Current Canine Guidelines for the Prevention, Diagnosis, and Management of Heartworm (Dirofilaria immitis) Infection in Dogs
(Revised 2018)

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AHS-Recommended Protocol
Table 2. AHS-Recommended Protocol

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Preamble

These recommendations supersede previous editions and are based on the information presented at the 2016 Triennial Symposium of the American Heartworm Society (AHS), new research, and additional clinical experience. The recommendations for the prevention, diagnosis, and management of heartworm infection in cats are contained in a companion feline document (available on the AHS website).

HIGHLIGHTS

• Diagnostics
AHS recommends annual antigen and microfilaria testing. (As the interpretation of diagnostics has become more complex, please see the “Microfilaria and Antigen Testing” section for more complete information.)

• Prevention
AHS recommends year-round administration of preventive drugs approved by the US Food and Drug Administration (FDA) to prevent heartworm infection and enhance compliance, the latter being particularly important in light of the documented presence of resistant subpopulations. Application of an Environmental Protection Agency (EPA) registered mosquito repellent/ectoparasiticide has been shown to increase the overall efficacy of a heartworm prevention program in laboratory studies involving known resistant heartworm isolates by providing control of the arthropod vector of heartworm. In addition, AHS recommends reduction of exposure to mosquitoes through standard environmental control of mosquitoes and their breeding environments, and when possible, reducing outdoor exposure during key mosquito feeding periods.

• Adulticide Therapy
AHS recommends use of doxycycline and a macrocyclic lactone prior to the three-dose regimen of melarsomine (one injection of 2.5 mg/kg body weight followed at least one month later by two injections of the same dose 24 hours apart) for treatment of heartworm disease in both symptomatic and asymptomatic dogs. Any method utilizing only macrocyclic lactones as a slow-kill adulticide is not recommended.
Heartworm infection in dogs has been diagnosed around the globe. In the United States, its territories, and protectorates, heartworm is considered at least regionally endemic in each of the contiguous 48 states, Hawaii, Puerto Rico, US Virgin Islands, and Guam (Bowman et al, 2009; Kozek et al, 1995; Ludlam et al, 1970). Heartworm transmission has not been documented in Alaska; however, there are regions in central Alaska that have mosquito vectors and climate conditions to support the transmission of heartworms for brief periods (Darsie and Ward, 2005; Slocumbe et al, 1995; Terrell, 1998). Thus, the introduction of microfilaricidal dogs or wild canids could set up a nidus of infection for local transmission of heartworm in this state (see box on page 5 for more on the role of transport of infected dogs). Such relocation of microfilaricidal dogs and expansion of the territories of microfilaricidal wild canids in other areas of the United States continue to be important factors contributing to further spread of the parasite.

A pivotal prerequisite for heartworm transmission is a climate that provides adequate temperature and humidity to support a viable mosquito population, and can also sustain sufficient heat to allow maturation of ingested microfilariae into infective, third-stage larvae (L3) within the intermediate host.

The length of the heartworm transmission season in the temperate latitudes is critically dependent on the accumulation of sufficient heat to incubate larvae to the infective stage in the mosquito (Knight and Lok, 1998; Lok and Knight, 1998). The peak months for heartworm transmission in the Northern Hemisphere are typically July and August. Models predict that heartworm transmission in the continental United States is limited to 6 months or less above the 37th parallel at approximately the Virginia–North Carolina border.

Urban sprawl has led to the formation of “heat islands,” as buildings and parking lots retain heat during the day (Figure 1), creating microenvironments with potential to support the development of heartworm larvae in mosquito vectors during colder months, thereby lengthening the transmission season (Morchon et al, 2012, Nelson, 2016).

As mosquito vectors expand their territory and new non-native vectors are introduced (e.g., Aedes notoscriptus introduction to California; Peterson and Campbell, 2015) the number of animals infected will continue to increase. A pivotal prerequisite for heartworm transmission is a climate that provides adequate temperature and humidity to support a viable mosquito population, and can also sustain sufficient heat to allow maturation of ingested microfilariae into the infective, third-stage larvae (L3) within this intermediate host. It has been shown in three mosquito species that maturation of larvae ceases at temperatures below 57˚F (14˚C) (Christensen and Hollander, 1978; Fortin and Slocumbe, 1981). Heartworm transmission does decrease in winter months, but the presence of microenvironments in urban areas suggests that the risk of heartworm transmission never reaches zero (Nelson, 2016). Furthermore, some species of mosquitoes overwinter as adults. While heartworm larval development in these mosquitoes may cease in cool temperatures, development quickly resumes with subsequent warming (Christensen and Hollander, 1978; Ernst and Slocumbe, 1983).
state line (Guerrero et al, 2004).

While model-based predictions of transmission using climatic data are academically appealing, they typically fail to consider several potentially important factors, such as influence of microclimate, unique biological habits and adaptations of the mosquito vector, variations in time of larval development, mosquito life expectancy, and temperature fluctuations. Predictive risk maps assume that mosquito vectors live for only one month; however, several significant mosquito vectors live and breed for much longer periods, including:

- *Aedes albopictus* (3 months) (Löwenberg-Neto and Navarro-Silva, 2004).
- *Aedes aegypti* (3 months) (Gjullin et al, 1950).
- *Ochlerotatus (formerly Aedes) trivittatus* (2 months) (Christensen and Rowley, 1978).
- *Aedes vexans* (2 months) (Gjullin et al, 1950), and
- *Ochlerotatus (formerly Aedes) canadensis* (several months) (Pratt and Moore, 1960).

There are also documented cases of hibernating *Ochlerotatus* (several canadensis (formerly (2 months) (Gjullin et al, 1950), and

- *Aedes albopictus* for much longer periods, including:

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Anopheles quadrimaculatus surviving for 4 to 5 months (Himmann and Hurlybut, 1940), so the predictive risk maps likely reflect a shorter transmission season than actually exists in some areas. Survey studies of trapped mosquitoes randomly collected at various locations have demonstrated heartworm infection rates in mosquitoes ranging from 2% to 19.4% in known endemic areas. When mosquito sampling was restricted to kennel structures where known positive dogs were being housed, the infection rates of the mosquitoes in these restricted samplings resulted in rates of 30% adjacent to and 74% inside the facilities (McKay et al, 2013). Based upon these data, it is important to protect pets from mosquito exposure (see Vector Control starting on page 11) in addition to administering year-round heartworm preventive.

Once a reservoir of microfilaremic domestic and wild canids is established beyond the reach of veterinary care, the ubiquitous presence of one or more species of vector-competent mosquitoes makes transmission possible and eradication improbable.

**Figure 2.** The heartworm life cycle.

**KEY POINTS:**

- The relatively long life cycle of *D. immitis* (7 to 9 months) requires a reservoir of infection, a vector capable of transmitting infection, and a susceptible host.
- The mosquito, the required vector for transmission of *D. immitis*, becomes infected as she takes a blood meal from a microfilaricidal host. It is important to note that microfilariae cannot develop into adult heartworms without first developing into larval stage 1 (L1) in the malpighian tubules of the mosquito, then molting into larval stage 2 (L2), and finally molting into infective third-stage larvae (L3) (Taylor, 1960). The third-stage larvae, the infective stage, then migrate via the body cavity to the head and mouthparts of the mosquito, where they are positioned for transmission. The time required for the development of microfilariae to the infective stage within the mosquito is temperature dependent. At 27°C (80.6°F) and 80% relative humidity, development takes about 10 to 14 days; with cooler temperatures maturation takes longer (Kartman, 1953; Slocombe et al, 1989).

**BIOLOGY AND LIFE CYCLE**

The life cycle of *Dirofilaria immitis* is relatively long (usually 7 to 9 months) compared with most parasitic nematodes (Kotani and Powers, 1982) (Figure 2). This protracted life cycle requires a reservoir of infection, a vector capable of transmitting infection, and a susceptible host.

The domestic dog and some wild canids are the normal definitive hosts for heartworms and are inclined to develop high microfilaria counts, thus allowing them to serve as the main reservoir of infection. Less suitable hosts, such as cats and ferrets, occasionally have low-level, transient microfilaraemia and theoretically may serve as a limited source of infection for mosquitoes during their short periods of microfilaraemia (McCull et al, 2008b).

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- A final molt into juvenile/mature adults occurs between days 50 and 70, while they are migrating through the body; and they eventually reach the smallest pulmonary arteries as early as day 67 after transmission.
- Sexual maturity occurs about day 120 post infection with dogs developing patent infections (i.e., having circulating microfilariae) as early as 6 months but usually by 7 to 9 months after infection.
- A clear understanding of heartworm transmission, development, prepatent period, and the susceptibility of the different life stages of the parasite to available pharmaceutical drugs is critical to the successful management of infected dogs.
and 1.5 inches in length. As they mature, female heartworms ultimately grow tenfold to reach 10 to 12 inches in length. Sexual maturity occurs about day 120 post infection with dogs developing patent infections (i.e., having circulating microfilariae) as early as 6 months but usually by 7 to 9 months after infection (Kotani and Powers, 1982; Orihel, 1961). When juvenile heartworms first arrive in the lungs the flow of blood forces them into the small pulmonary arteries (Rawlings, 1980). As the worms increase in size, they progressively occupy larger and larger arteries until they become fully mature. The eventual location of the mature adult worm appears to depend mainly on the size of the dog and the worm burden. A medium-sized dog (e.g., Beagle) with a low worm burden (<5) usually has worms mainly in the lobar arteries and main pulmonary artery. As the worm burden increases, worms also can be located in the right ventricle. Dogs with more than 40 worms are more likely to develop caval syndrome, where the worms maneuver into the right ventricle, right atrium, and the vena cava, thus interfering with valvular function and blood flow and producing hemolysis, liver and kidney dysfunction, and heart failure (Atwell and Buoro, 1988; Ishihara et al, 1978; Jackson, 1975).

A clear understanding of heartworm transmission, development, prepatent period, and the susceptibility of the different life stages of the parasite to available pharmaceutical drugs is critical to be able to effectively select the most appropriate adulticidal treatment option and treatment time, and to convey realistic expectations to the client for the outcome of therapy.

HEARTWORM PREVENTION

The prescription and administration of heartworm preventive medication requires authorization by a licensed veterinarian having a valid relationship with the client and patient. To establish this relationship, heartworm prevention must be discussed with the client. If records of past treatment and testing do not exist, it is necessary to test the patient before dispensing or prescribing preventive. Options for effective preventive include several drugs administered monthly either orally or topically, or parenterally at 6-month intervals.

Heartworm disease is preventable despite the dog’s inherently high susceptibility. Because all dogs living in heartworm-endemic areas are at risk, preventive medications are a high priority. Puppies should be started on prevention consisting of a macrocyclic lactone as early as possible, no later than 8 weeks of age. In highly endemic regions the addition of a mosquito repellent/ectoparasiticide is warranted. Puppies started on a heartworm preventive after 8 weeks of age should be tested 6 months after the initial dose and annually thereafter. Before initiating a preventive regimen in older dogs (7 months of age or Older), antigen and microfilaria testing should be performed (see PRIMARY DIAGNOSTIC SCREENING). This practice avoids delays in detecting subclinical infections and the potential confusion concerning effectiveness of the prevention program if a pre-existing infection becomes evident after beginning preventive (e.g., preventive initiated during the prepatent period).

Even though continuous, year-round transmission may not occur throughout the country, the administration of broad-spectrum preventive products with endoparasitic and/or ectoparasitic activity for 12 months each year likely enhances compliance and may assist in preventing other pathogenic and/or zoonotic parasitic infections.

Macrocyclic Lactones

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- Macro cyclic lactones, when given according to label instructions, are highly effective and are among the safest medications used in veterinary medicine.
- It is possible for an animal to become infected because of skipped or delayed administration of just one preventive dose, particularly in highly endemic areas.
- While the vast majority of reported claims of lack of efficacy of macrocyclic lactones can be linked to poor compliance, isolated pockets of resistant heartworm subpopulations have been documented, mainly in the southeastern US.
- AHS and the FDA recommend year-round administration of FDA-approved preventive drugs to prevent heartworm infection and enhance compliance.
- Application of an EPA-registered mosquito repellent/ectoparasiticide has been shown to increase the overall efficacy of a heartworm prevention program by controlling the mosquito vector in laboratory studies.
- In addition, reduction of exposure to mosquitoes through standard environmental control of mosquitoes and their breeding environments, and when possible, reducing outdoor exposure during key mosquito feeding periods is recommended.

KEY POINTS: HEARTWORM PREVENTION

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Some Collies and other P glycoprotein-deficient dogs that have the MDR 1 mutation are unusually sensitive to a variety of commonly used veterinary drugs, including some antidepressants, antimicrobial agents, opioids, immunosuppressants, and cardiac drugs (Mealey, 2008). (For more information on drugs that cause problems in dogs with the MDR 1 mutation visit http://vepl.vetmed.wsu.edu/problem-drugs.) The macrocyclic lactones are also included in this list with toxicities being particularly high in dogs with the MDR 1 mutation.

Differentiating between overdosing and underdosing (e.g., monthly) or continuous release of small amounts over long periods (e.g., six months), they have excellent therapeutic/toxic ratios. Macrocyclic lactones, when given according to label instructions, are highly effective and are among the safest medications used in veterinary medicine.

All orally and topically administered macrocyclic lactone preventive products are labeled for a 30-day dosing interval. Beyond this interval efficacy against late fourth-stage larvae declines and is unpredictable (Paul et al, 1986). Juvenile worms, which can be found as early as 52 days post infection, are even less susceptible to the effects of preventives. As worms age, they require progressively longer-term administration to achieve a high level of protection (McCall, 2005; McCall et al, 2001). Therefore, continuous, year-round administration of heartworm preventive is a partial safeguard in the event of inadvertent delay or omission of regularly scheduled doses.

Macrocyclic lactones can be administered by three routes:

- Oral administration: Ivermectin and milbemycin oxime are available for monthly oral administration. Some formulations are flavored and chewable to increase patient acceptance and facilitate administration. Dose units are packaged for dogs within prescribed weight ranges. To be maximally effective, heartworm prophylaxis should be given year-round, but if seasonal treatment is chosen, administration should begin at least one month prior to the anticipated start of heartworm transmission and, depending on the product used, may need to be continued for up to 6 months after transmission typically ceases to meet label requirements for some products (see section on Lack of Efficacy).
- Topical administration: Moxidectin and selamectin are available as topically applied liquid formulations. The parameters for treatment with topical products are the same as for monthly oral preventive.
- Parenteral administration: A single dose of the slow-release (SR) formulation of subcutaneously injected moxidectin-impregnated lipid microspheres provides continuous protection for 6 months, with the potential to enhance compliance. Administration every 6 months is necessary for maximal protection.

Reports of Lack of Efficacy

Lack of efficacy (LOE) of a heartworm preventive product is considered by the FDA’s Center for Veterinary Medicine (CVM) to be a treated dog testing positive for heartworm regardless of appropriateness of dosage or administration consistency. Possible reasons for reports of LOE include:

- Failure to administer sufficient preventive.
- Failure to administer the preventive at the proper time.
- Failure of a dog to retain a dose and failure of expected absorption of the active ingredient.
- Biological variation between hosts in drug metabolism and immune response, and in parasite susceptibility to the drug.

Thus, the exact cause of a specific reported LOE can be difficult or impossible to determine. Fortunately, most LOE claims can be explained by compliance failure, either between the clinic and the client or the client and the pet, rather than product failure. It is possible for an animal to become infected because of skipped or delayed administration of just one preventive dose, particularly in highly endemic areas. Such areas typically have warm temperatures most of the year, an abundance of standing water, and substantial mosquito populations. These endemic areas also have large populations of infected dogs and wild canids providing a reservoir of infection.

Research is ongoing to determine the reasons for LOE. Every new study adds to our knowledge base and increases our understanding but also produces new questions. The complex biology of the parasite, the effect of changing environmental conditions that affect vector populations, the dynamics of host (wild and domestic) populations, and even the dynamics of human interactions with pets are also relevant. In the face of the many variable factors, it is critical that all members of the veterinary practice ensure that clients understand the risk and implications of heartworm infection in their area, and that they are providing appropriate year-round heartworm prevention for their pets. The macrocyclic lactones continue to be the only FDA-approved option for preventing heartworm infection and efforts need to be intensified to increase the number of dogs receiving preventive and to increase the number of dogs administered effectively. Individual heartworm prevention products should be implemented to assist pet owners in purchasing and administering products in a timely manner.

It is now generally accepted that isolated instances of resistant heartworms have been identified. The extent, the degree of spread, and the reasons for resistance are not well understood and are controversial. Although an algorithm utilizing the microfilarial suppression test (MST) to help clinicians evaluate cases of suspected resistance to macrocyclic lactones was recently developed (Moorehead et al, 2017), no definitive test for resistance exists, making determination of its distribution difficult. Therefore, the client or the pet owner compliance is the biggest factor in the “failure” of preventives (Atkins et al, 2014). There is general agreement that resistance to experimental infections is concerning, and that the products now available are highly effective and should continue to be used as the manufacturers suggest.

Vector Control

Heartworm disease has the greatest morbidity and mortality of any vector-borne disease affecting dogs in the United States, and despite the excellent products available to prevent heartworm disease in dogs, the range and number of cases grows annually. Because the mosquito is an obligate intermediate host and vector for heartworms, the opportunity to interrupt the chain of transmission at the level of the vector should not be ignored by the pet owner, the veterinarian, or the local municipalities responsible for environmental health-mosquito abatement. A multimodal approach to address both heartworm transmission and infection needs to be considered as an important opportunity to improve outcomes for both individual dogs and the population at large. There are many examples both in veterinary and human medicine where individual and community based multimodal approaches to vector-borne disease control are strongly advocated, if not the standard of care. Examples are Lyme borreliosis in dogs and malaria in humans.

Several tactical approaches can be employed to support the overall strategy of vector control. Vector biology has been addressed elsewhere...
in these guidelines. The first community-based approach should be elimination of mosquito larval habitats like standing water sources wherever possible or treatment of these habitats with chemical and biological tools such as, but not limited to, insect growth regulators, Bacillus species, and mosquitofish. Local application of insecticidal sprays and fogs and deployment of adult mosquito traps are other approaches. Low winds greatly disturb internally directed flight patterns of mosquitoes, and fan-generated wind has been shown to dilute attractants like carbon dioxide and is a practical approach to protecting people and pets in back yard settings (Hoffman et al, 2003). Public municipal organizations as well as private professional businesses can provide expert guidance and tools for these efforts.

Direct protective measures that can be recommended to the dog owner include risk-behavior modification such as limiting outdoor activities during peak mosquito feeding times and avoidance of known mosquito habitats. A highly effective direct protective measure is the use of topically applied ectoparasiticide products with demonstrated mosquito repellency and insecticidal claims.

Use of Repellents and Ectoparasiticides

Repellents work by inhibiting blood-feeding by vector mosquitoes and the associated transmission of infective heartworm larvae to the treated dog or microfilariae to mosquitoes. This decreases the likelihood of an uninfected dog becoming infected, or a microfilaremic dog from serving as a reservoir for infecting mosquitoes and subsequently infecting other pets. A repellent was demonstrated to be highly effective (>95%) in preventing mosquito feeding in two well-controlled laboratory studies. When treated microfilaremic dogs were challenged with uninfected mosquitoes, a repellent was 95% effective in preventing heartworm infection in the mosquito as compared with the control group (McCall et al, 2017a). These initial study results are encouraging but additional studies are needed to determine outcomes under field conditions.

Ectoparasiticides work by killing mosquitoes that have contacted or fed on a treated animal. Because mosquitoes die within 3 days following exposure to treated dogs, they are incapable of transmitting heartworms. This, in essence, renders the treated dog a non-reservoir, and as an added benefit kills the female mosquito, therefore preventing egg laying, and ultimately reducing the local mosquito population with further reduction in heartworm transmission in the area.

While repellents and ectoparasiticides alone or together are helpful, they are not completely effective as monotherapy for heartworm prevention in highly endemic areas. In a recent study using a repellent-ectoparasiticide along with a macrocyclic lactone, however, dogs challenged with mosquitoes carrying a highly ML resistant strain of heartworm were 100% protected from infection (McCull et al, 2017b). Thus, a macrocyclic lactone preventive, concurrent with the use of a topical mosquito repellent-ectoparasiticide, may provide more complete protection from resistant as well as susceptible heartworms.

Multimodal Risk Management

The risk management approach for heartworm disease in dogs is a process of qualitatively and quantitatively evaluating the threat of infection and disease followed by coordinated and reasonable application of countermeasures to mitigate each of those threats. The threat of heartworm infection can be readily assessed from the AHS Incidence Maps (heartwormsociety.org) and from information provided elsewhere in these Guidelines. Veterinarians should be encouraged to make recommendations for heartworm infection and disease countermeasures that are commensurate with the known level of threat. For example, a dog residing in an area of low incidence may be administered a macrocyclic lactone product as a reasonable year-round countermeasure. As the threat increases, the application of a topical ectoparasiticide product having demonstrated mosquito repellency and insecticidal claims during the months of highest mosquito activity is a reasonable addition to the year-round macrocyclic lactone. For dogs residing in areas of the country where the threat is highest and sustained, the best recommendation to counter the threat of heartworm infection is year-round use of both a macrocyclic lactone and a topical ectoparasiticide product with demonstrated mosquito repellency and insecticidal claims, in addition to ensuring environmental mosquito abatement measures are taken.

Using a multimodal risk-management approach to address the threat of heartworm infection and disease enhances the potential to break the cycle of heartworm transmission, addresses the challenges of resistant phenotypes in the heartworm population, and benefits both the individual dog as well as the population at risk.

Vector Control Measures to Reduce Heartworm Transmission

• Eliminate sources of standing water where mosquitoes can breed.
• If standing water cannot be eliminated, it should be treated with chemical and/ or biological tools such as insect growth regulators, Bacillus species, and mosquitofish.
• Utilize local application of insecticidal sprays/ fogs and adult mosquito traps.
• Reduce exposure of dogs by limiting outdoor activities during peak mosquito feeding times (dusk and dawn) and avoiding known mosquito habitats.
• Use topical ectoparasiticide products with demonstrated mosquito repellency and insecticidal claims.
In cases of noncompliance or changing the product, annual testing is an integral part of ensuring that prophylaxis is achieved and maintained. Should an infection be diagnosed, more timely treatment can be provided to minimize pathology. 

**Test Timing for Optimal Results**

Currently available heartworm antigen tests detect protein secreted mainly by adult female *Dirofilaria immitis* (Courtney and Cornell, 1990), and the most useful microfilaria tests concentrate microfilariae (modified Knott or filtration test) and allow for greater sensitivity (Courtney and Georgi, 1992; Knott, 1939). The earliest that heartworm antigen and microfilariae can be detected is about 5 and 6 months post infection, respectively. Antigenemia usually precedes but sometimes lags the appearance of microfilariae by a few weeks. Antigen may never be detected or may only be sporadically detected in dogs with very low female worm burdens (Atkins, 2003; McCall, 1992). In addition, antigenemia may be suppressed until about 9 months post infection in infected dogs receiving macrocytic lactone preventive (McCall et al, 2001b). To determine when testing might become useful, a pre-detection period should be added to the approximate date on which infection may have been possible. A reasonable interval is 7 months. Thus, there is no need or justification for testing a dog for antigen and microfilariae prior to 7 months of age.

**Microfilaria and Antigen Testing**

Whether screening a population of asymptomatic dogs or seeking verification of a suspected heartworm infection, antigen testing is the most sensitive diagnostic method. It is now recommended, however, that microfilaria testing be done in tandem with antigen testing. This is especially important if there is a high degree of suspicion or if the heartworm prevention history is unknown (e.g., dogs adopted from shelters). It has come to light that in some dogs infected with heartworms, antigen blocking, presumably from antigen–antibody complexes, may lead to false-negative antigen test results. These dogs will be antigen negative and possibly microfilariae positive; a study conducted on shelter dogs in the southeastern United States reported this occurred at a rate of 7.1% (Velasquez et al, 2014). It is important that these dogs are identified and treated to decrease the potential for selection of resistant subpopulations of heartworms. There will be instances where an infected dog is both antigen and microfilaria negative.

**Antigen Tests**

Enzyme-linked immunosorbent assay (ELISA) and immunochromatographic test systems are available for detecting circulating heartworm antigen. Each testing format has proven to be clinically useful. The current generation of heartworm antigen tests identifies most “occult” (adult worms present but no circulating microfilariae) infections consisting of at least one mature female worm and are nearly 100% specific (Atkins, 2003; Courtney and Zeng, 2001; Lee et al, 2011; McCall et al, 2001b). Differences in sensitivity exist especially in cases with low worm burdens and/or low antigenemia. Currently there are no verified tests capable of detecting infections consisting of only adult male worms.

To obtain reliable and reproducible results, antigen tests must be performed in strict compliance with the manufacturer’s instructions. Accuracy of all heartworm tests under field conditions is influenced by adherence to the instructions and storage and handling of the test kit and sample. This process has been simplified for several test kits that use devices that minimize the number of steps and partially automate the procedure. Both false-positive and false-negative results can occur. When a test result is unexpected, either positive or negative, the test should be repeated. If the result remains ambiguous, independent confirmation by a reference laboratory is recommended to confirm or refute the result.

While a positive heartworm antigen test indicates the presence of specific heartworm antigen, there are factors that can initiate a false-positive result. Currently, it is recommended that all positive antigen tests be confirmed through additional testing prior to the administration of any therapy. Confirmation is accomplished upon the identification of circulating microfilariae, or when antigen testing, resulting in false-negative tests. Laboratory studies have shown that heating serum will release blocked antigen, and result in more positive test results (Velasquez et al, 2014). (For more on heat treatment, see the box on page 16). A negative antigen test result does not verify an animal to be free of heartworm infection; it simply indicates that no antigen can be detected by that particular testing method.

**Microfilariae Tests**

In areas where the prevalence of heartworm infection is high, many (~20%) heartworm-infected dogs may not be microfilariae positive, and this figure is even higher for dogs on a macrocyclic lactone prevention program (McCall, 2005). Considering this, most microfilaricidal drugs can be detected by microscopically examining a drop of fresh blood under a cover slip for microfilariae or cell
When Should Heat Treatment of Serum Samples Be Considered?

Heat treatment of serum samples prior to heartworm antigen tests as well as other non-heat methods to release blocked antigen is currently available through reference laboratories. This process should be considered when a negative antigen test result does not correlate with the presence of circulating microfilariae, or when there is suspicion of active clinical disease. However, the routine heating of serum samples IS NOT PRESENTLY RECOMMENDED for routine heartworm screening.

While heat treatment of samples has been shown to release blocked antigen that can cause false-negative test results, it is contrary to the label instructions for commonly used in-house tests and may interfere with the accuracy of results of not only heartworm testing but also the results of combination tests that include antibody detection of other infectious agents. Further studies on the possible cross-reactivity of heartworms with other helminths are needed to more accurately interpret the conversion from “no antigen detected” to “antigen positive” after heat treatment.

How to Perform the Modified Knott Test

The modified Knott test is performed by mixing 1.0 mL of EDTA blood with 9.0 mL of 2% formalin in a centrifuge tube. The tube is inverted several times to mix the blood with the formalin solution, lysing the red blood cells. The tube is then placed in a centrifuge, spun at 1100 to 1500 rpm for 5 to 8 minutes, and the liquid is poured off leaving the sediment. A drop of methylene blue is added to the sediment and then the stained sediment is placed on a glass slide and a cover slip applied. The slide is examined under low power (100X) for the presence of microfilariae. To observe the characteristics of the microfilariae, the slide can be examined under high-dry (400X). The microfilariae of *Dirofilaria immitis* are 295 to 325 microns (μm) long and have tapered heads. The microfilariae of *Acanthocheilonema reconditum* are 250 to 288 μm long with blunt heads and curved tails (Figure 4) (Rawlings, 1986).

![Figure 4](https://example.com/figure4.png)

**Figure 4.** *Acanthocheilonema reconditum* (top) and *Dirofilaria immitis* (below). Photograph courtesy of Byron Blagburn, PhD.

Movement caused by the motile microfilariae (Rawlings, 1986). A stationary rather than a migratory pattern of movement is indicative of a *Dirofilaria* species, nearly always *D. immitis* in the United States. Movement above theuffy coat in a microhematocrit tube also may be visible. These are insensitive testing methods when low numbers (50–100/mL) of microfilariae are present; however, such patients are at a lower risk for severe reaction after the administration of a microfilaricide and are less likely to pose a threat as a reservoir of infection.

For more accurate results a concentration technique (modified Knott test) should be used to determine the absence or presence of microfilariae (Georgi and Georgi, 1992; Knott, 1939). The modified Knott test (see box on left) remains the preferred method for observing morphology and measuring body dimensions to differentiate *D. immitis* from non-pathogenic filarial species, such as *Acanthocheilonema* (formerly *Dipetalonema*) *reconditum*.

All dogs should be tested for microfilariae. Microfilaraemia validates serologic results, identifies the patient as a reservoir of infection, and alerts the veterinarian to a high microfilariae burden, which may precipitate a severe reaction following administration of a microfilaricide.

Testing Considerations Following Noncompliance and When Changing Products

In instances of noncompliance or changing the brand or type of heartworm preventive, it is important to determine the heartworm status of the dog. The dog should be antigen and microfilaria tested prior to starting or changing products. A positive test indicates preexisting infection. The dog should always be retested 6 months later (Figure 5). A positive test at this time would most likely be due to an infection acquired before starting or resuming preventive therapy; however, in rare instances, an existing infection might be missed (i.e., false-negative test due mainly to young or low worm burden infection). Antigen and microfilaria testing should be performed on the one-year anniversary date of the initial test and annually thereafter.

Other Diagnostic Aids

Additional testing methods, such as radiography and echocardiography, are useful for confirming the diagnosis and staging the severity of heartworm disease.

Radiography

Assessment of cardiopulmonary status may be useful for evaluating a patient’s prognosis. Radiography provides the most objective method of assessing the severity of heartworm cardiopulmonary disease secondary to heartworm infection. Typical (nearly pathognomonic) signs of heartworm vascular disease are enlarged, tortuous, and often truncated peripheral intralobar and interlobar branches of the pulmonary arteries, particularly in the diaphragmatic (caudal) lobes (Figure 6). These findings are accompanied by variable degrees of pulmonary parenchymal disease. The earliest and most subtle pulmonary arterial changes are most commonly found in the dorsal caudal wedge of the diaphragmatic lung lobes. As the severity of infection and chronicity of disease progress, the pulmonary arterial signs are seen in successively larger branches (Figure 7). In the worst cases, the right heart eventually enlarges (Bowman and Atkins, 2009; Calvert and Rawlings, 1988; Rawlings, 1986).

![Figure 5](https://example.com/figure5.png)

**Figure 5.** The testing protocol following known noncompliance includes three tests in the first year, with annual testing thereafter.

![Figure 6](https://example.com/figure6.png)

**Figure 6.** Moderate heartworm disease. Right heart enlargement (reverse “D” shape) is seen in heartworm disease. Radiographic images courtesy of C. Thomas Nelson, DVM.
Confirmation of caval syndrome (Badertscher et al., 2001) orifice of the tricuspid valve provides conclusive hemoglobinuria, visualization of heartworms in the heart where they can be imaged easily. In dogs with interlobar branches or within the right side of the lungs, heartworms often are limited to the peripheral pulmonary arteries. Radiographic images courtesy of Marisa Ames, DVM.

**Echocardiography**

The body wall of adult heartworms is highly echogenic and produces distinctive, short parallel-sided images with the appearance of “equal signs” where the imaging plane cuts across loops of the parasite. Echocardiography can provide definitive evidence of heartworm infection and also allows for assessment of cardiac anatomic and functional consequences of the disease (Figure 8). It is not an efficient method of making this diagnosis, however, particularly in lightly infected dogs, because the worms often are limited to the peripheral branches of the pulmonary arteries beyond the echocardiographic field of view. When heartworms are numerous, they are more likely to be present in the main pulmonary artery, right and proximal left interlobar branches or within the right side of the heart where they can be imaged easily. In dogs with hemoglobinuria, visualization of heartworms in the orifice of the tricuspid valve provides conclusive confirmation of caval syndrome (Badertscher et al., 1988; Moise, 1988; Venco et al., 2001).

**Diagnostics for Pre-Adulticide Evaluation in an Infected Dog**

The extent of diagnostic testing necessary in the pre-adulticide evaluation varies depending on the clinical status of each patient. Selected clinical and laboratory tests should only be performed to complement information obtained from a thorough history, physical examination, and antigen and microfilaria tests. It is important to note that some key factors influencing the probability of post-adulticide thromboembolic complication and outcome of treatment are not easily measured with standard diagnostic procedures, including 1) the activity level of the dog, 2) the extent of concurrent pulmonary vascular disease, and 3) the severity of infection (high versus low worm burdens).

Restricting activity is imperative as exercise, excitement, and overheating are harbingers of complications. High activity level of the dog during treatment and for 6 to 8 weeks after the last meglumine injection is one of the most significant factors contributing to post-adulticidal complications (Dillon et al., 1995; Fukami et al., 1998). Prior to treatment, the owner’s ability and willingness to properly confine treated dogs should be thoroughly investigated. A helpful resource for pet owners, “Battling Boredom: Tips for Surviving Cage Rest,” is available on the American Heartworm Society website.

Thoracic radiographs can assist in providing an assessment of the animal’s cardiopulmonary status, each plan must be developed considering the extent of diagnostic testing necessary in the pre-adulticide evaluation varies depending on the clinical status of each patient. Selected clinical and laboratory tests should only be performed to complement information obtained from a thorough history, physical examination, and antigen and microfilaria tests. It is important to note that some key factors influencing the probability of post-adulticide thromboembolic complication and outcome of treatment are not easily measured with standard diagnostic procedures, including 1) the activity level of the dog, 2) the extent of concurrent pulmonary vascular disease, and 3) the severity of infection (high versus low worm burdens).

Historically, due to financial limitations of some pet owners and animal shelters, large numbers of adulticide treatments have been successfully performed without the benefit of extensive diagnostics. While diagnostics can be an important part of defining an individual’s heartworm disease status, each plan must be developed considering both the animal and individual pet owner. No set protocol has been established for pre-treatment workup and reasonable judgment should always be used to weigh the necessity, benefit, and extent of each diagnostic procedure performed. Adult heartworms are a grave risk to our canine patients. The longer they remain in an animal, the greater the damage to the cardiopulmonary system and the greater the risk of illness and death.
HEARTWORM TREATMENT KEY POINTS:

- The goals of any heartworm treatment are to improve the clinical condition of the animal and to eliminate all life stages of the heartworms (microfilariae, larval stages, juveniles, and adults) with minimal post-treatment complications.
- Dogs exhibiting significant clinical signs of heartworm disease should be stabilized before administering an adulticide; this may require administration of glucocorticosteroids, diuretics, vasodilators, positive inotropic agents, and fluid therapy.
- Melsaromine, administered via deep intramuscular injection into the belly of the epaxial lumbar muscles (between L3 and L5), is the only adulticidal drug approved by the FDA.
- Exercise restriction during the entire treatment and recovery period is ESSENTIAL for minimizing cardiopulmonary complications, as there is a distinct correlation between the activity level of the dog and the severity of disease.
- Adjunct therapy with doxycycline for 4 weeks prior to the administration of melsaromine eliminates Wolbachia, an endosymbiont bacteria harbored within D. immitis, reduces pathologic association with dead heartworms, and disrupts heartworm transmission.
- A macrocyclic lactone preventive should be administered for 2 months prior to administering melsaromine to reduce new infections and eliminate existing susceptible larvae.
- The effectiveness of the macrocyclic lactone can also be potentiated with concurrent use of doxycycline for 4 weeks, as this will essentially eliminate all developing larvae during the first 60 days of treatment.
- Caval syndrome, which develops acutely in some heavily infected dogs when adult heartworms partially obstruct blood flow through the tricuspid valve, usually ends fatally within 2 days if surgical extraction of the worms is not pursued promptly.

PRINCIPLES OF HEARTWORM TREATMENT

Treating heartworm infections in asymptomatic patients or those exhibiting signs of mild disease usually is not problematic if exercise is curtailed. Infections associated with moderate or severe heartworm disease (Table 1) or in patients with concurrent disease often are challenging. The goals of any heartworm treatment are to improve the clinical condition of the animal and to eliminate all life stages of the heartworms (microfilariae, larval stages, juveniles, and adults) with minimal post-treatment complications. Dogs exhibiting significant clinical signs of heartworm disease should be stabilized before administering an adulticide. This may require administration of glucocorticosteroids, diuretics, vasodilators, positive inotropic agents, and fluid therapy.

A thorough understanding of the host–parasite relationship is necessary to effectively manage all cases. As expected, the number of worms has an effect on the severity of disease; but of equal, if not greater, importance is the activity level of the dog. Controlled studies have shown that dogs infected by surgical transplantation with 50 heartworms and exercise-restricted took longer to develop clinical disease and developed less pulmonary vascular disease than dogs with 14 heartworms and allowed moderate activity (Dillon et al, 1995). This was also evident in a study in naturally infected dogs where there was no correlation between the number of heartworms and pulmonary vascular resistance and is an indication that the host–parasite interaction plays a significant role in the severity of disease (Calvert, 1988). A subsequent study reported similar findings in dogs being treated with melsaromine (Fukami et al, 1998).

Whereas live heartworms can cause endarteritis and muscular hypertrophy of arteriolar walls, primarily of the caudal pulmonary arteries, dying and dead heartworms cause a significant portion of pathology seen in clinical disease (Figures 9 and 10). As worms die from either natural causes or as a result of adulticidal therapy, they collapse and are forced by the blood flow into the distal branches of the pulmonary arteries. These dead worms, along with the elicted inflammation and platelet aggregation result in thromboembolic disease. During periods of increased activity or exercise, the increased blood flow to these blocked vessels can cause capillary delamination, rupture, and subsequent fibrosis (Case et al, 1995; Dillon et al, 1995; Hoskins et al, 1985; Rawlings et al, 1993a). As blood flow becomes restricted, pulmonary artery pressures can increase, and in severe cases, right-sided heart failure can ensue. There is a distinct correlation between the activity level of the dog and the severity of disease.

Adulticide Therapy

Melsaromine Dihydrochloride

Melsaromine, administered via deep intramuscular injection into the belly of the epaxial lumbar muscles (between L3 and L5), is the only adulticidal drug approved by the FDA. Mild swelling and some soreness at the injection site may be present for a few days, but this can be minimized by ensuring that the injection is deposited into the belly of the epaxial musculature with a needle newly changed after the drug is drawn into the syringe and of appropriate length and gauge for the size of dog and body condition. Strictly adhering to the manufacturer’s instructions for administration is imperative. Administration of an analgesic such as tramadol or hydrocodone at the time of injection reduces the acute myalgia associated with melsaromine. Exercise restriction during the recovery period is ESSENTIAL for minimizing cardiopulmonary complications (see Pulmonary Thromboembolism).

Melsaromine has been shown to have activity against immature worms 2 and 4 months old (Dzimianski et al, 1990; Dzimianski et al, 1989, McCall et al, 2010); however, activity against 3, 5, and 7 month old worms has not been assessed. The two-injection protocol with melsaromine (i.e., two injections of 2.5 mg/kg body weight 24 hours apart)
listed on the product insert for treating class 1 and 2 heartworm disease kills only about 90% of the adult worms. The three-dose alternate protocol (one dose of 2.5 mg/kg body weight followed at least one month later by two injections of the same dose 24 hours apart) listed for treating class 3 heartworm disease kills 98% of the worms (Keister et al, 1992; Vezzoni et al, 1992). These overall efficacy values reflect the percentage of worms killed in groups of dogs and not the percentage of dogs cleared of worms, which are considerably lower than these overall efficacy values. The three-dose protocol has the added advantage of decreased complication rates and increased safety as a number of the adult worms are killed with the first melarsomine injection and most, if not all, of the remaining worms are killed with the second and third injections.

Staging of the disease, as described on the melarsomine label, and use of the two-dose protocol has failed to adequately ensure treatment success. Therefore, regardless of the severity of the disease (with the exception of caval syndrome), the three-dose protocol is recommended by the American Heartworm Society due to the increased safety and efficacy.

Pulmonary Thromboembolism
Pulmonary thromboembolism is an inevitable consequence of successful adulticide therapy and may be severe if infection is heavy and pulmonary arterial disease is extensive. If signs of embolism (low grade fever, cough, hemoptysis, exacerbation of right heart failure) develop, they are usually evident within 7 to 10 days, but occasionally as late as 4 weeks after completion of adulticide administration (Hirano et al, 1992). Mild embolism in relatively healthy areas of lung may be clinically unapparent. A pivotal factor in reducing the risk of thromboembolic complications is STRICT exercise restriction.

Adjunct Therapy
Steroids
Administration of diminishing anti-inflammatory doses of glucocorticosteroids helps control clinical signs of pulmonary thromboembolism (Atwell and Tarish, 1995). Whereas studies showed a decrease in efficacy of the arsenical thiacetarsamide when glucocorticosteroids were administered concurrently (Rawlings et al, 1984), a study showed no decrease in the efficacy of melarsomine when used in conjunction with prednisone (Dzimianski et al, 2010); therefore, the use of glucocorticoids is recommended.

NSAIDs/Aspirin
The empirical use of aspirin for its antithrombotic effect or to reduce pulmonary arteritis is not recommended for heartworm-infected dogs (Boudreau et al, 1991). Convincing evidence of clinical benefit is lacking and there is some research suggesting that aspirin may be contraindicated.

Doxycycline
Many filial nematodes, including Dirofilaria immitis, harbor obligate, intracellular, gram-negative, endo-symbiotic bacteria belonging to the genus Wolbachia (Rickettsiales) (Kozek, 2005; Taylor et al, 2009). Doxycycline reduces Wolbachia numbers in all stages of heartworms. Doxycycline administration during the first or second month following experimental heartworm infection was lethal to third- and fourth-stage heartworm larvae (McCcall et al, 2011). In addition, in dogs with adult infections, doxycycline gradually suppressed microfilariaemia (Bazocchi et al, 2008; McCall et al, 2008a). Microfilariae ingested by mosquitoes on dogs treated with doxycycline developed into third-stage larvae that appeared to be normal in appearance and motility, but these larvae were not able to develop into adult worms, thus reducing the risk of selecting for resistant subpopulations (McCcall et al, 2008a; 2014a).

Wolbachia have also been implicated as a component in the pathogenesis of filarial diseases, possibly through their metabolites (Bouchery et al, 2010; McCall et al, 2005). Recent studies have shown that a major Wolbachia surface protein (WSP) induces a specific IgG response in hosts infected by D. immitis (Kramer et al, 2005). It is hypothesized that Wolbachia may contribute to pulmonary and renal inflammation through its WSP.

When incorporated into a heartworm treatment protocol, doxycycline should be given before administration of melarsomine so the Wolbachia organisms and their metabolites are reduced or absent when the worms die. Doxycycline is administered at 10 mg/kg BID for 4 weeks (Bandi et al, 1999; Kramer et al, 2011; Nelson et al, 2017). Protocols using a lesser dose or shorter duration have not been established. A one-month wash-out period before administration of doxycycline but after administration of melarsomine is currently recommended as it is hypothesized to allow time for the WSPs and other metabolites to decrease before killing the adult worms. It also potentially allows more time for the worms to wither as they become unthrifty after the Wolbachia endosymbionts are eliminated.

Doxycycline has been shown to eliminate over 95% of the Wolbachia organisms in the filarial nematode Wuchereria bancrofti, resulting in microfilariaemia for 12 months (Hoeaeraul et al, 2003). These data suggest that the presence of Wolbachia, or at least very low numbers of the organism, is necessary for embryogenesis. In D. immitis (adults and microfilariae) data suggest Wolbachia numbers remain low for at least 12 months following doxycycline administration (Rossi et al, 2010).

Minocycline has been shown to be highly effective in eliminating Wolbachia organisms from the filarial nematode Onchocerca gutturosa (Townson et al, 2006). No published studies have been conducted in D. immitis but available pharmacological data and anecdotal reports suggest this is a viable alternative if doxycycline is not available. The dosing regimen is the same as doxycycline.

The use of doxycycline tablets/capsules or minocycline for oral administration to a dog is considered Extra Label Drug Use and is permitted under the Animal Medicinal Drug Use Clarification Act of 1994 (AMDUCA).

Macrocyclic Lactones
It is highly probable that a heartworm-positive dog harbors heartworms that can range from less than 1 month to as much as 7 years of age. The potential incomplete efficacy of melarsomine against young adult worms could present a problem in achieving the goal of eliminating all of the worms.

A macrocyclic lactone preventive should be administered for 2 months prior to administering melarsomine to reduce new infections and eliminate existing susceptible larvae. The effectiveness of the macrocyclic lactone can also be potentiated with concurrent use of doxycycline for 4 weeks, as this will essentially eliminate all developing larvae during the first 60 days of treatment.

Macrocyclic lactones administered as microfilaricides may cause a rapid decrease in the numbers of microfilariae and should be used with caution in dogs with high microfilarial counts. Pretreatment with antihistamines and glucocorticosteroids will minimize potential reactions. Topical moxidectin is now FDA-approved for use in heartworm-positive dogs to eliminate microfilariae. No adverse reactions due to high microfilarial counts were observed in the laboratory or field studies conducted for approval of this label claim (McCall et al, 2014b).

Macrocyclic Lactones/Doxycycline
Studies have shown that experimentally infected heartworm-positive dogs pretreated with ivermectin and doxycycline prior to receiving melarsomine injections had less pulmonary pathology associated with the death of the heartworms (Figure 11) (Kramer et al, 2011; McCall et al, 2008a). Select macrocyclic lactones (ivermectin and moxidectin) coupled with doxycycline individually suppress embryogenesis, weaken adult heartworms, and have adjuvant activity (McCcall et al, 2008a; Grandi et al, 2010; Savadelis et al, 2017; Ames et al, 2017). As mentioned previously doxycycline reduces Wolbachia levels in all stages of heartworms. Studies have shown that administration of doxycycline in combination with ivermectin provided more rapid adjuvant activity than ivermectin alone as well as reducing Wolbachia numbers more effectively than doxycycline alone (Bazocchi et al, 2008). No studies have been published on combining milbemycin or selamectin with doxycycline.
In cases where arsenical therapy is not possible or is contraindicated, the use of a monthly oral ivermectin or topical moxidectin heartworm preventive along with doxycycline at 10 mg/kg BID for a 4-week period might be considered. It should be noted that this protocol is NOT RECOMMENDED as a standard first-line treatment but instead as a salvage procedure. The safety and long-term effects of these protocols have not been evaluated. In one study in client-owned animals in which exercise restriction was not enforced (Ames et al., 2017), coughing during the treatment period was twice (44%) the reported rate of treatment with melarsomine alone and six times the rate reported in the AHS recommended treatment protocol described below (see Table 2). In another study of experimentally infected dogs treated with doxycycline and topical moxidectin, radiographic evidence of disease progressed at the same rate as untreated controls and arterial thrombi scores were significantly higher in the treated dogs (Savadelis et al., 2017). In comparison, dogs treated with ivermectin, doxycycline, and melarsomine had a virtual absence of thrombi (Kramer et al., 2011). An antigen test should be performed every 6 months and the dog should not be considered cleared until two consecutive NAD (no antigen detected) heartworm antigen tests, 6 months apart, have been obtained. If the dog is still antigen positive after one year, repeat the doxycycline therapy. Exercise should be rigidly restricted for the duration of the treatment process.

**AHS-Recommended Treatment Protocol**

The AHS recommends a multimodal approach to treating heartworms based on the information presented above and depicted in the following example management protocol (Table 2) (Nelson, 2012).

A retrospective study of clinical cases comparing the protocol listed in Table 2 with a similar protocol without doxycycline showed a decrease in the rate of coughing during the treatment period.

### Table 2. AHS-Recommended Heartworm Management Protocol

<table>
<thead>
<tr>
<th>Day</th>
<th>Treatment</th>
</tr>
</thead>
</table>
| **Day 0** | In a dog diagnosed and verified as heartworm positive:  
- Positive antigen (Ag) test verified with microfilaria (MF) test  
- If no MF are detected, confirm with second Ag test from a different manufacturer  
- Apply an EPA-registered canine topical product labeled to repel and kill mosquitoes  
- Begin exercise restriction—the more pronounced the signs, the stricter the exercise restriction  
- If the dog is symptomatic:  
  - Stabilize with appropriate therapy and nursing care  
  - Prednisone prescribed at 0.5 mg/kg BID first week, 0.5 mg/kg SID second week, 0.5 mg/kg every other day (EOD) for the third and fourth weeks |
| **Day 1** |  
- Administer appropriate heartworm preventive  
- If MF are detected, pre-treat with antihistamine and glucocorticosteroids, if not already on prednisone, to reduce risk of anaphylaxis  
- Observe for at least 8 hours for signs of reaction |
| **Days 1–28** |  
- Administer doxycycline 10 mg/kg BID for 4 weeks  
- Reduces pathology associated with dead heartworms  
- Disrupts heartworm transmission |
| **Day 30** |  
- Administer appropriate heartworm preventive  
- Apply an EPA-registered canine topical product to repel and kill mosquitoes |
| **Days 31–60** |  
- A one-month wait period following doxycycline before administering melarsomine is currently recommended as it is hypothesized to allow time for the Wolbachia surface proteins and other metabolites to dissipate before killing the adult worms. It also allows more time for the worms to wither as they become unthrifty after the Wolbachia endosymbionts are eliminated. |
| **Day 61** |  
- Administer first melarsomine injection, 2.5 mg/kg intramuscularly (IM)  
- Prescribe prednisone 0.5 mg/kg BID first week, 0.5 mg/kg SID second week, 0.5 mg/kg EOD for the third and fourth weeks  
- Decrease activity level even further: cage restriction, on leash when using yard |
| **Day 90** |  
- Administer second melarsomine injection, 2.5 mg/kg IM  
- Prescribe prednisone, 0.5 mg/kg BID first week, 0.5 mg/kg SID second week, 0.5 mg/kg EOD for the third and fourth weeks |
| **Day 91** |  
- Administer third melarsomine injection, 2.5 mg/kg IM  
- Continue exercise restriction for 6 to 8 weeks following last melarsomine injections |
| **Day 120** |  
- Test for presence of MF  
- If positive treat with a microfilaricide and retest in 4 weeks  
- Continue a year-round heartworm prevention program based on risk assessment described in prevention section |
| **Day 365** |  
- Antigen test 9 months after last melarsomine injection; screen for MF  
- If still Ag positive, retreat with doxycycline followed by two doses of melarsomine 24 hours apart |

**Figure 11.** Pulmonary pathology associated with the death of heartworms in experimentally infected heartworm-positive dogs pretreated with ivermectin and doxycycline prior to receiving melarsomine injections. Photographs courtesy of John McCall, PhD and Laura Kramer, DVM, PhD.
in respiratory complications and mortality rates when doxycycline was included (Nelson et al, 2017). A study on experimentally infected dogs showed that dogs that received doxycycline and ivermectin prior to melarsomine administration had less severe arterial lesions and the virtual absence of thrombi (Kramer et al, 2011).

**Elimination of Microfilariae**

Macro cyclic lactones administered as microfilaricides may cause a rapid decrease in the numbers of microfilariae and should be used with caution in dogs with high microfilarial counts. Pretreatment with antihistamines and glucocorticosteroids is advisable in the face of high microfilaria burdens to minimize potential reactions and the dog should be observed for the day after administration of a microfilaricide (Bowman and Atkins, 2009). Topical moxidectin is approved by the FDA to eliminate microfilariae (McCall et al, 2014a). No adverse reactions due to high microfilaria counts were observed in the laboratory or field studies conducted for approval of this label claim.

Historically, microfilaricidal treatment was usually done about 3 weeks to a month after adulticide therapy, with the understanding that several weekly treatments were often required to completely eliminate circulating microfilariae (Knight, 1995; McCall et al, 2008b). Current protocols utilizing doxycycline in combination with regular preventive doses of macrocyclic lactones have essentially eliminated the need for post-adulticidal elimination of microfilariae (Bazzocchi et al, 2008; McCall et al, 2008a) although microfilaria testing is still recommended. Administration of a macrocyclic lactone should always begin as soon as the dog is diagnosed with a heartworm infection. Including doxycycline in the treatment protocol as previously described hastens the elimination of microfilariae. When elimination of microfilariae is accomplished in the course of heartworm treatment, a microfilaria test should be performed in adulticide-treated dogs at the time the antigen test is conducted 9 months post treatment. Controlling the spread of heartworms entails decreasing the microfilaricidal reservoirs of infection in the dog population and the benefits of doing so have been cited (see HEARTWORM PREVENTION).

**Surgical Extraction of Adult Heartworms**

**Caval Syndrome (Dirofilarial Hemoglobinuria)**

Caval syndrome develops acutely in some heavily infected dogs when adult heartworms partially obstruct blood flow through the tricuspid valve and also interfere with valve closure (Figure 12). Severe passive congestion of the liver, a coarse systolic murmur of tricuspid regurgitation, and jugular pulsations are characteristic features of the syndrome. The diagnosis is based on a sudden onset of severe lethargy, dyspnea, pale mucous membranes, and weakness accompanied by hemoglobinemia and hemoglobinuria (Atwell and Buoro, 1988; Kitagawa et al, 1986; Venco, 1993). Caval syndrome can be confirmed conclusively by echocardiographic visualization of heartworms within the tricuspid orifice and posterior vena cava (Figure 13) (Atkins et al, 1988). The clinical course usually ends fatally within 2 days if surgical extraction of the worms is not pursued promptly.

The main pulmonary artery and lobar branches can be visualized ultrasonically if available, by fluoroscopic guidance. Intraoperative mortality rate of recovery of dogs at high risk of pulmonary thromboembolism is improved significantly by physical removal of worms as possible before beginning adulticide therapy (Morini et al, 1998). When the facilities are available, worm extraction of adult heartworms is a safe and effective procedure even in critically ill, hypovolemic dogs to restore hemodynamic and renal function. Within a few weeks following recovery from surgery, adulticide chemotherapy is recommended to eliminate any remaining worms, particularly if many are still visible echocardiographically.
Most microfilaremic dogs with post-adulticide, antigen-producing females (Kiester et al, 1992). Clinical improvement is possible without completely confirming Adulticide Efficacy with compounded arsenicals. Confirmation of Adulticide Efficacy with compounded doxycycline (Papich et al, 2013) and macrocyclic lactones and toxicity would continue to progress (Rawlings et al, 2001). Another important concern in using macrocyclic lactones in monotherapy of heartworm-positive dogs as stand-alone therapy is the potential for selection of resistant subpopulations of heartworms (Bowman, 2012; Geary et al, 2011).

**Herbal Therapies**

No “natural” or herbal therapies have been shown to be safe and effective prevention or treatment for heartworm disease.

**Compounded Medications**

The use of compounded medications in the prevention and treatment of heartworm disease is seldom justified, not recommended, and in most circumstances, violates the Animal Medicinal Drug Use Act (AMDUCA). In addition to the legal ramifications there are concerns with stability and potency with compounded doxycycline (Papich et al, 2013) and macrocyclic lactones and toxicity with compounded arsenicals.

**Confirmation of Adulticide Efficacy**

Clinical improvement is possible without completely eliminating the adult worms. Worms that do survive adulticide treatment are invariably the antigen-producing females (Kiester et al, 1992). Most microfilaremic dogs with post-adulticide, female unisex infections become occult within 6 to 9 months, with or without microfilaricide treatment, and particularly if they were treated with doxycycline and are on a macrocyclic lactone preventive during and after adulticidal therapy (Grandi et al, 2010; McTier et al, 1994). Consequently, clinical improvement and successful clearance of microfilariae from the blood do not verify a complete adulticide effect. Recurrence of microfilaraemia 6 months later may be due to incomplete clearance of adult worms, maturation of immature worms if a preventive and doxycycline was not given during adulticide therapy, or a new infection due to a lapse in preventive.

Heartworm antigen testing is the most reliable method of confirming the efficacy of adulticidal therapy. If all of the adult female worms have been killed, heartworm antigen should become undetectable by 6 months post treatment (Maxwell et al, 2014; McTier et al, 1994). However, this single test result does not verify that the dog is negative for heartworms, as larval and/or juvenile heartworms may be present in the dog and an insufficient amount of antigen is being produced by these young worms to elicit a positive test result. This is especially critical if a macrocyclic lactone and doxycycline were not administered prior to or initiated concurrently with adulticidal therapy. If a heartworm-positive dog is immediately treated with adulticide and a macrocyclic lactone is not given until 3 to 4 weeks after the last dose of adulticide, the dog should have a negative antigen test 7 months after the initial dose of macrocyclic lactone before being considered cleared of adult worms. Because adult worms may continue to die for more than a month following adulticide administration, dogs that are still antigenemic at any time less than 9 months post treatment should be allowed more time to clear antigen before retreatment is considered.

**Elective Surgeries on Dogs with Heartworms**

Veterinarians are frequently faced with the decision whether to perform an elective procedure, such as a spay or neuter, on a heartworm-positive dog. A study has shown no increase in perioperative complications in heartworm-positive dogs with no to mild clinical signs of heartworm disease (Peterson et al, 2014). Elective surgical procedures should be avoided in dogs exhibiting signs of more advanced disease, and treatment utilizing the protocol in Table 2 should be initiated. Surgery can then be performed 6 months after adulticidal treatment if the dog has recovered sufficiently.

**REFERENCES**


Courtney CH. Predicting heartworm burdens with a heartworm antigen test kit. JAAHA, 1987;23:387-390.


