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Clinical Sonography & Telecytology
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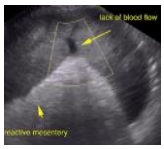
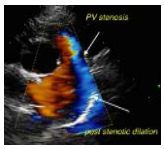
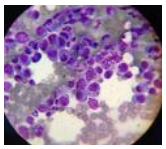
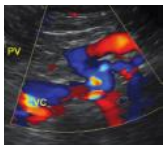

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1-800-838-4268 info@sonopath.com

PATIENT
Peanut Turrisi

SPECIES
Canine

BREED
Yorkshire Terrier

SEX
Neutered male

AGE
14 years 10 months

WEIGHT
7 pounds

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

IMAGING PERFORMED BY
Shari Reffi CVT

HOSPITAL NAME
ACC Flanders

REFERRING VET
Dr. Casulli

INVOICE
10146ag

DATE
03/08/2022

PRESENTING CLINICAL SIGNS

History: Hx- collapsing trachea, valve dz and enlarged heart, chronic pulm dz, PHT (not medicated)- worsening cough. Current meds: Tussigon 1/4 TID

Abnormal PE/Chem/CBC/UA Results: B-Cell lymphoma, stable

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 m/sec	2.8	1.2	1.1	51.1	86.1	0.25
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	149	0.91	1.0		2.0	1.84	

Cardiac Presentation

The echocardiogram in this patient demonstrated normal left atrial size based on 3 different LA measurement methods. Chamber volumes and echogenicity were normal. The cranial and caudal mitral valve leaflets presented vegetative thickening consistent with endocardiosis without evidence of valvular prolapse or CT rupture. Doppler indicated measurable subjectively mild eccentric insufficiency. 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 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 mild thickening with mild to moderate TV insufficiency. 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.

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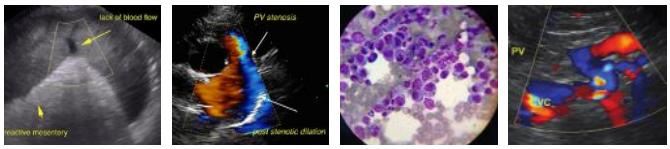

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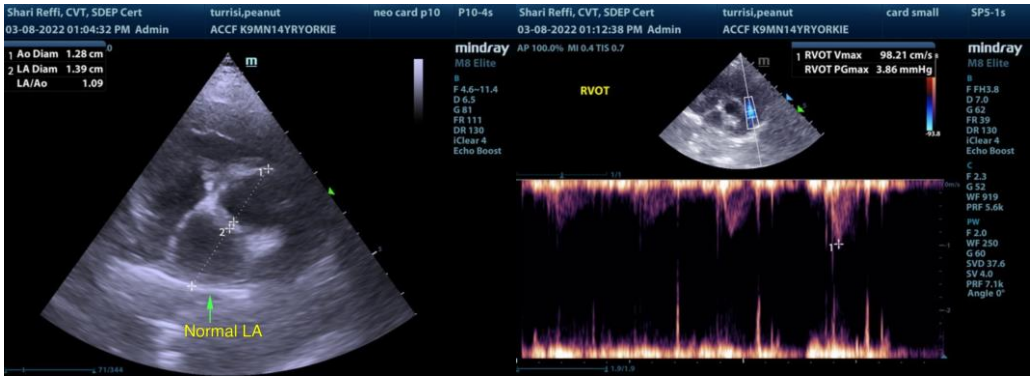
ULTRASONOGRAPHIC FINDINGS

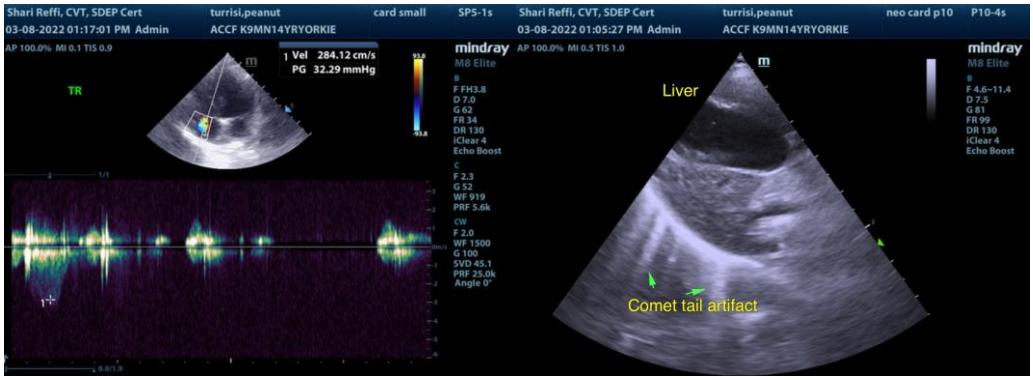
- Compensated chronic mitral valve disease (ACVIM B1).
- TR with normal RA/RV size-estimated pulmonary pressure gradient approximately 33 mmHg on measured TR velocity is suggestive of mildly elevated pulmonary pressure yet not overtly consistent with clinical pulmonary hypertension.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The progressive cough in this patient is suspected to be primary lower airway in origin given the history of collapsing trachea, history of chronic pulmonary disease and cardiac presentation without overt evidence of LA enlargement, LV systolic function or overt clinical pulmonary hypertension. The potential for low grade pulmonary hypertension however cannot be definitely excluded. Continued respiratory therapy with as needed antitussive medication would be reasonable. However, if progressive cough is nonresponsive to conservative respiratory support, a low dose sildenafil trial at 0.5-1 mg/kg PO BID initially for 10-14 days could be considered with assessment of clinical response.

A recheck echocardiogram is suggested if progressive clinical signs which may suggest pulmonary hypertension are noted.





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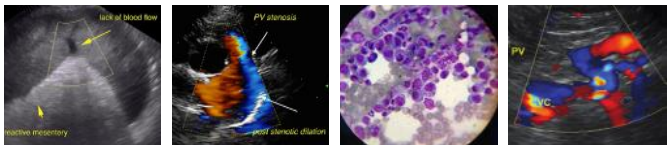

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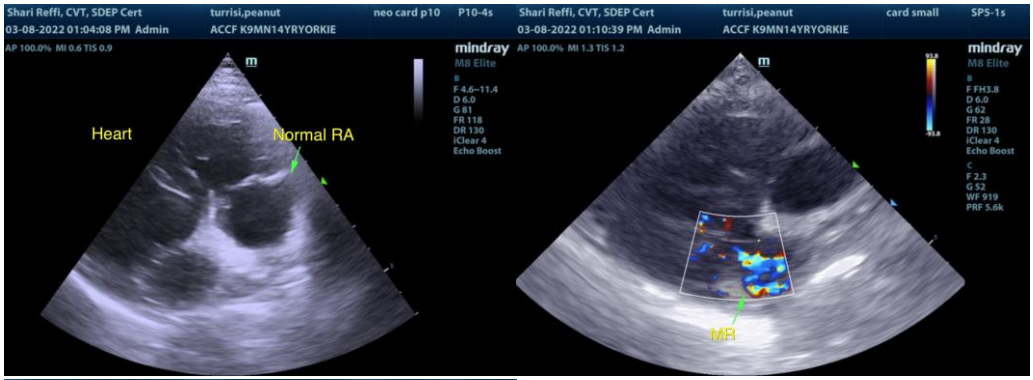

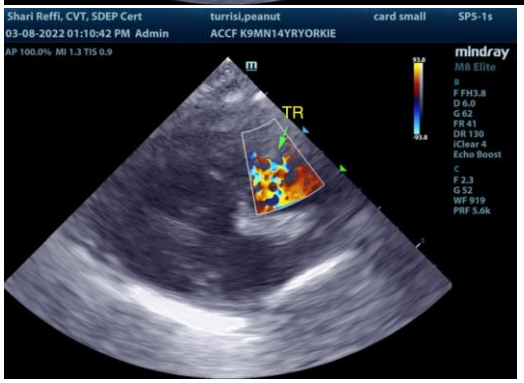

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@SonoPath.com