



PATIENT

Ollie Hoogerhyde

SPECIES

Canine

BREED

Miniature
Dachshund

SEX

MN

AGE

13 years

WEIGHT

18.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Vazquez

HOSPITAL NAME

North Haledon
Veterinary Care

REFERRING VET

Dr. Mansfield

INVOICE

17202

DATE

6/29/23

PRESENTING CLINICAL SIGNS

Patient with history of heart murmur - "Chronic mitral valve disease (ACVIM B1) and mild TR", presents for follow up echo. Most recent echo performed on 7/28/22. Current meds: L-Thyroxine.

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	5.2	2.0		2.4	50	82	0.25
CANINE	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)
CARDIAC PARAMETERS							
NORMAL PARAMETER	50-100	0.7-1.7	0.7-1.6				
PATIENT	NM	1.3	1.1		4.5	3.4	

Cardiac Presentation

The echocardiogram in this patient demonstrated moderately enlarged **left atrial** size based on 2 different LA measurement methods. Deviation of the interatrial septum towards the right atrium, consistent with increased left atrial pressure, was present. The cranial and caudal **mitral** valve leaflets presented moderate thickening consistent with endocardiosis. Minor septal mitral valve leaflet prolapse was noted. Doppler indicated measurable moderate eccentric insufficiency. The **left ventricle** presented thicknesses with maintained linear contour with 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. No arrhythmia was noted.



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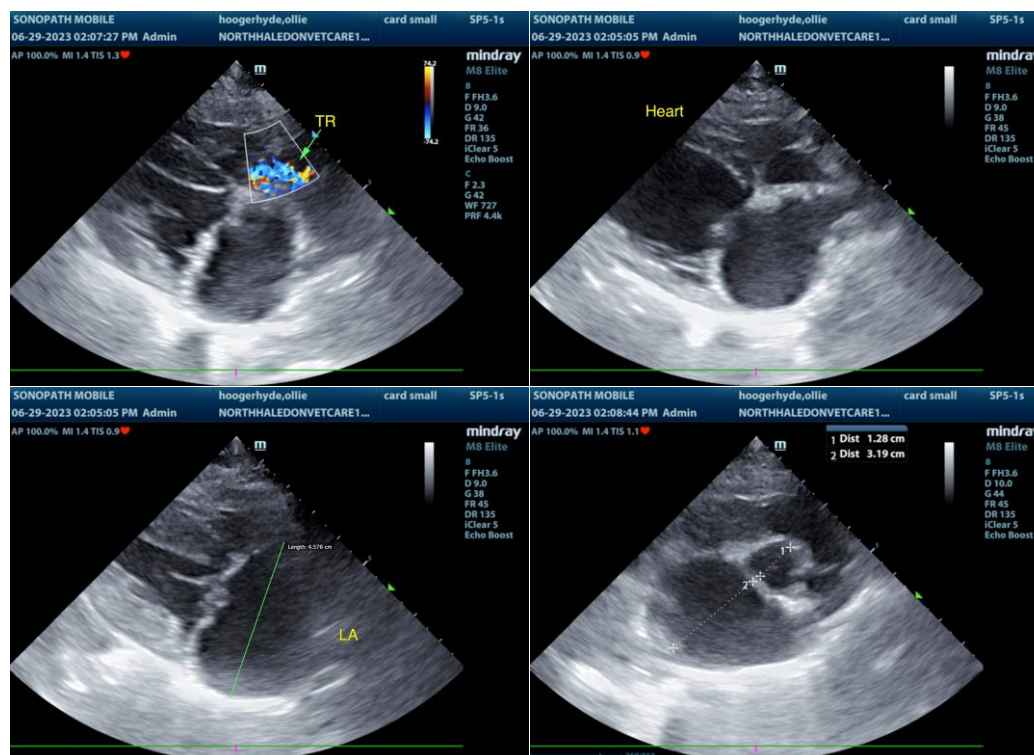
ULTRASONOGRAPHIC FINDINGS

- Chronic mitral valve disease (ACVIM B2)
- Mild TR - estimated pulmonary pressure gradient not consistent with clinical pulmonary hypertension

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This study reveals progression compared to the previous study with current moderate LA/LV enlargement consistent with emerging left heart volume overload. The increase in LA/LV dimension indicates that the current and future risk of complications secondary to MR at this stage is at least moderately elevated.

Pimobendan 0.3 mg/kg PO BID is recommended. Three-view chest radiographs are suggested to assess for evidence of pulmonary edema or other pulmonary changes. Baseline monitoring of resting respiration rate going forward is advised. If evidence of radiographic pulmonary edema or increased resting respiration rate, diuretic protocol Lasix 1.0-2.0 mg/kg PO BID is recommended. ACE inhibitor medication may be considered if systemic BP >130 (not advised if BP <130). Omega fatty acids and mild salt restriction may prove beneficial. Prognosis remains variable yet guarded going forward, given the degree of LA enlargement. Serial sonographic monitoring is advised. Recheck echocardiogram is suggested in 6 months, sooner if clinically indicated.





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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