

Referring Veterinarian:

Clinic Name:

Postal Address:

Phone:

Fax:

Email:

Client:

Patient Name:

Case Number:

Species:

Canine

Breed:

Weimaraner

Age:

5 yrs 6 months

Sex:

MC

Imaging modalities:

Cardiology/Ultrasound

Date Study

December 31,

Occurred:

2006

Number of Images Sent:

18

Date Sent:

January 2, 2007

Wt.: 60.0 lbs/27.1 kgs

Temp.: 102.2 F/39.0 C

Pulse: 120/min

Resp.: 52/min

Responses to specialty question form(s)

Systolic(mm/Hg): N/A

Diastolic(mm/Hg): N/A

Syncope: no

Excercise Intolerance: no

Mean(mm/Hg): N/A

Familial History: no

Anorexia: no

Wt. Loss: yes

PU: N/A **PD:** N/A **PP:** N/A

Cough: yes **Duration:** N/A

Weakness: no

Ascites: no

Cyanosis: no

Tachypnea: yes

Murmur: N/A **Timing:** N/A **Grade:** N/A **Location:** N/A

Gallop: no

Arrhythmia: N/A **Describe:** N/A

Other: N/A **Describe:** N/A

Case History:

labored breathing to varying degrees 10 days prior to presentation, occasional slight cough prior many months; treated for lung infection by referring DVM prior to presentation at Northwood - tetracycline, aminophylline and unknown antihistamine - seemed better while on meds; no history of trauma; on Interceptor (most recent dose mid-December); Kaiser has lost a moderate amount of weight in the last 10 days

Description:

on presentation: mm pink, crt 1-2 s, moderate dyspnea with fine crackles in dorsal lung fields, heart sounds clear - no muffling of heart sounds - no skipped beats - femoral pulse pressure subjectively normal, lymph nodes normal, eyes/ears/nose normal, abdomen gaunt, body condition score 3/9; chest radiographs revealed moderate generalized alveolar pattern with air bronchograms, moderate generalized cardiac enlargement and rounding of the cardiac silhouette with no evidence of a diaphragmatic hernia, megaesophagus, mediastinal or pleural lesions, or hilar lymphadenopathy; heartworm antigen negative; chem/cbc revealed hypoalbuminemia (alb 1.7) and low cholesterol (56), inflammatory leukogram (twbc 27400, pmn 17600, lymphs 5100, monos 2900, eos 1700), mild anemia (hct 29.7), and hyponatremia (sodium 135) with all other parameters normal (including potassium 4.4, bun 17, gluc 82, alt 53, alpk 50, tbil 0.2, etc.); fecal floatation negative for parasites/ova; echocardiogram revealed a fractional shortening of approx 14%, LVD diastole 5.83cm and LVD systole 5.0cm resulting in a presumptive diagnosis of DCM; a FT4(ED) is pending; at this time (1/2/07), Kaiser has responded to furosemide/enalapril/digoxin and is also on a low sodium diet, enrofloxacin and clindamycin

Findings:

Still images of an echocardiogram are submitted for review. The left atrium is mildly to moderately enlarged in size. All valves viewed appear normal. The left ventricular cavity is markedly dilated in diastole (5.4 cm) and systole (4.5 cm) with a depressed fractional shortening (16 %) consistent with myocardial failure. The EPSS is also increased, consistent with left ventricular dilation. The left ventricular walls are thinned (0.7 cm septal wall and 0.7 cm free wall). The right ventricle is normal and the right atrium appears normal in size. There is no pleural or pericardial effusion or evidence of neoplasia on this exam. An irregular rhythm is seen on M-mode exam.

Assessment:

The echocardiogram is consistent with dilated cardiomyopathy with mild to moderate left atrial enlargement and an episode of heart failure. The condition appears relatively advanced at this time with the degree of structural changes seen here. The condition may be idiopathic in origin but may also be due to a nutritional deficiency such as taurine deficiency. The presence of a tachycardia induced cardiomyopathy or perhaps other sources of a volume overload also cannot be completely ruled out, particularly with the lack of changes to the right heart noted on this exam.

Blood and plasma taurine levels are recommended to see if there were a nutritional component to the condition.

If the dog were being fed an unusual or lamb-diet diet, this can be switched to a high quality senior or cardiac support diet. Taurine supplementation is also recommended at 500 mg PO BID. An ECG is also recommended to more fully define the heart rate and rhythm. An echocardiogram including Doppler exam could also be considered to make sure there is no other source of a volume overload.

The current medications can be continued with the lasix tapered to the lowest effective dose and the dose of the digoxin can be adjusted as guided by blood digoxin levels. If the heart rate were persistently elevated over 140 bpm, a cardioprotective beta-blocker, metoprolol can be added as well at 6.25 mg PO BID and increased to 12.5 mg PO SID after a week if it is well tolerated. Side effects include weakness, lethargy, hypotension, anorexia and worsening heart failure. If these are seen, the medication can be discontinued for a day and the restarted at 1/2 dose. The dose can gradually be increased again until the highest dose tolerated is reached. Pimobendan can also be considered at 0.25 mg/kg PO BID but is not approved for use in the US. It is available at some referral hospitals as well as some web sites with individual FDA approval. The thoracic radiographs can be repeated to make sure the pulmonary edema has cleared. A renal profile is recommended a week after the final adjustments to the medications have been made to make sure they are well tolerated. A blood digoxin level is recommended 5 - 7 days after starting the medication and should be at the lower end of the therapeutic range, 0.7 - 2.0 ng/dl. If toxicity is seen, it generally occurs about 3 days after starting therapy with a missed meal, vomiting or diarrhea. If this is seen, the medication can be discontinued for a day and then re-started with a 1/4 dose reduction. The condition can be followed by thoracic radiographs every 4 months to monitor for signs of progression or decompensation. The echocardiogram can be repeated in 4 months to monitor for any further changes to the cardiac structure.

Specialist:

Specialty

Cardiology

Phone:

Fax:

Email:

Date of Report:

Wednesday January 3, 2007

Any questions regarding this report should be directed to the reporting specialist.

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