



PATIENT

Henry Dunzie

SPECIES

Canine

BREED

Pit Bull

SEX

MN

AGE

11 years

WEIGHT

65 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Diane McFadden

HOSPITAL NAME

North Warren AH

REFERRING VET

Dr. Corrado

INVOICE

12714

DATE

12/3/21

PRESENTING CLINICAL SIGNS

-cardiac BNP greater than 3400; enlarged cardiac silhouette on rads from rDVM. not on any meds
Abnormal PE/Chem/CBC/UA Results: increased ALKP and ALT

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			--	2.3	22.2	49.5	0.5
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	156	1.8	0.9		4.0	4.5	

Cardiac Presentation

The echocardiogram in this patient demonstrated moderately enlarged **left atrial** size based on 3 different LA measurement methods. The cranial and caudal **mitral** valve leaflets presented minor vegetative thickening suggestive of endocardiosis without valvular prolapse. Doppler indicated measurable eccentric insufficiency. The **left ventricle** presented normal thicknesses and linear contour with increased left ventricle volume. The **myocardium** presented normal echogenicity without subjective evidence of significant fibrotic or ischemic disease. **Contractility** of the ventricular walls was subnormal for this patient evidenced by the fractional shortening measurement above. The **left ventricular outflow** tract demonstrated normal laminar flow and subjective structural integrity. The **right atrium** and auricle revealed increased size, normal overall structure and content without overt evidence of masses. **Tricuspid** valvular assessment demonstrated adequate linear morphology. Color doppler assessment of the tricuspid valve revealed concurrent insufficiency. The **right ventricle** revealed mild increased size compared to the left ventricle, with normal thickness. **Pulmonic** tract assessment revealed normal valve structure, laminar flow, and diameter (approx. 1:1 pa/ao ratio). No visible **pericardial** or overt 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 evidence of arrhythmogenic disease. Brief assessment of the cranial abdomen revealed congestive liver and cranial abdominal ascites.



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ULTRASONOGRAPHIC FINDINGS

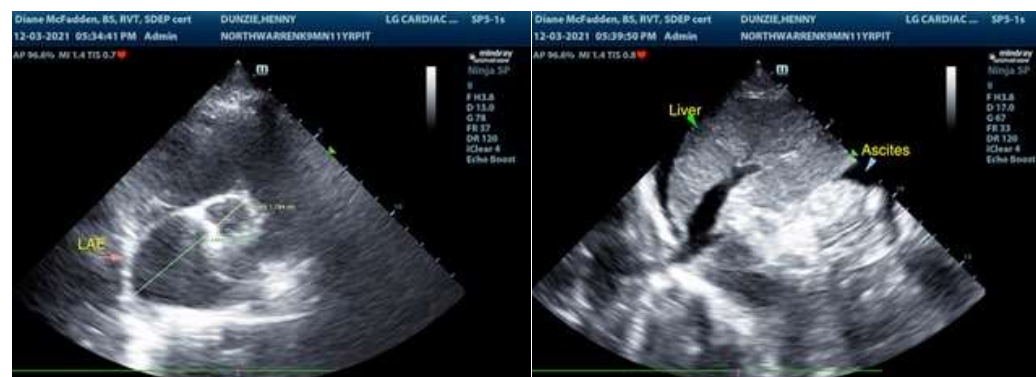
Primary Findings

- LA/LV enlargement
- Decreased LV systolic function
- RA/RV enlargement
- MR/TR
- Congestive hepatomegaly and ascites

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This study confirmed the presence of cardiomyopathy. The cardiomyopathy may be primary in nature potentially owing to chronic mitral valve insufficiency and secondary left and right-side volume overload. The tricuspid valve insufficiency velocity is consistent with mildly elevated pulmonary pressures. The cardiomyopathy may be primary in nature although potential secondary factors such as taurine deficiency, hypothyroidism, myocarditis, or less likely Infiltrative disease cannot be definitively excluded.

Regardless of classification, the presence of congestive hepatomegaly and cranial abdominal ascites is consistent with congestive heart failure. Recommend Pimobendan 0.3 mg/kg PO BID along with Spironolactone / Lasix combination 1.0-2.0 mg/kg PO BID for both medications. If clinically indicated, dietary history, T4 levels, +/- troponin levels may be considered. Assessment of renal panel, ECG, and blood pressure is suggested if possible. This patient may be at continued risk for CHF episodes pending response to medical therapy. A guarded prognosis is warranted. Recheck echocardiogram is suggested in 4-6 months, sooner if continued evidence of heart failure is noted.





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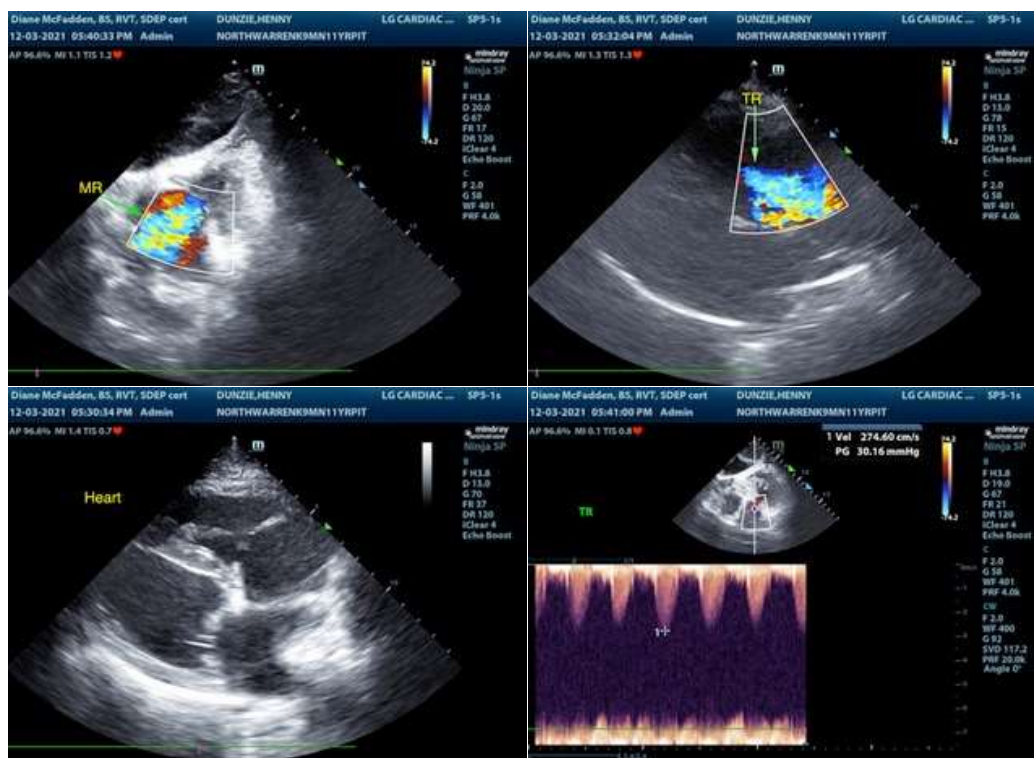
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
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