



PATIENT

Mia Schwabe

SPECIES

Canine

BREED

Terr/Mix

SEX

FS

AGE

3 years

WEIGHT

37 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Kim Liedberg

HOSPITAL NAME

SVS Imaging WI

REFERRING VET

Dr. Seneczko,
Genoa AH

INVOICE

12612

DATE

11/15/21

PRESENTING CLINICAL SIGNS

1 Month recheck. DCM due to grain free diet.

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	<1.6	28-40	40-100	<0.6
PATIENT	5.1 m/s	25. m/s	NM	2.4	7.7	24.8	2.2
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	BELOW	BELOW	BELOW	BELOW
PATIENT	134	1.6	1.1		6.0	6.5	

Cardiac Presentation

The echocardiogram for this patient presented severely excessive **left atrial size** based on 2 different LA measurement methods. Left atrial content was anechoic. Deviation of the interatrial septum towards the right atrium, indicative of elevated left atrial pressure, was present. No evidence of "smoke" was noted. The atrial septum was deviated owing to volume overload. The cranial and caudal **mitral** valve leaflets presented normal linear structure yet mild mitral valve insufficiency was still present. The **left ventricle** demonstrated excessive volume (LVIDd measurement below). Ventricular function was severely subnormal expressed by the fractional shortening measurement listed above. Myocardium appeared subjectively thin typical of DCM or DCM-like cardiomyopathy. 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 with concurrent insufficiency on color doppler assessment present. 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. The cranial **mediastinum and pericardial regions** were free of masses in the visible window.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Persistent severe yet static DCM-like cardiomyopathy
- Severe LA / LV enlargement with severe systolic dysfunction



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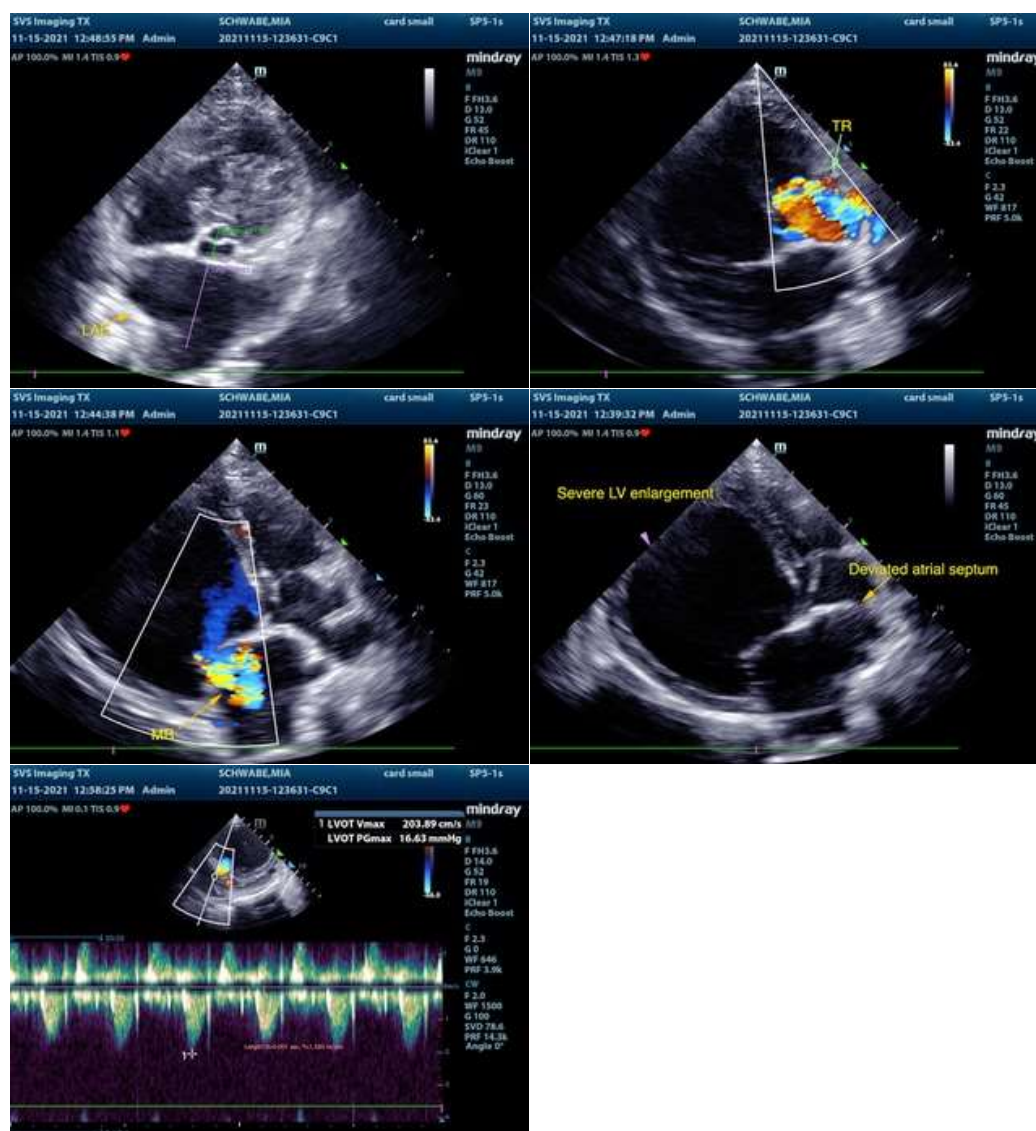
DATE

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Essentially, the heart presented a similar appearance and dimensions compared to the previous echocardiogram without evidence of significant progression. However, the heart continued to exhibit severe cardiomyopathy and systolic dysfunction consistent with left heart volume overload and likely secondary increased pulmonary pressure not overtly consistent with clinical pulmonary hypertension.

Continued current medical therapy at the lowest effective dose of Furisomide +/- Spironolactone 1-2 mg/kg PO BID, and Taurine supplementation if a history of grain-free or boutique diet. Discontinuation of medications is not recommended at this time, as this patient continues to be at a severely elevated risk for congestive failure and/or sudden death. Eventual TID dosing of Pimobendan 0.3 mg/kg may be Indicated given the severely subnormal fractional shortening. Troponin levels could be considered if not already evaluated. Serial sonographical monitoring is suggested with initial recheck echocardiogram in 3-4 months, sooner if clinical signs consistent with heart disease and cardiogenic congestion are noted.





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The information and recommendations provided are based on the images presented by the referring veterinarian. 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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