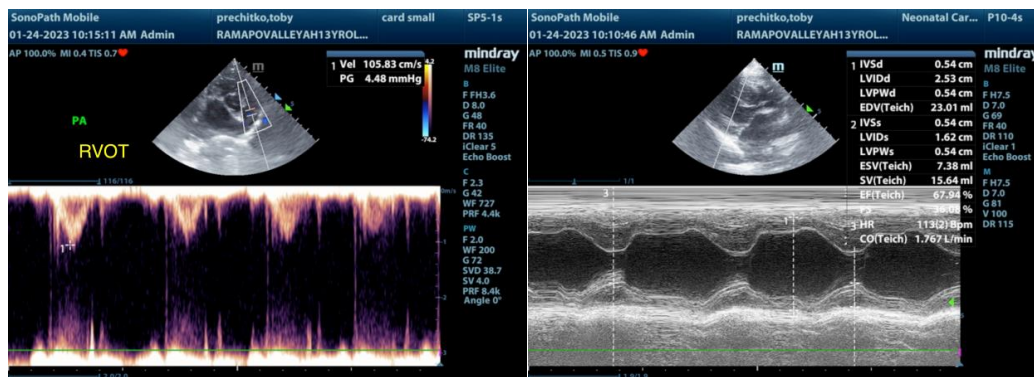
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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