



PATIENT

Nandi Enderle

SPECIES

Canine

BREED

Vizsla

SEX

Neutered Male

AGE

10 Years

WEIGHT

~71 Pounds

INTERPRETED BY

Sara Brethel DVM,
DACVIM (Cardiology)

IMAGING PERFORMED BY

Andrea Nicastro, DVM,
DACVIM

HOSPITAL NAME

Meadowlawn Animal
Services Market
Commons

REFERRING VET

Dr. Hunt

INVOICE

35170

DATE

12/31/25

PRESENTING CLINICAL SIGNS

History: April 2025 - 3/6 murmur; Now, 5/6 murmur with an arrhythmia; cough, exercise intolerance, inc resp effort.

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	~6.0	~2.0	NM	1.7	65.21	--	NM
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT (kg)	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	--	~1.0	~0.5	~32.27	6.3	4.6	1.6

Chest Radiographic Interpretation

There is left atrial enlargement. The pulmonary vasculature is normal. There is no evidence of cardiogenic pulmonary edema. There are radiopaque opacities throughout the thorax. The significance and source are unknown.

ECG Interpretation

Sinus rhythm with isolated polymorphic ventricular premature complexes occurring in a bi- and trigeminal pattern.

Cardiac Presentation

The mitral valve leaflets are moderately thickened with moderate mitral regurgitation posteriorly directed. There is moderate prolapse of the mitral valve leaflets. The left atrial size is moderately increased. Left ventricular internal dimensions during diastole are increased and systolic function is preserved in the face of mitral regurgitation. There is normal right atrial size with mild tricuspid regurgitation. There is no prolapse of the tricuspid valve leaflets and no evidence of pulmonary hypertension based upon tricuspid regurgitant velocities. The right ventricle subjectively appears normal in structure and function. The aortic and pulmonic valves have normal morphology and the corresponding outflow velocities are within normal limits. There is no evidence of pulmonic or aortic



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insufficiency. The aorta appears normal. The pulmonary artery and associated branches appear normal. There is no evidence of pleural effusion, pericardial effusion, or intracardiac masses.

ULTRASONOGRAPHIC FINDINGS

- Degenerative valve disease, ACVIM stage B-2
- Moderate left atrial enlargement
- Mild degeneration of the tricuspid valve without evidence of significant pulmonary hypertension
- Polymorphic ventricular premature complexes occurring, isolated, and in a bi- and trigeminal pattern

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The patient has degenerative valve disease ACVIM stage B2 and pimobendan therapy at 0.27-0.32mg/kg PO q12 is recommended. This will be a lifelong therapy. A recheck echocardiogram is recommended in 4-6 months to monitor the condition since starting pimobendan. A sooner recheck is recommended if the patient develops cardiovascular clinical signs or the heart murmur is worsening in intensity.

The client should start closely monitoring respiratory rate and effort at home if not already doing so. The resting respiratory rate should be < 35-40 breathes/minute when the patient is resting or sleeping. If the breathing rates are increasing, then chest radiographs are recommended.

Recommend obtaining a blood pressure on the patient to ensure it is <160mmHg. If the blood pressure is elevated recommend following ACVIM guidelines for systemic hypertension and treating if indicated.

The patient is having VPCs. Sometimes these can be seen with primary heart disease in dogs and cats. Other diseases that can cause these abnormal heart beats include diseases of the liver or spleen, infectious tick-borne diseases, endocrine disorders, or sometimes they can be brought about by anxiety.

I recommend sotalol at a dose of 120 mg tablets. Directions: given ½ of a tablet by mouth every 24 hours for 3 days, then increase and give ½ tablet by mouth every 12 hours until directed otherwise.

A recheck electrocardiogram, ideally a Holter, is done in the next 4 weeks, sooner if the patient is decompensating. If Holter is unavailable, then I would do another full 6 lead electrocardiogram.

The patient is not a good anesthetic candidate at this time.



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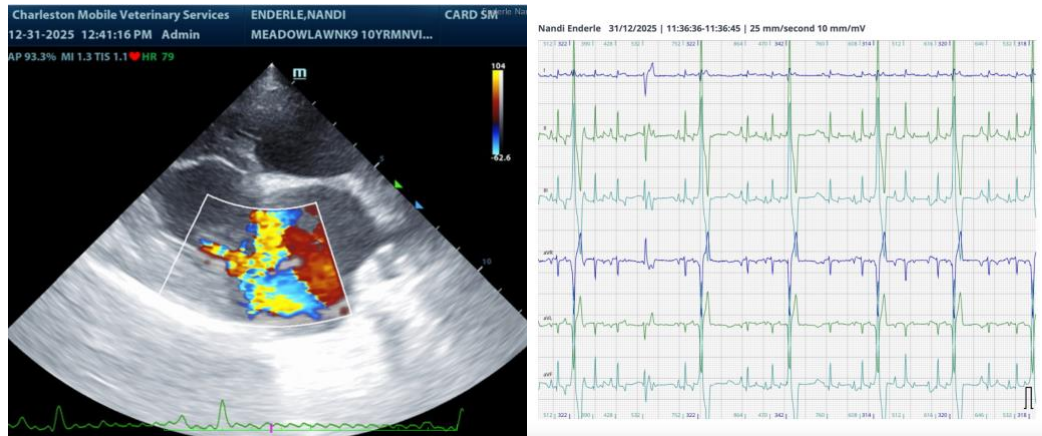
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Sara Brethel DVM, DACVIM (Cardiology)

info@SonoPath.com