

PATIENT

Dutch Sexton

SPECIES

Canine

BREED

Maltese

SEX

Neutered Male

AGE

13 Years

WEIGHT

14 lbs

INTERPRETED BY

Sara Brethel DVM,
DACVIM (Cardiology)

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Pet Care Clinic of the
High Country

REFERRING VET

Dr. Sturgill

INVOICE

15849

DATE

05/06/26

PRESENTING CLINICAL SIGNS

P presented for echo due to cough- Rads no pulmonary edema seen Started DOxy and Cerenia, P needs dental. Please comment on anesthesia risk and best protocol. P is not currently on any heart meds

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	4.96	3.11	2.18	2.76	53.22	--	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	134	1.42	0.71	6.36	4.4	3.57	1.67

Cardiac Presentation ECG

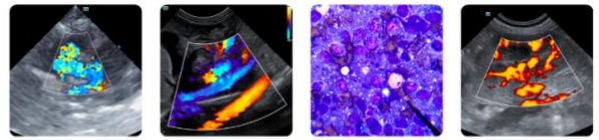
The mitral valve leaflets are moderately thickened with moderate mitral regurgitation posteriorly directed. There is moderate prolapse of the mitral valve leaflets. The left atrial size is severely 3increased. Left ventricular internal dimensions during diastole are increased and systolic function is 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 mild 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.

ECG

Sinus rhythm with a sinus arrhythmia.

ULTRASONOGRAPHIC FINDINGS

- Degenerative valve disease ACVIM stage B2.
- Severe left atrial enlargement.
- Mild tricuspid regurgitation with mild pulmonary hypertension- not clinically significant.



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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 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 cause of the cough is likely secondary to main stem bronchus compression due to the severity of the left atrial enlargement. If there's minimal to no response to doxycycline and Cerenia, can also consider a cough suppressant with hydrocodone at a dose of 0.2 mg/kg twice daily.

The patient is at an increased anesthetic risk particularly for congestive heart failure due to the severity of the heart enlargement. If anesthesia is needed for quality of life, I would recommend the patient be on Pimobendan for at least one to three weeks prior to procedures.

Close monitoring of breathing rates is encouraged. Judicious perioperative fluids i.e. 3.0 mL/kg are recommended and also avoid therapies such as alpha-2 agonists like dexmedetomidine and ketamine. If there's any concern for elevated breathing rates, chest radiographs should be rechecked to ensure there is no emerging pulmonary edema.



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)

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