Initial treatment date	Patient ID	Species
10/7/2021	265200	Feline

Breed	Sex	Age	Weight in kg
Domestinc Short Hair (DSH)	Female Spayed	10.08	3.6

Diagnosis (or differential list)
Unclassified cardiomyopathy – suspect end-stage hypertrophic cardiomyopathy, mitral valve regurgitation, congestive heart failure, pleural effusion

Case presentation
The patient presented for evaluation of recurrent pleural effusion, tachypnea, and a gallop sound secondary to presumed heart disease. The patient needed three emergent thoracocentesis in two weeks before being seen by the cardiology department.

Acquired a systolic blood pressure of 131mmHg using a Doppler non-invasive blood pressure device with a #1 sized blood pressure cuff over the patient's coccygeal artery after 5 readings (8). The width of the cuff measured approximately 30-40% of the diameter of the tail to ensure a proper fit. This is done prior to the physical exam, whenever possible, to minimize patient stimulation for the most accurate readings.

Physical examination: Patient had a regular rhythm with strong and synchronous pulses. Heart and lung sounds were muffled ventrally with a gallop sound present (2). Dorsal lung sounds were normal. Patient was tachypneic and had mildly efforted breathing with a respiratory rate of 60rpm.

Echocardiogram interpretation: Identified severe left atrial enlargement (77) with mildly reduced left ventricular systolic function (75), asymmetrical thinning of the left ventricular free wall, mitral valve thickening (73), moderate mitral valve regurgitation (68), and pleural effusion (67).

Sedated patient using alfaxalone (2.54mg/kg) 9mg combined with butorphanol (0.1408mg/kg) 0.5mg and administered IM in the patient's epaxial muscles. The patient was allowed to sit in her carrier with flow-by oxygen supplementation while the sedation took effect for 15 minutes. While waiting for the patient's sedation to take effect, the applicant set up for a thoracocentesis (see attached pull list) (110). Shaved and aseptically prepped using betadine and alcohol on the right hemithorax between the 5th-10th intercostal spaces at the level of the costochondral junction. The resident used the ultrasound to find the best fluid pocket to tap, which was between the 8th-9th intercostal spaces. A local block was performed using 0.25mL of 2% lidocaine in the intercostal space before finishing the aseptic prep. Thoracocentesis was performed by the resident on the case with the applicant aspirating 60mL of straw-colored fluid from the patient's pleural space. The fluid was submitted for analysis and cytology in no additive and EDTA tubes.

Advanced skills the applicant performed
Utilize a Doppler non-invasive blood pressure device (8)
Identify patients with a gallop rhythm (2)
Identify pleural effusion (67)
Identify valvular regurgitation/insufficiency on color flow Doppler (68)
Identify mitral valve thickening (73)
Identify systolic dysfunction or ventricular hypokinesis (75)
Identify LA enlargement (77)
Set up for thoracocentesis – see pull list (110)

Advanced skills the applicant assisted with
Echocardiogram
Thoracocentesis

Outcome
The patient was discharged once she recovered from the sedation for her thoracocentesis, with a recheck scheduled for 10/13/2021. The patient's torsemide 5mg/mL suspension was increased to (0.141mg/kg) 0.5mg PO in the morning and (0.282mg/kg) 1mg at night OR (0.423mg/kg) 1.502mg PO SID if unable to medicate BID, this option was offered since owners expressed difficulty medicating patient historically. Pimobendan 1.25mg tablets were continued at (0.528mg/kg) 1.875mg PO BID.

Calculations based off weight of 3.55kgs.

Patient was doing well at home. The owners decided they didn't want to put her through the stress of additional visits, so they canceled follow up appointments. Patient presented to our emergency room on 11/22/2021. Owners elected not to pursue a necropsy.

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Case Log 2

Initial treatment date	Patient ID	Species
10/1/2021	3218651	Canine

Breed	Sex	Age	Weight in kg
Cavalier King Charles Spaniel	Male Neutered	8.50	8.1

Diagnosis (or differential list)
Myxomatous mitral valve disease (MMVD) ACVIM stage C

Case presentation
The patient presented to the cardiologist for a heart murmur evaluation with previously reported increased respiratory rate (RR) and effort plus cough. The applicant obtained a comprehensive history from the owner which included the following medication history: furosemide 2.46 mg/kg (20 mg) PO BID. The applicant obtained the patient's vital signs. The applicant restrained the patient for a PE as performed by the cardiologist. The applicant identified a grade 4 out of 6 left apical systolic murmur with a regular rhythm. The applicant obtained a Doppler BP which was 120 mmHg. The applicant obtained diagnostic quality thoracic radiographs as ordered by the cardiologist. The applicant calculated a vertebral heart score (VHS) on the right lateral thoracic radiograph which was 13.5 (reference range 8.7 – 10.7). The applicant identified left atrial enlargement (LAE) on the right lateral radiograph. The applicant identified enlarged pulmonary veins on the right lateral and VD thoracic radiographs. The applicant identified pulmonary edema on the VD projection of the thoracic radiographs. The applicant acquired and printed a 6-lead ECG at 50 mm/sec paper speed. The applicant identified sinus tachycardia on the ECG. The applicant calculated the MEA of the ECG which was +60 degrees (normal). The applicant calculated the ECG measurements: P wave amplitude 0.4 millivolts (mV), P wave duration 0.06 seconds (prolonged, P mitrale, indicative of LAE), PR interval 0.1 seconds, QT interval 0.18 seconds, QRS complex duration 0.04 seconds, R wave amplitude 2.3 mV, T wave amplitude 0.8 mV. The applicant obtained a blood sample, and the cardiologist ordered the following serum chemistries: BUN, CREA, phosphorus (PHOS), sodium, chloride, potassium, and albumin. The applicant restrained the patient for an echocardiogram as performed by the cardiologist. The applicant identified LAE with mitral valve (MV) regurgitation on color flow Doppler, and MV thickening with prolapse on echocardiogram.

Advanced skills the applicant performed
• Identified a grade 4 out of 6 left apical systolic murmur with a regular rhythm on auscultation
• Obtained BP via Doppler: 120 mmHg
• Obtained diagnostic quality thoracic radiographs

Advanced skills the applicant assisted with
Echocardiogram

• Calculated a VHS on the right lateral thoracic radiograph: 13.5 (reference range 8.7 – 10.7)
• Identified LAE on the right lateral radiograph
• Identified pulmonary veins on the right lateral and VD radiographs
Advanced skills the applicant assisted with
• Echocardiogram
• Identified pulmonary edema on the VD radiograph
• Acquired and printed a 6-lead ECG at 50 mm/sec paper speed
• Calculated the MEA of the ECG: +60 degrees (normal)
• Calculated ECG measurements: P wave amplitude 0.4 mV, P wave duration 0.06 seconds (P mitrale, indicative of LAE), PR interval 0.1 seconds, QT interval 0.18 seconds, QRS complex duration 0.04 seconds, R wave amplitude 2.3 mV, T wave amplitude 0.8 mV
• Identified LAE on echocardiogram
• Identified MV regurgitation/insufficiency on color flow Doppler on echocardiogram
• Identified MV thickening and prolapse on echocardiogram

Outcome
The patient was discharged to the care of his owner later that day. His electrolytes showed a chloride just below the reference range at 108 mmol/L (109 mmol/L – 122 mmol/L); the remainder of his serum chemistries and electrolytes were within normal limits. The chloride value just below the reference range was likely secondary to furosemide administration. His furosemide was continued at 2.46 mg/kg (20 mg) PO BID; and pimobendan 0.46 mg/kg (3.75 mg) PO BID, enalapril 0.61 mg/kg (5 mg) PO BID, and spironolactone 3.08 mg/kg (25 mg) PO SID were started. The applicant reviewed the medications with the owner including administration and possible side effects. The applicant educated the owner on signs to watch for that could indicate progressive cardiac disease. This included coughing, increased RR and effort, fainting, and/or exercise intolerance. The applicant also instructed the owner to transition the patient to a low sodium diet. A recheck was recommended in 1 week.

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Case Log 3

Initial treatment date	Patient ID	Species
10/19/2021	98054	Canine

Breed	Sex	Age	Weight in kg
Boxer	Male Neutered	12.00	35.7

Diagnosis (or differential list)
Arrhythmogenic right ventricular cardiomyopathy (suspected); Ventricular premature complexes; Chronic degenerative valve disease (ACVIM Stage B1); Syncope

Case presentation
The patient presented to his rDVM after two episodes of collapse. He was also noted to have a potential heart murmur (grade not available within rDVM record). A spot ECG was stated to be abnormal (no

further description available within rDVM record). CXR were described as unremarkable. A cardiology consultation was recommended for further evaluation of cardiac status. The patient was presented to the Applicant's facility for a cardiac evaluation. Upon PE, the Applicant identified a grade II/VI LAS heart murmur, with radiation to the right hemithorax. She also auscultated an abnormal rhythm with ectopic beats and associated pulse deficits. The Applicant performed a non-invasive BP via Doppler that was WNL (112 mmHg systolic). The Applicant then acquired a 50 mm/sec ECG strip for evaluation, identifying single VPCs, as well as some motion artifacts. The Applicant assisted in performing an echocardiogram, and identified mild MV thickening and subsequent MR on CF Doppler.

Advanced skills the applicant performed
1. Identified cardiac murmur
4. Identified abnormal rhythm on auscultation
5. Identified ectopic beats on auscultation with correlating pulse deficits
8. Obtained non-invasive BP via Doppler
34. Acquired and printed 50 mm/sec ECG strip
39. Identified ECG artifacts due to motion
59. Identified VPCs on ECG
68. Identified valvular regurgitation on CF Doppler on echocardiogram
73. Identified mitral valve thickening and prolapse on echocardiogram

Advanced skills the applicant assisted with
Echocardiogram

Outcome
The patient was diagnosed with suspected arrhythmogenic right ventricular cardiomyopathy (ARVC) due to his breed predisposition, ventricular arrhythmias, and lack of significant cardiac structural changes that would cause ventricular ectopy. Due to the patient having a Hx of syncope suspected to be secondary to the ventricular arrhythmias, he was started on sotalol 1.68 mg/kg (60 mg) PO q 12 hr as a beta blocker for treatment of his arrhythmia. It was recommended to return in one to two weeks for a recheck ECG and possible Holter monitor. The owner contacted the Applicant's facility one day prior to recheck stating that they were electing humane euthanasia due to quality of life concerns.

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Case Log 4

Initial treatment date	Patient ID	Species
2/8/2022	101613	Feline

Breed	Sex	Age	Weight in kg
DSH	Male Neutered	12.00	4.1

Diagnosis (or differential list)
Hypertrophic cardiomyopathy (secondary to hyperthyroidism); Aortic thromboembolism; Hyperthyroidism

Case presentation
The patient was presented to his rDVM after his owners observed him having an episode of open-mouth panting, rolling around on the floor, and being unable to jump onto furniture. PE described paralysis of the hind limbs, though the rear nail beds were noted as being adequately perfused. A serum chemistry panel was performed, and revealed hyperthyroidism (T4 5.8 µg/dL, ref. range 0.4-4.0 µg/dL) with no other abnormalities. He was started on furosemide 1.22 mg/kg (5 mg) PO q 24 hr based on concern for cardiac disease, and methimazole 0.3 mg/kg (1.25 mg) PO q 12 hr for thyroid management. Four days later, the patient returned to his rDVM for a follow-up examination, and pimobendan 0.24 mg/kg (1 mg) PO q 12 hr

was initiated to aid in cardiac contractility. A cardiology consultation was recommended. The patient presented to the Applicant's facility for evaluation. His owners reported continued difficulties walking on the paw pads, but seemed to have regained some function of the hind legs. The Applicant appreciated a gallop sound without a heart murmur upon auscultation, and noted the presence of strong and synchronous femoral pulses bilaterally. The Applicant obtained BPs from both the left forelimb and left hind limb via Doppler, that were equal in pressure (110 mmHg systolic), suggestive of at least partial resolution of a potential ATE. A 50 mm/sec ECG strip was obtained by the Applicant, and was identified to meet the criteria for left anterior fascicular block (LAFB). The Applicant performed the following measurements on the obtained ECG strip: MEA -90 (indicating severe left axis deviation); P-R interval 80 ms; Q-T interval 150 ms; P wave amplitude 0.2 mV; P wave duration 20 ms; QRS duration 40 ms; R wave amplitude 0.9 mV; T wave amplitude 0.1 mV. The Applicant assisted the DACVIM with an echocardiogram, and identified left ventricular concentric hypertrophy (IVSd 5.4 mm; LVPWd 7.7 mm), and LAE (LA/Ao 2.1). No obvious SEC or formed clot was observed, though there was low velocity flow in the LAA. The Applicant then performed CXR that showed a mild bronchointerstitial pattern consistent with mild residual CHF on both the DV and lateral projections. The Applicant identified the bronchi, pulmonary arteries, pulmonary veins, the caudal vena cava, and the aorta on a lateral projection. She calculated a VHS using a lateral projection (8.3), which is on the high end of normal. A limited blood panel that consisted of BUN, Crea and K was performed to evaluate tolerance to medications, and was WNL. As it had been more than three weeks since initiating thyroid treatment, a thyroid level was also obtained to evaluate efficacy of medication and showed him to be euthyroid (T4 2.9 µg/dL, ref. range 0.4-4.0 µg/dL).

Advanced skills the applicant performed

1. Identified a gallop sound/split sound/mid-systolic click
8. Obtained non-invasive BP via Doppler
14. Produced diagnostic quality thoracic radiographs on a cat
16. Calculated a Vertebral Heart Score on a lateral thoracic radiograph
19. Identified pulmonary edema on a DV/VD thoracic radiograph
25. Identified pulmonary edema on a lateral thoracic radiograph
28. Identified bronchi on a lateral thoracic radiograph
29. Identified pulmonary arteries on a lateral thoracic radiograph
30. Identified pulmonary veins on a lateral thoracic radiograph
31. Identified the caudal vena cava on a lateral thoracic radiograph
32. Identified the aorta on a lateral thoracic radiograph
34. Acquired and printed 50 mm/sec ECG strip
38. Calculated the Mean Electrical Axis (MEA)
39. Calculated the P-R interval
40. Calculated the Q-T interval
41. Calculated the P wave amplitude and duration
42. Calculated the QRS complex duration
43. Calculated the R wave amplitude
44. Calculated the T wave amplitude
58. Identified a left anterior fascicular block on ECG

Advanced skills the applicant assisted with

Echocardiogram

75. Identified ventricular hypertrophy on echocardiogram
76. Identified left atrial enlargement on echocardiogram

Outcome
Due to the subjective improvement of the use of the patient's hind limbs in the short time following the initial event, it was recommended to continue at-home nursing care. It was recommended to increase his furosemide to 1.22 mg/kg (5 mg) to PO q 12 hr based on concern for mild residual pulmonary edema, and initiate clopidogrel 4.57 mg/kg (18.75 mg) PO q 24 hr to aid in any further thrombi from forming. No changes were made to his methimazole or pimobendan dosing. It was recommended to continue to monitor at home for changes in the function of his hind limbs. A recheck kidney and electrolyte panel and thyroid level was recommended in one month. The patient returned approximately four months later for a cardiac recheck. He was noted to continue to have an abnormal gait, but otherwise had recovered most function of his hind limbs. There was mild improvement to echocardiographic measurements in both his LVH (IVSd from 5.4 mm to 3 mm; LVPWd from 7.7 mm to 7.0 mm), and his LAE (LA/Ao from 2.1 to 1.5). CXR showed improvement from moderate to mild generalized cardiomegaly. A serum chemistry panel was WNL. His previously diagnosed hyperthyroidism seemed to be medically controlled at that time, as it too was WNL, suggesting hyperthyroidism to be a primary component to the patient's cardiac disease.

With his structural improvement, it was recommended to decrease the patient's furosemide to 1.22 mg/kg (5 mg) PO q 24 hr. No changes were made to his other cardiac medications. A full recheck was recommended in October. During a visit with his rDVM, it was reported that his owners felt his hind limb strength had continued to improve.

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Case Log 5

Initial treatment date	Patient ID	Species
6/10/2022	3262801	Canine

Breed	Sex	Age	Weight in kg
Golden Retriever/Poodle mix	Female Spayed	4.00	19.8

Diagnosis (or differential list)
Dilated Cardiomyopathy (DCM) phenotype

Case presentation
The patient presented to the cardiologist for a murmur evaluation. The applicant obtained a comprehensive history from the owner. The applicant obtained the patient's vital signs. The applicant restrained the patient for a PE as performed by the cardiologist. The applicant identified a grade 3 out of 6 left basilar systolic murmur and a regularly irregular rhythm that varies with respiration on auscultation (suspect respiratory sinus arrhythmia but need an ECG to confirm). The applicant obtained an oscillometric BP which was 111/63 (77) mmHg. The applicant acquired and printed a 6-lead ECG at 50 mm/sec paper speed. The applicant identified sinus arrhythmia on the ECG. The applicant calculated the MEA of the ECG which was +60 degrees (normal). The applicant calculated the ECG measurements: P wave amplitude 0.15 mV, P wave duration 0.04 seconds, PR interval 0.12 seconds, QT interval 0.2 seconds, QRS complex duration 0.04 seconds, R wave amplitude 3.3 mV (abnormal, suggestive of LV enlargement), T wave amplitude 0.6 mV. The applicant restrained the patient for an echocardiogram as performed by the cardiologist. The applicant identified LV eccentric hypertrophy and LAE on echocardiogram. The applicant also identified reduced systolic function on echocardiogram.

Advanced skills the applicant performed
• Identified a grade 3 out of 6 left basilar systolic murmur on auscultation
• Identified a regularly irregular rhythm that varies with respiration on auscultation (suspect respiratory sinus arrhythmia but need an ECG to confirm)
• Obtained an oscillometric BP: 111/63 (77) mmHg
• Acquired and printed a 6-lead ECG at 50mm/sec paper speed
• Identified sinus arrhythmia on the ECG
• Calculated the MEA of the ECG: + 60 degrees (normal)
• Calculated the ECG measurements: P wave amplitude 0.15 mV, P wave duration 0.04 seconds, PR interval 0.12 seconds, QT interval 0.2 seconds, QRS complex duration 0.04 seconds, R wave amplitude 3.3 mV (abnormal, suggestive of LV enlargement), T wave amplitude 0.6 mV
• Identified LV enlargement on the ECG
• Identified LV eccentric hypertrophy on echocardiogram
• Identified LAE on echocardiogram
• Identified systolic dysfunction on echocardiogram

Advanced skills the applicant assisted with
Echocardiogram

Outcome
The patient was discharged to the care of her owner later that day. Her echocardiogram was consistent with DCM phenotype. She was sent home with pimobendan 0.25 mg/kg (5mg) PO BID. Taurine supplementation at 50.5 mg/kg (1000 mg) PO BID was also recommended and left for the owner to decide about starting. The applicant reviewed the medication and supplements with the owner including administration and frequency. The applicant educated the owner on signs to watch for that could indicate progressive cardiac disease. This included coughing, increased RR and effort, fainting, and/or exercise intolerance. The applicant instructed the owner to transition the patient to a diet that meets the WSAVA Global Nutrition Committee's guidelines. A recheck was recommended in 6 mo.

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Case Log 6

Initial treatment date	Patient ID	Species
8/22/2022	108330	Canine

Breed	Sex	Age	Weight in kg
Australian Cattle Dog	Female Spayed	8.00	19.0

Diagnosis (or differential list)
Third degree atrioventricular block; Accelerated idioventricular rhythm; Ventricular premature complexes; Chronic degenerative valve disease (ACVIM Stage B2)

Case presentation
The patient was presented to a local ER for episodes of collapse. Her heart rate was variable (between 45 and 120 BPM) with bradycardia noted during episodes of collapse. A spot ECG was reported to show 3AVB. A CBC/serum chemistry profile was WNL. She was transferred to the Applicant's facility for potential pacemaker implantation. At presentation through ER, the Applicant appreciated a grade III/VI

LAS heart murmur with strong femoral pulses. At first, the patient had a heart rate of 120 BPM, but then abruptly became bradycardic (40 BPM). The Applicant obtained a 50 mm/sec ECG strip and identified an AIVR with AV dissociation at 130 BPM. She then printed a rhythm strip in which the patient transitioned to 3AVB with both junctional and ventricular escape beats. The Applicant identified thickening of the MV with moderate MR on CF Doppler, moderate LAE (LA/Ao 2.4), and trace PCE on echocardiogram. The Applicant prepared the fluoroscopy suite for temporary transvenous pacemaker placement. During preparation for the temporary pacemaker, the patient had a hypoxic seizure event. The patient was placed in right lateral recumbency, and the left jugular neck was aseptically scrubbed and prepared. The patient was draped, and an #11 blade was used to make a stab incision over the left jugular vein. A 16G needle was used to gain access to the vein, a guidewire was placed, and then a short introducer was advanced over the guidewire. Once the introducer was secured, a temporary pacing lead was inserted into the RV using fluoroscopy guidance. Once seated in the RV, the lead was connected to the temporary pacing generator, and pacing was confirmed via ECG monitoring. The Applicant assisted the DACVIM in carefully bandaging the neck to secure placement of the lead. The Applicant placed telemetry for overnight monitoring of the heart rate/rhythm. The patient was given butorphanol 0.3 mg/kg (5.7 mg) IV once, then started on a butorphanol CRI 0.2 mg/kg/hr (3.8 mg/hr or 0.38 ml/hr). Overnight the patient had periods of a paced rhythm, AIVR, as well as ventricular couplets with occasional R-on-T phenomenon. Overnight, the patient dislodged the temporary pacemaker, and another lead had to be placed by the DACVIM. The patient was started on CRIs of both alfaxalone 0.05 mg/kg/min (57 mg/hr or 5.7 ml/hr) and fentanyl 10 mcg/kg/hr (0.19 mg/hr or 3.8 ml/hr) for sedation, and an indwelling urinary catheter was also placed by an ICU technician due to the higher level of sedation. The next morning, an AUS was performed and was WNL. The Applicant set up the fluoroscopy suite, organized and identified equipment used for pacemaker implantation. The patient was induced for general anesthesia by another technician. The Applicant clipped and sterilely prepped the right neck and jugular vein, then scrubbed in to assist the DACVIM. The DACVIM made an incision over the right jugular vein. Together, the DACVIM and Applicant used a vein pick and vascular loops to insert a 58 cm active fixation lead into the right jugular vein. The lead was advanced into the RA, across the TV, and into the RV. With the aid of a stylet and fluoroscopy guidance, the lead was advanced into the RV apex. Once the lead was seated in the RV apex, the DACVIM used the A-wrench to extrude the tip into the RV apical myocardium. Sterile pacing cables were attached to the lead and plugged into the system analyzer. Threshold testing was performed and confirmed ventricular capture down to a threshold of 0.3 V. The DACVIM made a second incision at the right dorsolateral neck, and created a tunnel from the initial incision to this pocket. The lead was disconnected, pulled through the tunnel, and immediately connected to the ventricular port of the permanent pulse generator using the screwdriver. The patient began pacing using the preprogrammed generator at 80 BPM. The DACVIM seated the generator in the dorsal incision under the muscle tissue, and used suture to tack the generator in two separate locations. Once the patient's incisions were closed, the temporary pacing lead and introducer were pulled and pressure was applied for approximately ten minutes. The Applicant then bandaged the neck. The Applicant performed CXR, and identified the pacemaker generator and lead placement on both DV and lateral views.

Advanced skills the applicant performed

1. Characterized cardiac murmur
4. Identified abnormal rhythm on auscultation
15. Produced diagnostic quality thoracic radiographs on a dog
22. Identified a pacemaker lead wire on a DV/VD thoracic radiograph
34. Acquired and printed 50 mm/sec ECG strip
35. Acquired and printed a rhythm strip
55. Identified 3rd degree AV block on ECG
59. Identified VPCs on ECG
60. Identified ventricular escape complexes on ECG
66. Identified pericardial effusion on

Advanced skills the applicant assisted with

Echocardiogram
Temporary pacemaker implantation
Permanent pacemaker implantation

echocardiogram
68. Identified valvular regurgitation on CF Doppler on echocardiogram
73. Identified mitral valve thickening and prolapse on echocardiogram
77. Identified left atrial enlargement on echocardiogram
101. Identified vascular introducers and described its use in interventional cardiac catheterization
114. Created and utilized a pull list for transvenous temporary pacing
115. Created and utilized a pull list for transvenous permanent pacing

Outcome
She was continued overnight on cefazolin 22.11 mg/kg (420 mg) IV q 8 hr to aid in fighting bacterial infection, and trazodone 6.58 mg/kg (125 mg) PO q 8 hr for sedation. No pain management was necessary as she was given bupivacaine liposome 5.16 mg/kg (98.1 mg - divided into both incisions) by infiltration injection once during closure for pain control. The Applicant placed telemetry to monitor her heart rate and rhythm overnight. She continued to have both the paced rhythm, as well as the ventricular arrhythmias overnight. The following day, a final interrogation of her pacemaker was performed, with battery life estimated at 9 years and 4 months. The patient was sent home with cephalexin 26.32 mg/kg (500 mg) PO q 12 hr for 7 days to aid against bacterial infection, trazodone 5.26 mg/kg (100 mg) PO q 8 hr PRN for 30 days for sedation, and gabapentin 5.26 mg/kg (100 mg) PO q 12 hr PRN for 7 days for pain/sedation. Due to her LAE on echocardiogram secondary to valve disease (though chronic bradycardia could be excluded as a contributing factor), she was also RX pimobendan 0.26 mg/kg (5 mg) PO q 12 hr to aid in cardiac contractility. Additionally, she was sent home with a two weeks supply of sotalol 2.11 mg/kg (40 mg) PO q 12 hr as a beta blocker to treat her continued ventricular arrhythmias, with the potential to discontinue during her recheck if they resolved. Nine days later, the patient presented through ER for concerns of redness and swelling at one of her incision sites. Upon PE, the incision over the jugular insertion site was moderately red and inflamed (R/O seroma vs abscess vs suture reaction). Her owners noted she may have been scratching at it. The incision was carefully clipped and cleaned, but it was noted that two sutures had been removed that were no longer intact. A bandage was placed over the incision, and she was sent home on amoxicillin/clavulanate 13.16/3.29 mg/kg (250/62.5 mg) PO 12 hr for 14 days, and enrofloxacin 10.74 mg/kg (204 mg) PO q 24 hr for 14 days to aid against potential bacterial infection. During her two week recheck, it was found that her incision showed a small dehiscence, and aerobic/anaerobic cultures initially returned as pseudomonas aeruginosa. A pacemaker revision was strongly recommended, but ultimately the owners elected to euthanize due to financial constraints and quality of life concerns.