


PATIENT

Asia Windley

SPECIES

Canine

BREED

Chihuahua

SEX

F/S

AGE

10 years

WEIGHT

4.4 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

 Dave Stasiuk RDMS,
 RDCS

HOSPITAL NAME

Alpine 24/7

REFERRING VET

Dr. Wendy Drohan

INVOICE

14242ag

DATE

6/27/23

PRESENTING CLINICAL SIGNS

Previous echo on Sonopath. Assess degree of MR/ LA size and possible PH. Some pulmonary edema noted on CXR. Patient already on Pimobendan. Pre anaesthesia for dental.

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		2.6	1.8	1.8	49.6	83	0.2
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		1.1	1.1		2.7	2.7	

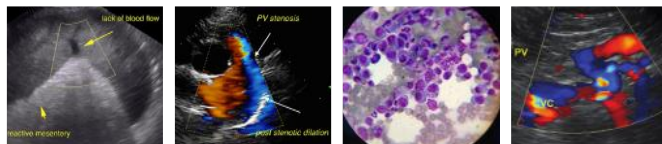
Cardiac Presentation

The echocardiogram for this patient presented moderate excessive left atrial size expressed both in the LA/AO and LA max measurements. Subtle deviation of the interatrial septum towards the right atrium suggestive of mild increased left atrial pressure was noted. The cranial and caudal mitral valve leaflets presented moderate thickening consistent with endocardiosis. Doppler indicated moderate eccentric insufficiency. The left ventricle presented thicknesses with linear contour and mild to moderate 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. 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).

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.

Measured MV inflow pattern was within normal limits. The E wave measured 1.1 m/s and the A wave measured 1.1 m/s in diastole. This indicates that the patient is not in left sided CHF (E wave velocity of >1.4 m/s associated with left sided congestive failure).

ULTRASONOGRAPHIC FINDINGS



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- Chronic mitral valve disease (ACVIM B2)
- Mild TR-no overt evidence of clinical pulmonary hypertension.

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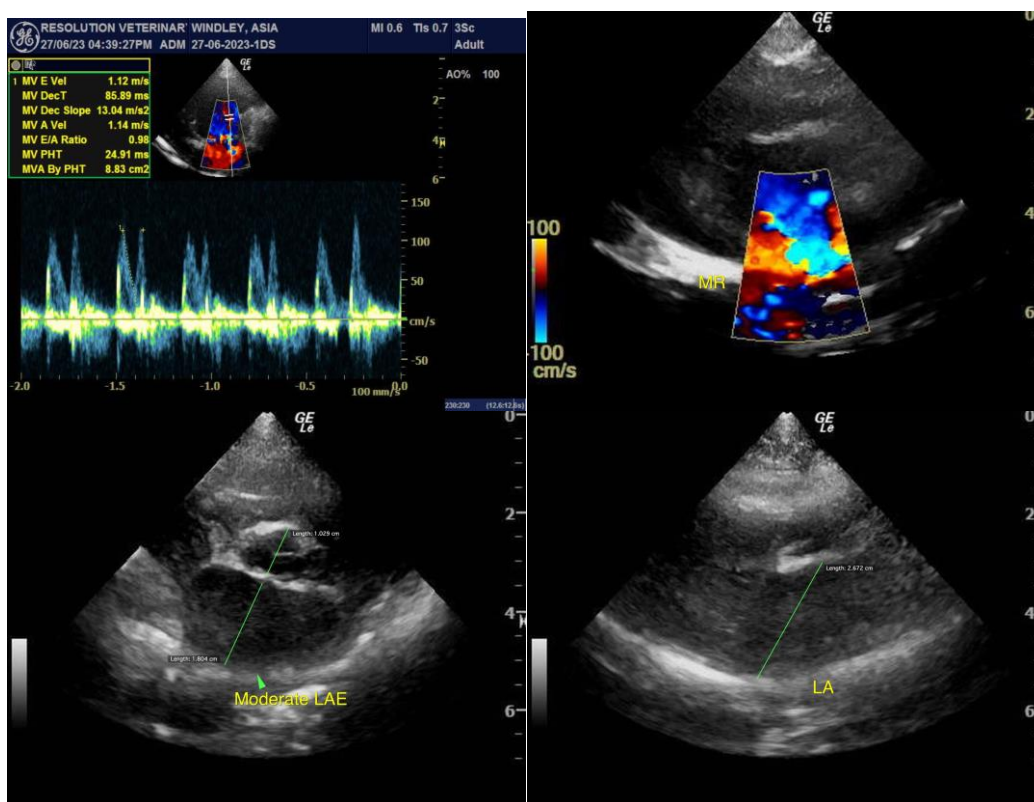
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

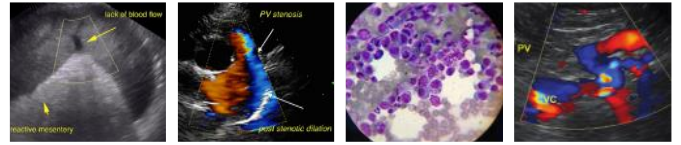
Essentially static echocardiogram compared to the previous study without significant progressive LA/LV enlargement. No other clinical issues such as LV systolic dysfunction or overt clinical pulmonary hypertension. The moderate static LA/LV enlargement continue to indicate that the risk of complication secondary to MR is moderately elevated. The LA/LV enlargement was not overtly consistent with cardiogenic pulmonary edema.

Continued Pimobendan 0.3 mg/kg PO BID, +/- spironolactone both 1-2 mg/kg PO BID if strong clinical concern for pulmonary edema and assessment of radiographic response could be considered. Baseline resting RR monitoring is suggested.

Anesthetic risk is considered mild given this presentation. 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. Limited anesthetic time and judicious IVF use is recommended.

Prognosis is highly variable and serial sonographic monitoring is required for further assessment. Recheck echocardiogram recommended in 6 months, sooner if clinically indicated.





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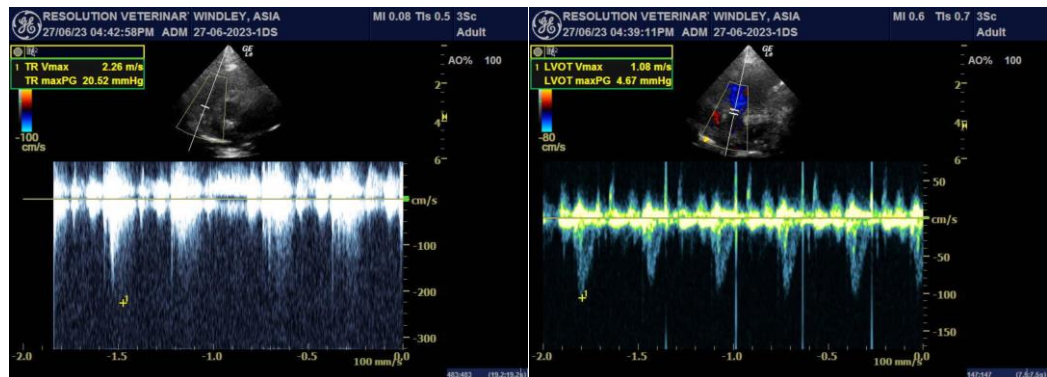
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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info@SonoPath.com