



## PATIENT

Tinkerbelle Coelho

## SPECIES

Canine

## BREED

Terrier Mix

## SEX

F/S

## AGE

13 yo

## WEIGHT

17.5 lbs.

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Dr. Meredith Swart

## HOSPITAL NAME

Swart Veterinary  
Imaging

## REFERRING VET

Dr. Meredith Swart

## INVOICE

16533

## DATE

4/6/23

## PRESENTING CLINICAL SIGNS

EMPLOYEE PET- Recheck echo from one month ago. Tink had an episode of CHF over the weekend. Mild pulmonary edema seen on radiographs. She was placed in oxygen and started on lasix and improved quickly throughout the day. She is currently on all her previously rx'ed heart meds and now taking lasix 12.5 mg bid. No crackles auscultated today prior to echo. RR has decreased back down to < 40 BPM.

Abnormal PE/Chem/CBC/UA Results: kidney values still stable when checked most recently

## 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	<1.3	28-40	40-100	<0.6
PATIENT	5.0		2.3	2.2	55.2	87	0.36
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				
PATIENT	NM	1.5	1.0		3.9	3.8	

## Cardiac Presentation

The echocardiogram in this patient demonstrated moderately enlarged **left atrial** size based on 3 separate evaluation methods. The cranial and caudal **mitral** valve leaflets presented mild thickening consistent with endocardiosis. Minor prolapse of the septal leaflet was present. No evidence of chordae tendinea rupture was noted. Doppler indicated measurable moderate insufficiency. The **left ventricle** presented thicknesses with linear contour with persistent increased LV volume. 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 LVOT velocity was noted. 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. 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). Normal measured RVOT velocity was noted. No visible **pericardial** or free



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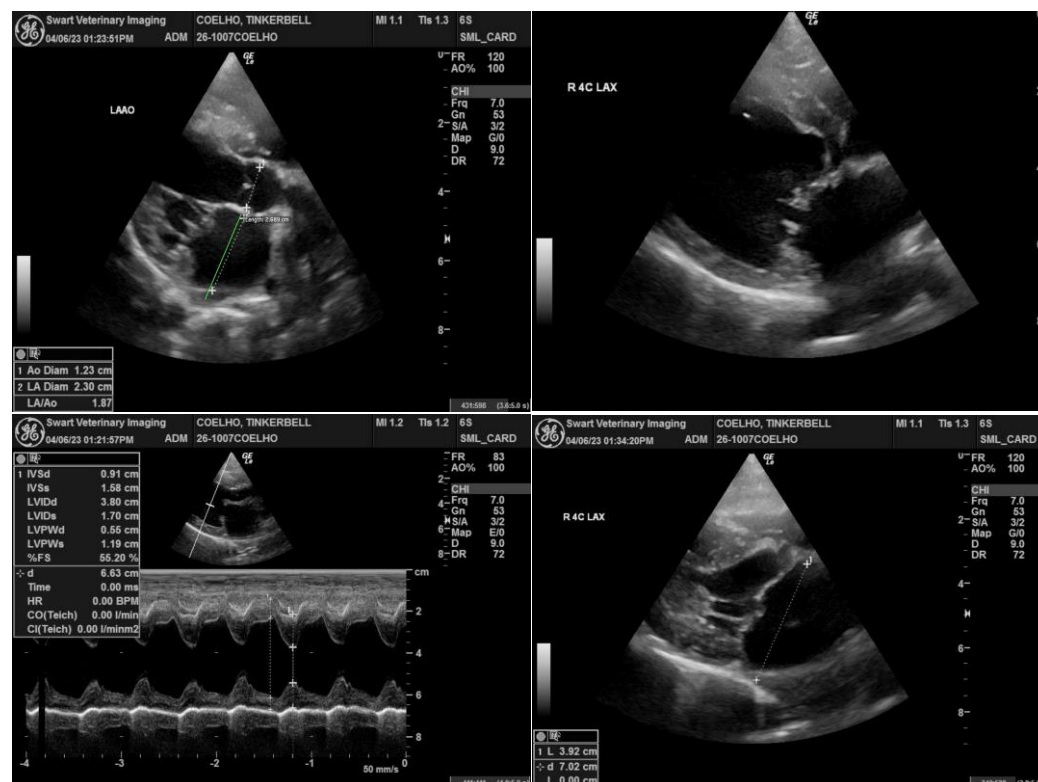
pleura fluid was noted. No echographically detectable evidence of infiltrative disease was visible. The cranial **mediastinum and pericardial regions** were free of masses in the visible window. No arrhythmia was noted.

## ULTRASONOGRAPHIC FINDINGS

- Chronic mitral valve disease with persistent left heart volume overload (ACVIM B2 / C)

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The LA measurement in this study, as well as the LA/AO measurements compared to the previous study, indicate potential mild progression which may correlate with recent CHF episode. Given that the patient is stable on the current protocol, recommend continuing Pimobendan 0.3 mg/kg PO BID, as well as the lowest effective dose of diuretic therapy with serial monitoring of resting respiration rate. No other evidence of additional clinical issues such as LV systolic dysfunction or evidence of clinical pulmonary hypertension was noted. ACE inhibitor medication may be considered if systemic BP is >130, (no advised if BP <130). Prognosis remains highly variable and sonographic monitoring is recommended. A recheck echocardiogram is suggested in 6 months, sooner if recurrent episodes of CHF.





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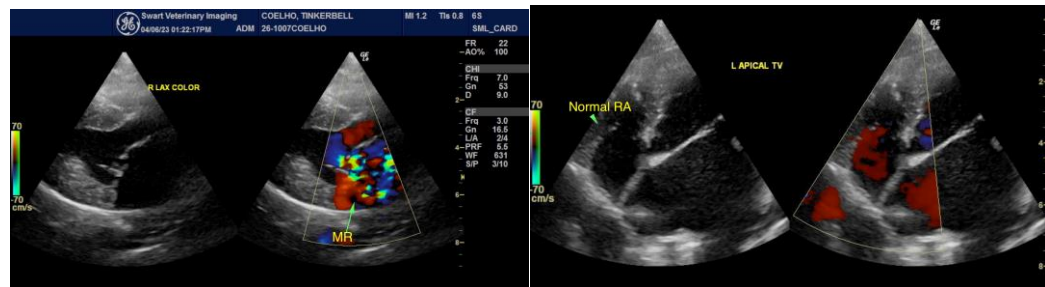
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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