



PATIENT

Nala Paulison

SPECIES

Canine

BREED

Mix

SEX

FS

AGE

12 years

WEIGHT

17.6 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Diane McFadden

HOSPITAL NAME

Fredon AH

REFERRING VET

Dr. Goldstein

INVOICE

16735

DATE

5/3/23

PRESENTING CLINICAL SIGNS

collapsing; irregular heart rhythm; asynynchronous pulse. EKG - sick sinus syndrome
Abnormal PE/Chem/CBC/UA Results: BUN 84, ALKP 1042, GGT 37, HCT 29%, RBC 4.44 , pro BNP 10,000

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

CANINE	MR	TR	LA/AO	LA/AO	FS	EF	EPSS
CARDIAC PARAMETERS	VMAX (m/s)	VMAX (m/s)	(Boon method)	(Heart Base; Swe)	(%)	(%)	(cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	<1.3	28-40	40-100	<0.6
PATIENT	5.6	2.8		1.55	50.6	83.3	0.24
CANINE	HR	AV	PV	BODY WEIGHT	LA	LVIDd	LVIDs
CARDIAC PARAMETERS	(BPM)	VMAX (m/s)	MAX (m/s)	(kg)	2D short axis Base view (cm)	Avg; 2D and m-mode short axis (cm)	Avg; 2D and m-mode short axis (cm)
NORMAL PARAMETER	50-100	0.7-1.7	0.7-1.6				
PATIENT	157	1.9	1.0		3.1	2.9	

Cardiac Presentation

The echocardiogram in this patient demonstrated minor increased **left atrial** size based on 2 different LA measurement methods. The cranial and caudal **mitral** valve leaflets presented mild to moderate thickening consistent with endocardiosis. No evidence of valvular prolapse. Doppler indicated measurable moderate 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 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). Trace pulmonic insufficiency velocity measuring 1.0 m/s was present on Doppler. 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. Irregular heart rate to arrhythmia was present.



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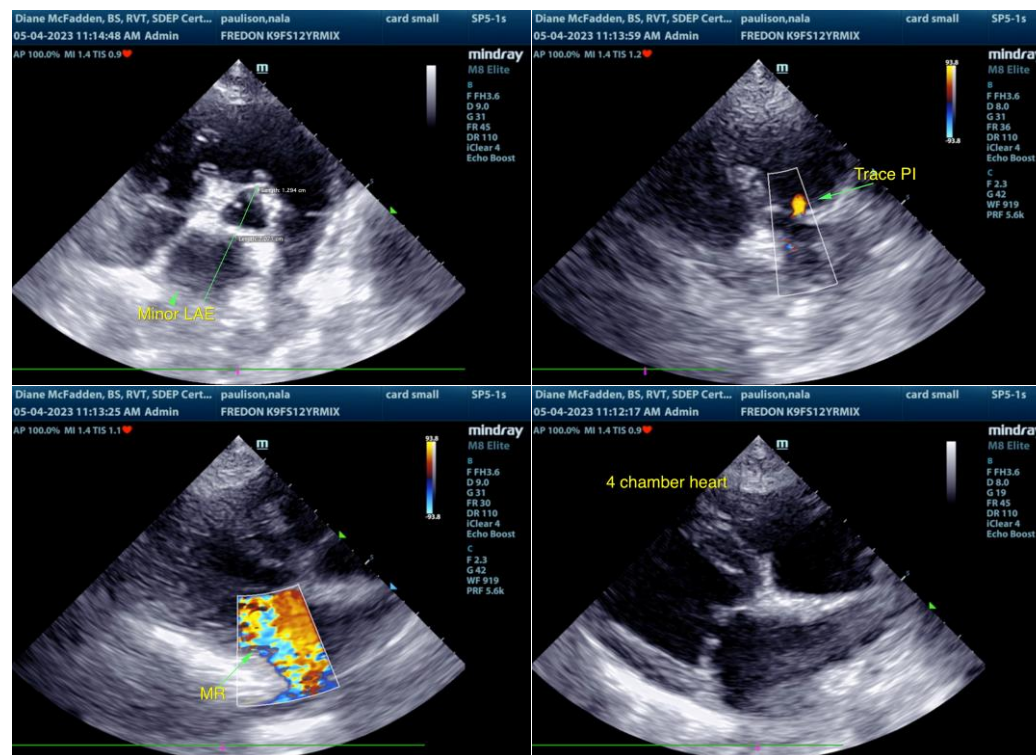
ULTRASONOGRAPHIC FINDINGS

- Chronic mitral valve disease (Early / Mild ACVIM B2)
- TR - estimated pulmonary gradient approximately 30.0 mmHg suggestive of mild increased pulmonary pressure, not overtly consistent with clinical pulmonary hypertension
- Trace pulmonic insufficiency
- Arrhythmia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The minor left atrium enlargement without evidence of significant left heart chamber enlargement or volume overload indicates that the current and future risk secondary to MR is relatively low.

In a nonclinical patient with only minor left atrium enlargement, no overt indication for cardiac medications used to treat structural cardiomyopathy. No evidence of LV systolic dysfunction in addition to no overt clinical pulmonary hypertension. Prognosis for MR, given mild LA enlargement, is highly variable and serial sonographic monitoring is recommended. Recheck echocardiogram is suggested in 6 months, sooner if clinical signs consistent with structural cardiomyopathy or evidence of left heart congestion arise. Cardiology consultation regarding ECG and Sick Sinus Syndrome is recommended.





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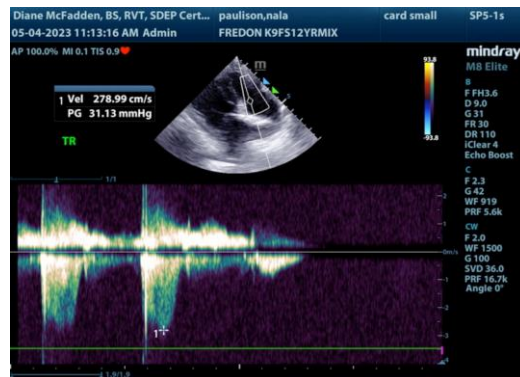
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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