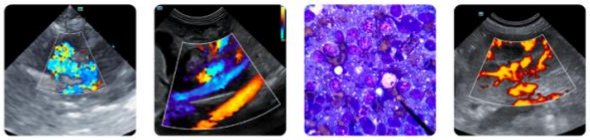

PATIENT

Lil Bit Obst

SPECIES

Canine

BREED

Chihuahua

SEX

Female

AGE

8 Years

WEIGHT

8 Pounds

INTERPRETED BY

Sara Brethel DVM, DACVIM (Cardiology)

IMAGING PERFORMED BY

Julia Bakker, DVM

HOSPITAL NAME

Orange Blossom VI

REFERRING VET

Kristie Johns, DVM

INVOICE

36200

DATE

3/12/26

PRESENTING CLINICAL SIGNS

- New Underdog Adoption. Previously diagnosed with mitral valve disorder.
- Taking Pimobendan Quad tabs 5mg ½ BID, Up Card-CA 1 oral solution 2mg/ml SID

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	5.37	--	Underest	1.81	40.9	--	0.15
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	NM	1.32	1.58	3.63	2.8	2.2	1.3

Cardiac Presentation

The mitral valve leaflets are mildly thickened with mild mitral regurgitation posteriorly directed. There is no prolapse of the mitral valve leaflet. The left atrial size is moderately increased. Left ventricular internal dimensions during diastole are within normal limits 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 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
- Moderate left atrial enlargement
- Normal right atrial size
- Mild tricuspid regurgitation without evidence of significant pulmonary hypertension

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

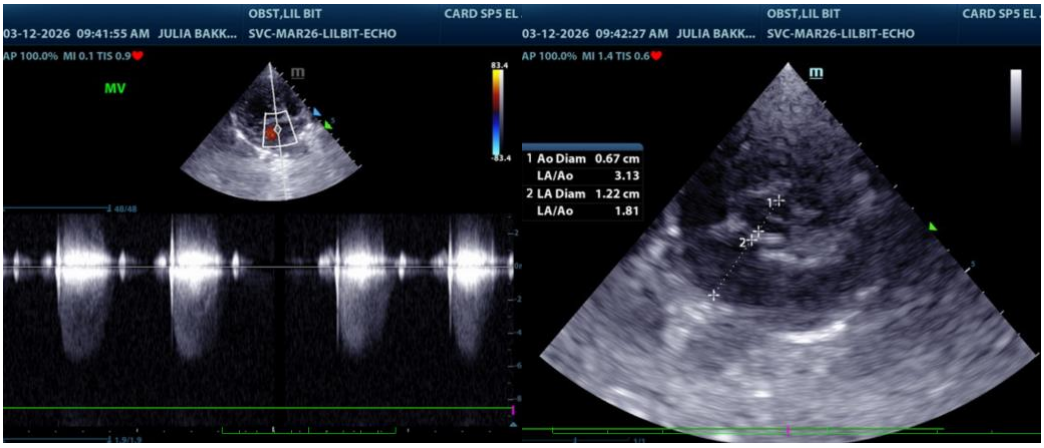
The patient is on diuretic therapy with torsemide. Typically, this is not considered a first-line therapy for congestive heart failure. There is no history provided suggesting if the patient has been in active congestive heart failure. If the patient has not had a previous history of respiratory distress, I would not recommend continuing the Epcard therapy. Can continue pimobendan; the patient is at an elevated dose. If they have been at this dose for a prolonged period of time, I recommend continuation of this. Otherwise, a targeted dose of 0.27 to 0.32 mg/kg twice daily is recommended. With the quad tabs, I recommend only using specific compounding pharmacies due to the finicky nature of pimobendan (Stokes versus Covetrus), otherwise using brand name pimobendan therapy.

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.

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.

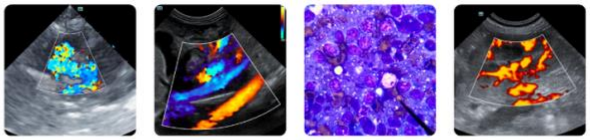
If the patient has been on Epcard and has had a previous episode of congestive heart failure, this therapy can be continued, and I recommend monitoring kidney values at least every 4-6 months while on this therapy. If continuing diuretic therapy, ideally, we would also have Ras suppression with an ACE inhibitor such as enalapril versus benazepril at a dose of 0.5 mg/kg once to twice daily and spironolactone at a dose of 2 mg/kg once daily. 2-3 weeks after starting ACE inhibition, recheck kidney values is also recommended.

If there is a previous history of cardiogenic pulmonary edema, elective anesthetic procedures are not recommended.



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



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can be of any further assistance please contact me.

Sara Brethel DVM, DACVIM (Cardiology)

info@SonoPath.com