

PATIENT

Dobby Clarke

SPECIES

Canine

BREED

Shepherd Mix

SEX

Neutered Male

AGE

10 Years

WEIGHT

70.6 pounds

INTERPRETED BY

Sara Brethel DVM,
 DACVIM (Cardiology)

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Centerville AH

REFERRING VET

Dr. Sandhu

INVOICE

13866

DATE

02/19/26

PRESENTING CLINICAL SIGNS

- Patient was diagnosed on 04/15/2025 (echocardiogram read by Dr. Sara Brethel) with degenerative valve disease stage b2and severe left atrial enlargement
- Was started on Vetmedin and was doing well clinically
- Patient presented last week for evaluation of a dry hacking cough, decreased energy levels on walks and owner did report that his heartbeat feels stronger when he lays his hand on chest
- In clinic patient had significant heart murmur and irregular arrythmia, synchronous with femoral pulse (weak), lung auscultation was decreased bronchovesicular sounds caudal lung fields, patient was alert and responsive
- Adjustments were made to medical management, and patient has been doing clinically better at home
- Current Medications: Vetmedin, Furosemide, Benazepril (recently added on)

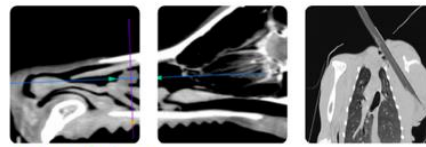
Abnormal PE/Chem/CBC/UA Results: labs and rads attached prev US report attached

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	5.66	3.7	--	2.8	38.66	--	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	132	1.47	0.91	32.1	6.73	5.25	3.22

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 severely increased. Left ventricular dimensions are within normal limits since systolic function is preserved in the face of mitral regurgitation. There is normal right atrial size with moderate tricuspid regurgitation. There is no prolapse of the tricuspid valve leaflets and mild to moderate 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 insufficiency. The aorta appears normal. The pulmonary artery and associated branches appear normal.



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There is no evidence of pleural effusion, pericardial effusion, or intracardiac masses. The rhythm is irregular.

ECG

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Atrial fibrillation.

Chest Radiographs

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Cardiogenic pulmonary edema.

ULTRASONOGRAPHIC FINDINGS

SEX

Neutered Male

- Atrial fibrillation.
- Cardiogenic pulmonary edema.
- Degenerative valve disease ACVIM stage C.

AGE

10 Years

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The patient has had progression of their disease since the previous echo performed and has developed stage C congestive heart failure and atrial fibrillation. With the clinical improvements and starting diuretic therapy, I recommend continued diuretic therapy which will be lifelong.

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An optimized dose of about 2 mg/kg twice daily is ideal. As long as the patient's kidney values remain normal and eating, benazepril therapy can be continued. I also recommend adding spironolactone for aldosterone antagonism at a dose of 2 mg/kg once daily, again as long as the patient is eating.

INTERPRETED BY

Sara Brethel DVM,
DACVIM (Cardiology)

With the atrial fibrillation, additional medications are needed. Diltiazem is often my first choice. A dose of the non-extended release of 0.5 mg/ kg to 1 mg/kg every 8 hours.

IMAGING PERFORMED BY

Kelly Reschny

Ideally, a Holter monitor would be performed 4-6 weeks after starting diltiazem to help monitor for response to treatment. Due to the severity of the patient's cardiac disease, a referral to a veterinary cardiologist is encouraged. If repeat lab work has not been done since starting diuretic therapy and benazepril, I recommend 1-2 week rechecks for chest radiographs, blood pressure, and blood work assessing kidney values and electrolytes.

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A recheck echo is recommended in 4-6 months. The client should start 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.

REFERRING VET

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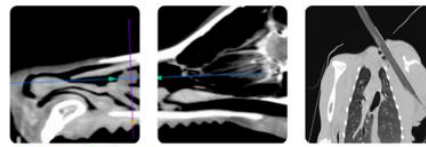
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If a Holter monitor is not being performed, then in about a month, I would recommend a repeat electrocardiogram to assess the overall rate and rhythm, sooner if exercise intolerance and/or cardiogenic pulmonary edema is difficult to control. Oftentimes with atrial fibrillation, patients will have a harder time controlling their heart failure due to the tachycardic rates.

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Unfortunately, with arrhythmias in the stage of the patient's disease, the patient is at risk of passing away suddenly.



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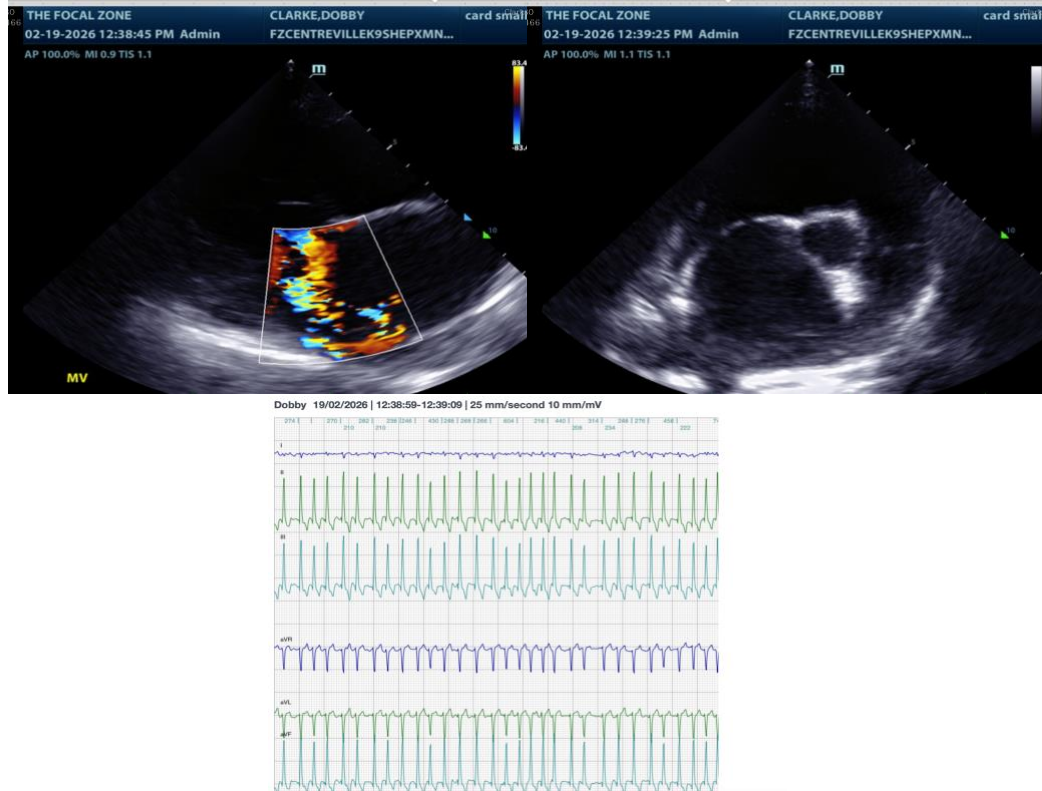
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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