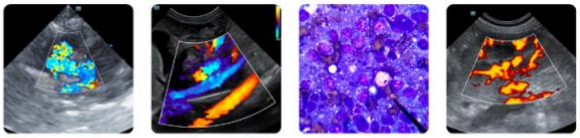

PATIENT

Keely Eavey

SPECIES

Canine

BREED

Corgi Mix

SEX

Spayed Female

AGE

17 Years

WEIGHT

20.8 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Meghan Morse LVT, CVT

HOSPITAL NAME

Animal Hospital of Sullivan County

REFERRING VET

Dr. Bodolsky

INVOICE

13675

DATE

02/10/26

PRESENTING CLINICAL SIGNS

- Evaluate heart
- See last echo from 5/2024
- Had cardiac episode on 2/8- went to ER
- Current meds: Vetmedin 2.5mg BID

Abnormal PE/Chem/CBC/UA Results: WNL

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	6.0	~2.0	NM	1.7	47	80	0.3
CANINE CARDIAC PARAMETERS	**HR** (BPM)	**AV VMAX** (m/s)	**PV MAX** (m/s)	**BODY WEIGHT** (lbs)	**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	NM	1.7	1.0	20.8	4.6	4.1	--

Cardiac Presentation

The echocardiogram in this patient demonstrated moderate increased **left atrial** dimension based on 2 different LA measurement methods with minor intra-atrial septal deviation. The cranial and caudal **mitral** valve leaflets presented thickening consistent with endocardiosis. Mild septal leaflet prolapse. Doppler indicated significant eccentric MR. The **left ventricle** presented thicknesses with linear contour and moderate increased LV dimension. 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. Normal measured LV outflow velocity with aortic valve insufficiency on doppler measuring 5.0 m/s. The **right atrium** and auricle revealed normal size, structure and content. No evidence of masses was noted or chamber overload. **Tricuspid** valvular assessment demonstrated thickening consistent with mild degenerative changes with mild TR 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

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free pleura fluid was noted. No echographically detectable evidence of cardiac / pericardial tumors was visible. No evidence of arrhythmia or hepatic congestion.

ULTRASONOGRAPHIC FINDINGS

- Chronic mitral valve disease with mild valve prolapse (ACVIM B2).
- Borderline increased measured LV outflow velocity with aortic valve insufficiency.
- Tricuspid valve insufficiency- no obvious clinical pulmonary hypertension.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

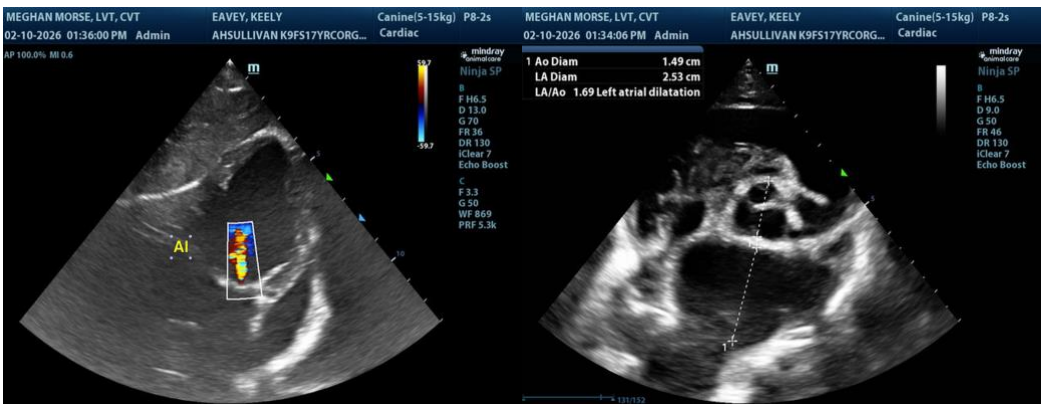
The cardiac presentation is consistent with previous diagnosis of ACVIM stage B2 chronic mitral valve disease. The degree of LA/LV enlargement indicates that the current and future risk of complication, secondary to MR, is moderately elevated yet the degree of chamber enlargement is not overtly consistent with congestive criteria.

Continued Pimobendan at current dose is recommended. Correlation with sleeping respiratory rate and three view chest radiographs, if not done, is suggested. Concurrent ECG to assess for or rule out possible paroxysmal arrhythmia is indicated. No overt indication for additional cardiac medication assuming sleeping respiratory rate is less than 30 and no evidence of radiographic pulmonary edema.

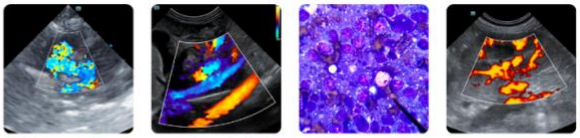
Low dose Spironolactone 1-2 mg/kg PO BID could be considered if concern for nonobvious to emerging congestive criteria. Assessment of systemic BP is recommended for evidence of hypertension given borderline increased MR velocity and concurrent aortic valve insufficiency. If present, abdominal ultrasound to assess for pathology which may contribute to hypertension is recommended.

Prognosis remains variable to guarded going forward with sonographic monitoring advised. Recheck echo is suggested in six months or sooner if progressive clinical signs.

No anesthetic contraindications. Anesthetic risk is considered moderately elevated. Elective anesthesia is not advised. if required, the following protocol is suggested with limited anesthetic time and judicious IV fluid administration with close monitoring. Suggested anesthetic protocol may include opioid or Benzodiazepine pre-med, induction with Propofol or Alfaxalone, and appropriate gas anesthesia with avoidance of alpha 2 agonists.



New Jersey Mobile
FUELED BY SONOPATH VETERINARY ULTRASOUND



Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath www.SonoPath.com info@sonopath.com 800.838.4268

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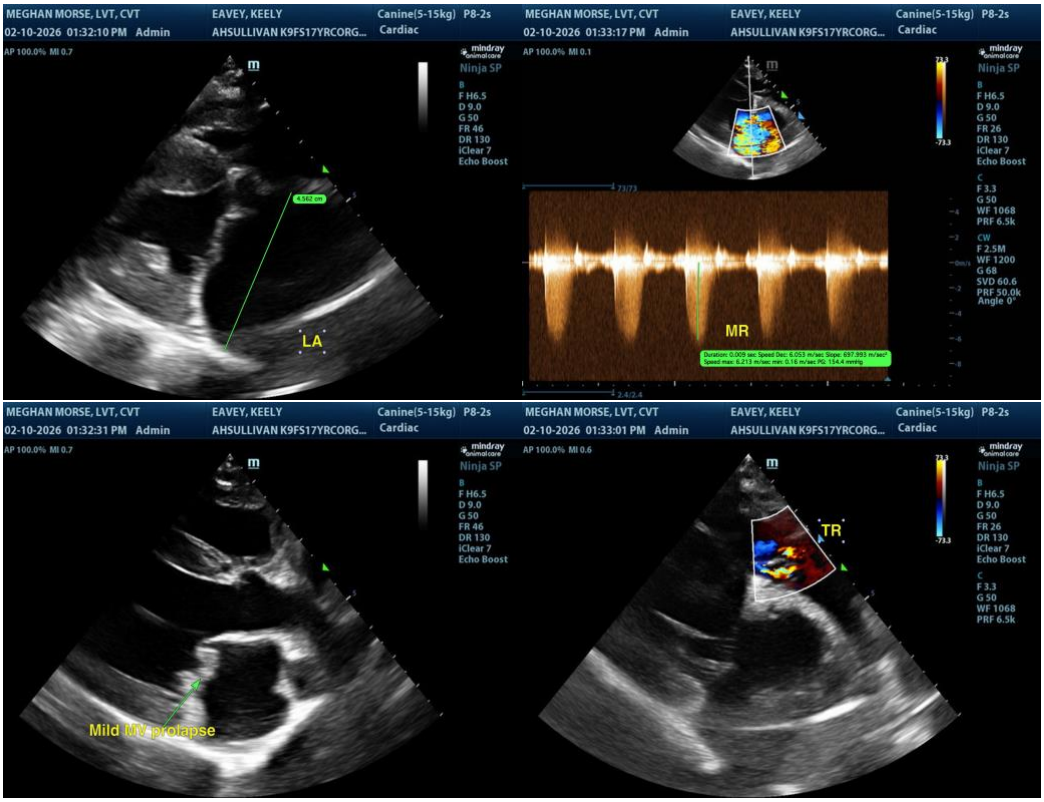

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@SonoPath.com