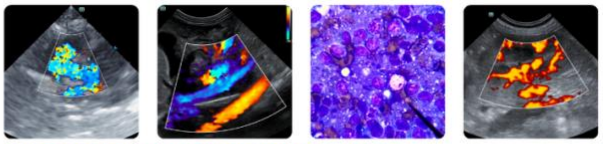

PATIENT

Dakota Gero

SPECIES

Canine

BREED

English Pointer

SEX

Spayed Female

AGE

11 Years

WEIGHT

46.1 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. carlos Abdul-Chani

HOSPITAL NAME

Byram Animal Hospital

REFERRING VET

Dr. Maria Cruz

INVOICE

16100

DATE

05/12/26

PRESENTING CLINICAL SIGNS

History of arrythmia. Syncope type episodes. Lethargic. Anorexic. Diarrhea. Current meds: Metronidazole 500mg 1 BID

Abnormal PE/Chem/CBC/UA Results: Abnormal CBC/Chem findings: T4 1.1 SGOT 123 SGPT 361 Alk Phos 312 CBC WNL HW (-) Lyme, Erhl. and Anaplasmosis (- x 3) Fecal (-) Abnormal UA- not done

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	--	--	NM	1.48	19	38	0.2
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	1.0	0.8	46.1	3.5	3.6	--

Cardiac Presentation

The echocardiogram in this patient demonstrated normal **left atrial** dimension. The cranial and caudal **mitral** valve leaflets presented mild irregular age-related changes or mild endocardiosis with adequate extension in systole and union in diastole. No evidence of MR on doppler. The **left ventricle** presented normal free wall and septal thicknesses with linear contour. The **myocardium** presented some echogenic remodeling consistent with expected age-related change. **Contractility** of the ventricular walls was subnormal as evidenced by the fractional shortening measurement. The **left ventricular outflow** tract demonstrated normal laminar flow with subjectively unremarkable structure. Normal measured LVOT velocity. Subjective assessment of the **right atrium** and auricle revealed normal size, structure and content. No evidence of masses was noted. **Tricuspid** valvular assessment demonstrated mild thickening with mild TR on doppler. The **right ventricle** was of normal size (1/3 diameter of LV), echogenicity and thickness. **Pulmonic** tract assessment revealed normal valve structure, laminar flow, and diameter (approx.1:1 pa/ao ratio). Normal measured RVOT velocity. No visible **pericardial** or free pleural fluid was noted. The **mediastinum** was free of masses in the visible window. No evidence of hepatic congestion with unspecified arrhythmia.

ULTRASONOGRAPHIC FINDINGS

- Overall normal cardiac structure with mild myocardial remodeling.

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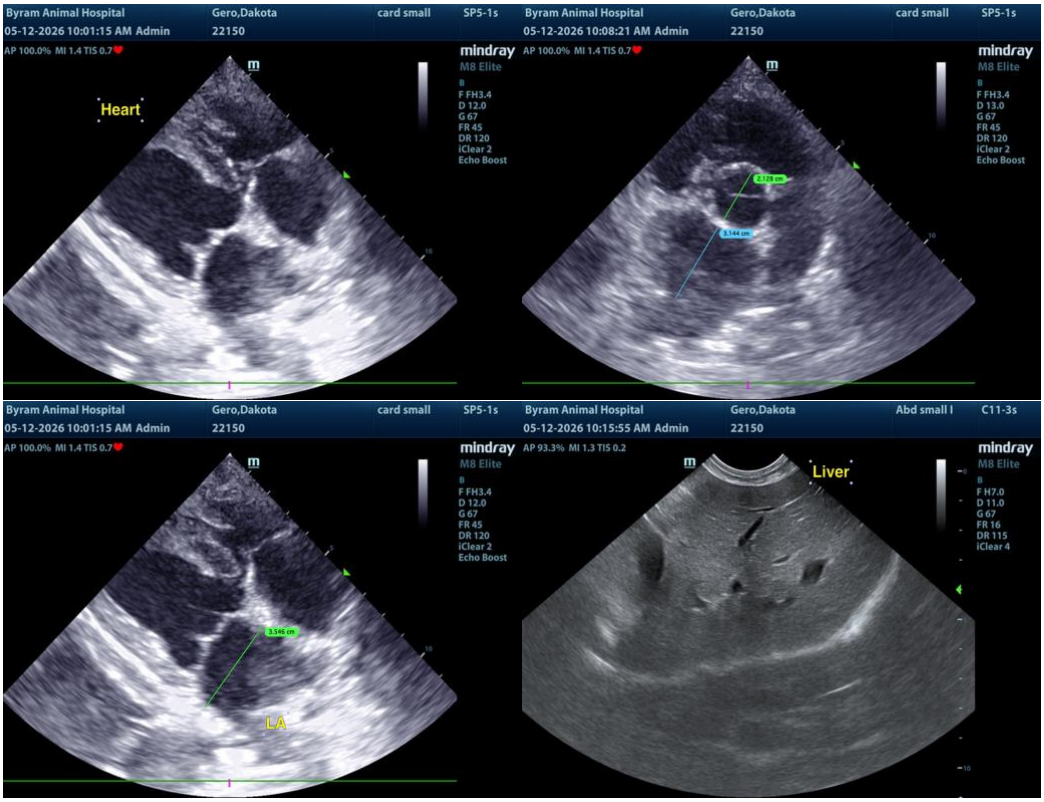
- Mild degenerative atrioventricular valvular changes with mild tricuspid insufficiency- no overt clinical pulmonary hypertension.
- Unclassified arrhythmia- subjective unclassified tachyarrhythmia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The subjective unclassified tachyarrhythmia may potentially predispose this patient to tachycardia induced cardiomyopathy going forward. Although without evidence of left to right heart chamber enlargement, no current evidence of congestive criteria or clinical pulmonary hypertension. Clinical signs including syncope associated with the arrhythmia and potential decreased LV systolic function are possible.

Initial further clarification of the arrhythmia via ECG or Holter monitor with possible concurrent rate control therapy is indicated. Pending further assessment, abdominal ultrasound could be considered to assess for contributing pathology. If persistent or progressive clinical signs associated with the arrhythmia and LV hypocontractility, Pimobendan trial at 0.3 mg/kg PO BID may be considered yet further classification and treatment of the underlying arrhythmia is suggested initially.

Elective anesthesia is not advised pending further diagnostics.



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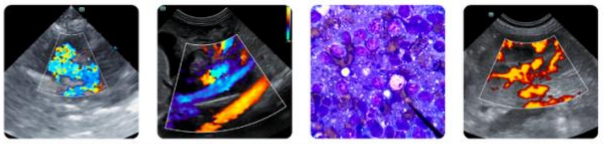

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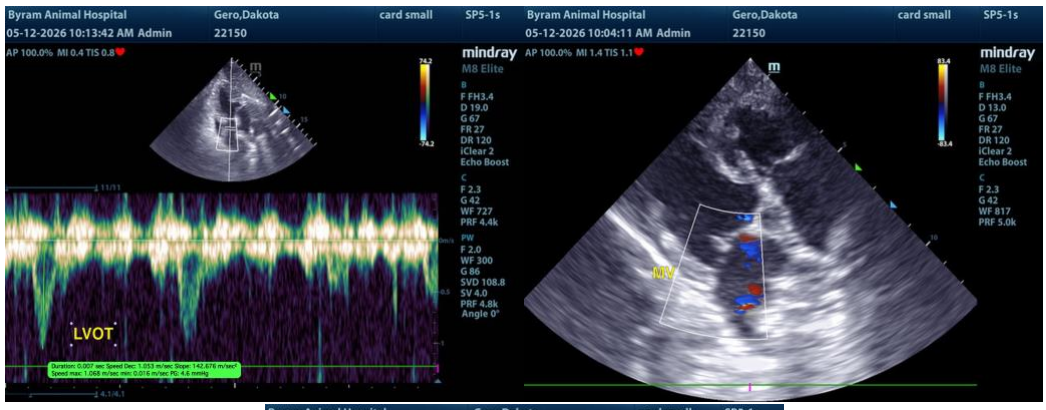

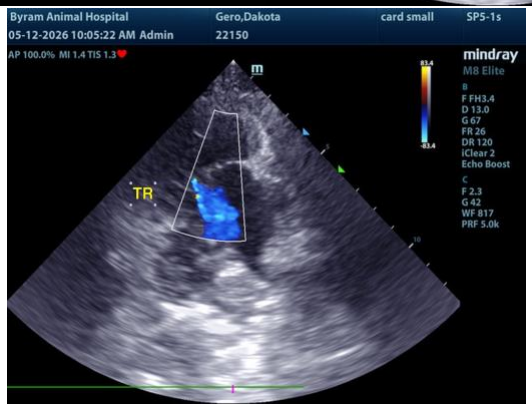

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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