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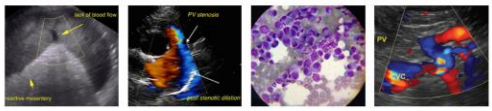
Pet Animal Ultrasound Service
4paus.com 781-635-5677



SonoPath
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PATIENT
Joanna Roeder

SPECIES
Feline

BREED
DSH

SEX
Female Spayed

AGE
10 years

WEIGHT
9.5lbs

INTERPRETED BY
Maggie Machen Lamy, DVM DACVIM (Cardiology)

IMAGING PERFORMED BY
Pamela Harrigan, RDCS

HOSPITAL NAME
Wignall Animal Hospital

REFERRING VET
Dr. Crigan

INVOICE
27010

DATE
10/20/22

PRESENTING CLINICAL SIGNS

History: Grade III-IV/VI systolic murmur. Increased respiratory rate. Episodes of falling over.
BP: 154 mmHg.

ELECTROCARDIOGRAPHIC FINDINGS *Note: Single lead ECGs are evaluated as a rhythm strip. Morphology/MEA cannot be definitively commented on.

A single lead ECG is available; 25mm/s, 20mm/mV; 4 min duration. The underlying rhythm is sinus in origin with an average HR of 214bpm. P and QRS morphologies are positive. Frequent single APCs; singles only. A single VPC is identified. No pauses or other dysrhythmias observed.
ECG diagnosis: Sinus tachycardia with frequent isolated APCs and a single VPC.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available.
Left ventricle: The LV diameter is normal with adequate myocardial function. The LV wall thicknesses are mildly increased with regions of irregularity. There is a diffusely hyperechoic endocardium consistent with mild fibrosis. The papillary muscles are hypertrophied and hyperechoic. The endocardium appears mildly remodeled.
Left atrium: The left atrium is markedly dilated. Dilated auricle. Subtle spontaneous contrast; no thrombi seen.
Mitral valve: The mitral valve is thickened and elongated. Systolic anterior motion is seen with moderate eccentric MR. Normal velocity.
Aortic valve/Aorta: The aortic valve is normal in morphology and mobility. Significantly elevated LVOT velocity with both a dynamic and fixed profile (superimposed). No aortic insufficiency.
Right ventricle: Normal right ventricular diameter and morphology indicating no overt evidence of pulmonary arterial hypertension.
Right atrium: The right atrium is normal in dimension.
Tricuspid valve: The tricuspid valve appears normal with no tricuspid regurgitation.
Pulmonic valve/Pulmonary artery: The pulmonic valve is normal in morphology and mobility. No pulmonic insufficiency. Normal RVOT velocity.
Pericardium/other: Scant pericardial effusion. No obvious pleural effusion noted. No obvious cardiac masses.

2-Dimensional Measurements

Ao diam (cm)	0.8
LA diam (cm)	2.1
LA:Ao (Swe)	2.6
IVS thickness (cm)	0.67
LVID diastole (cm)	1.2
PW thickness (cm)	0.61
LVID systole (cm)	0.8
FS (%)	38

Doppler Measurements

PV Vmax (m/s)	1.1
AoV Vmax (m/s)	4.2
MR Vmax (m/s)	5.4
TR Vmax (m/s)	NA
TR PG (mmHg)	NA

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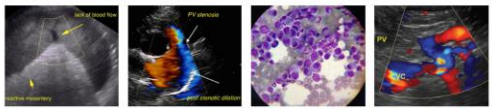

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INTERPRETATION OF THE FINDINGS

Hypertrophic obstructive cardiomyopathy (HOCM) is suspected, with LV thickening, an LVOT obstruction (SAM) and secondary MR. Two things are unusual. First is the degree of LV wall thickness is only mild, which is a mismatch given severe LA dilation. Additionally the MV appears abnormally thickened and elongated which may suggest a primary valve issue as well (r/o congenital dysplasia v degeneration). Regardless, left atrial dilation is present conferring an elevated risk for complication (spontaneous CHF and/or a thrombotic event). This likely suggest scant pericardial effusion and reported tachypnea are due to early congestive heart failure. No additional issues are identified.

Given these findings, full lifelong cardiac support is recommended as below.

The severity of LA dilation has also led to an arrhythmia, with frequent APCs identified. While these specifically do not warrant therapy, use of atenolol may improve both the outflow tract obstruction and the APCs. That being said, I would not institute this until stable on diuretics. Long term prognosis is poor, with high risk of recurrent CHF, malignant arrhythmias, and/or blood clot events going forward.

It is assumed that the collapse episodes are due to the significant outflow tract obstruction and potentially early congestion. If these persist despite therapy, reevaluation is advised.

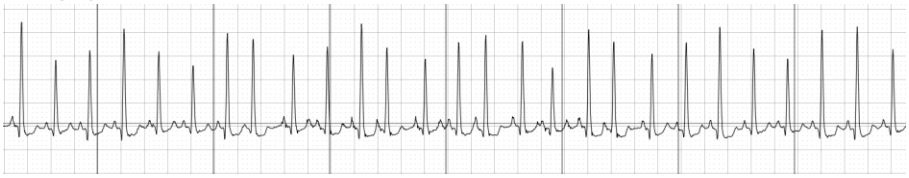
RECOMMENDATIONS

- Institute diuretic furosemide/Lasix 1-2mg/kg PO q12 hours.
- Institute Plavix (Clopidogrel) 18.75mg PO q24 hours lifelong (bitter on cut edge).
- Recheck blood work/BP in 1-2 weeks to ensure tolerance of medications, then every 3-4 months lifelong. If doing well at this visit, institute atenolol 6.25mg PO q24h. Recheck HR in 1-2 weeks with a target stressed rate of 140-160bpm. Up-titrate to effect.
- Elective anesthesia is not advised.
- Monitor for any clinical evidence of cardiac compromise, including respiratory changes and/or signs of a blood clot event (paralysis, neurologic changes, etc).

PLAN

- Recheck echocardiogram in 6 months, sooner if clinical issues arise.

IMAGES



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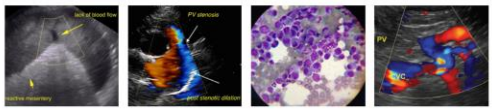

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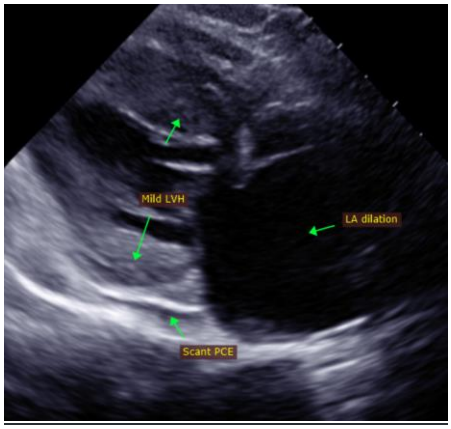

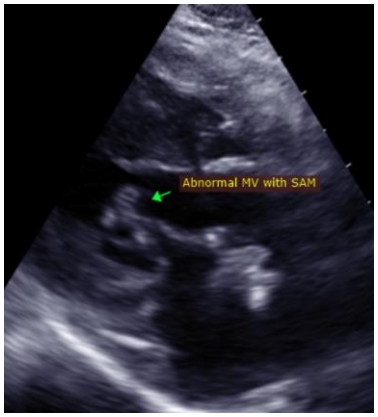

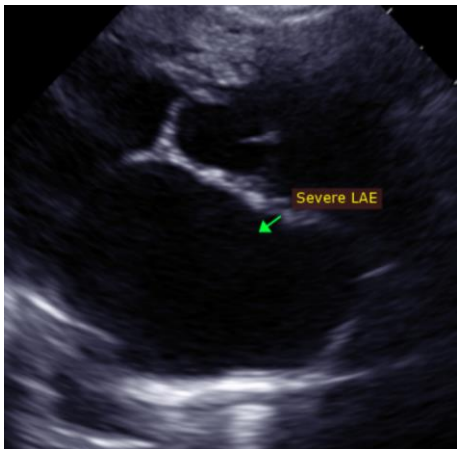

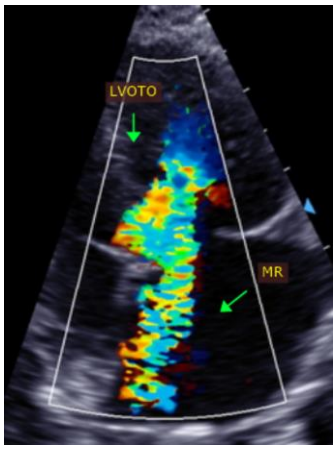

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. This report was generated using transcription software, and minor dictation errors may be present. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

Maggie Machen Lamy, DVM
Diplomate of the American College of Veterinary Internal Medicine (Cardiology)
info@sonopath.com