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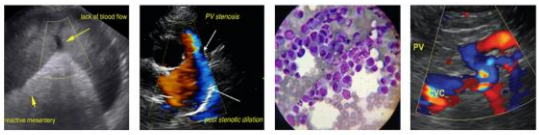

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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PATIENT

Philly Rescue

SPECIES

Canine

BREED

Golden Retriever

SEX

F

AGE

3 Months

WEIGHT

5.9

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebekah Jakum, CVT ARDMS/RVT

HOSPITAL NAME

New Britain VC

REFERRING VET

Dr. Bandekar

INVOICE

15430

DATE

11/9/22

PRESENTING CLINICAL SIGNS

Dog surrendered to rescue for having cardiac murmur

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				1.3	43.5	80	0.21
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	NM	3.4	1.4		1.8	2.2	

Cardiac Presentation

The echocardiogram in this patient demonstrated normal **left atrial** size based on 2 separate methods of LA evaluation. The cranial and caudal **mitral** valve leaflets presented normal linear structure, extension in systole, and union in diastole with normal kinesis. No overt MR was noted on Doppler. The **left ventricle** presented thicknesses with linear contour and was not dilated nor restricted. 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 turbulent to dynamic outflow with subjective focally thickened hyperechoic aortic valve. Possible discrete narrowing of the sub-valvular LV outflow tract is possible, although not definitive. Elevated measured LVOT velocity with concurrent aortic insufficiency was present on Doppler. The **right atrium** and auricle revealed normal size, structure and content. No evidence of masses was noted. **Tricuspid** valvular assessment demonstrated adequate linear morphology and kinesis. No evidence of overt TR on Doppler. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. **Pulmonary outflow** tract assessment revealed normal valve structure, laminar flow, and diameter (approx.1:1 pa/ao ratio). Normal measured RVOT velocity was present. No visible **pericardial** or free pleura fluid was noted. The cranial **mediastinum and pericardial and extra-cardiac regions** were free of masses in the visible window. No evidence of arrhythmia.

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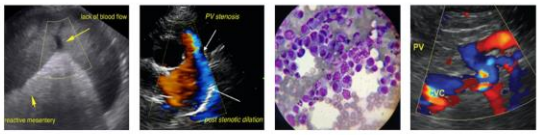

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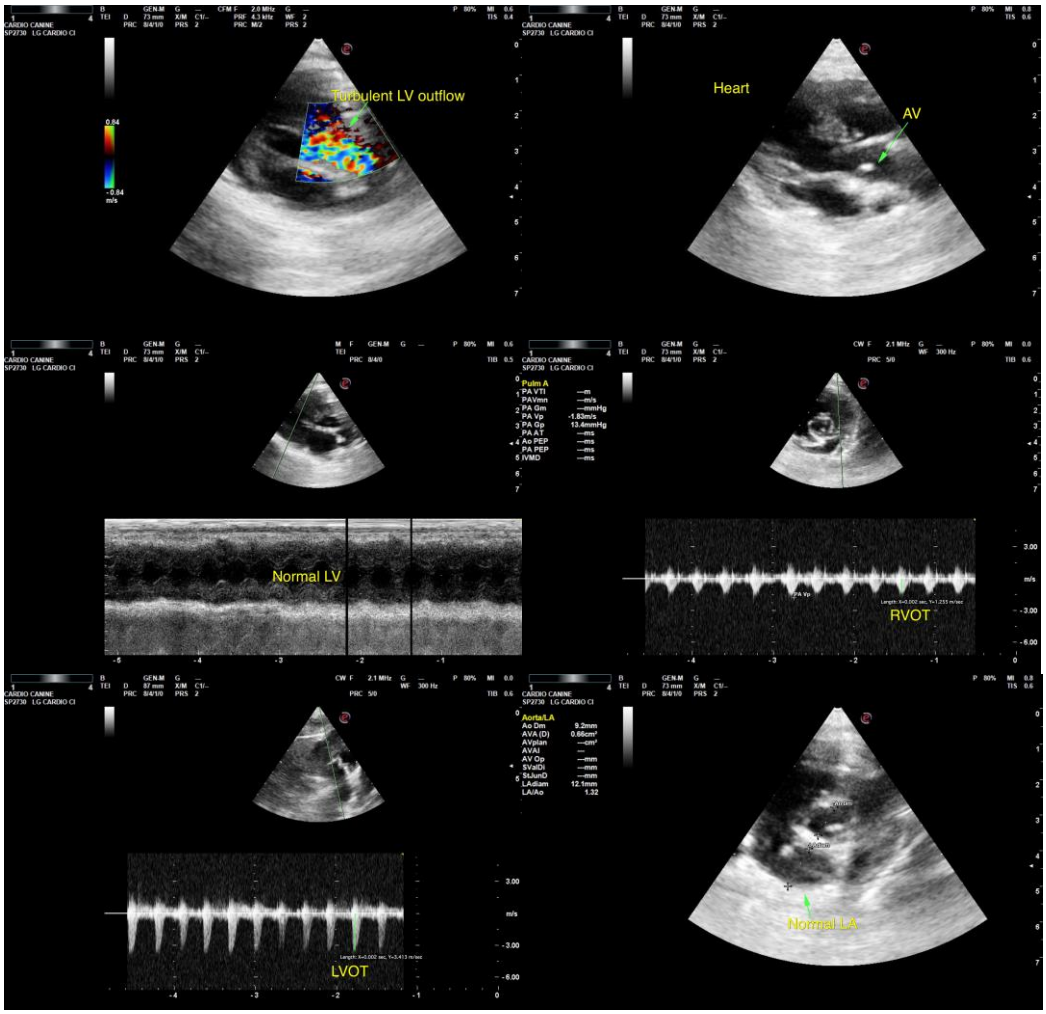
ULTRASONOGRAPHIC FINDINGS

- Aortic stenosis with concurrent aortic valve insufficiency

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The elevated LVOT velocity with concurrent turbulent to dynamic LV outflow is consistent with aortic to subaortic stenosis. Estimated pressure gradient based on measured LVOT velocity is consistent with mild to moderate stenosis. No other additional clinical issues such as evidence of additional stenotic disease, significant valvular insufficiencies, or evidence of a shunt, i.e., PDA, although possible small to discrete ventricular septal defect cannot be definitively excluded. No overt indication for cardiac medications, given the overall compensated appearance of the heart.

The heart appears to be compensated at this stage without evidence of left or right heart chamber enlargement or LV hypertrophy. However, immediate and future prognosis may be considered highly variable. Referral to local cardiologist is recommended, if possible, for further assessment. If referral is not possible, sonographic monitoring is required for further prognosis with an initial recheck echocardiogram suggested at 6 months of age. Anesthetic risk is considered elevated and cardiology/anesthesiology consult is advised prior to any potential anesthesia.



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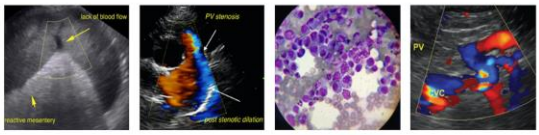

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
mac.daniel@sonopath.com