

PATIENT
Marley Anderson

SPECIES
Feline

BREED
DMH

SEX
Male Neutered

AGE
10 years

WEIGHT
12.88lbs

INTERPRETED BY
Maggie Machen
Lamy, DVM
DACVIM (Cardiology)

IMAGING PERFORMED BY
Pamela Harrigan,
RDCS

HOSPITAL NAME
Mass Veterinary
Specialty Services

REFERRING VET
Dr. Masloski

INVOICE
21729

DATE
10/27/21

PRESENTING CLINICAL SIGNS

History: Recheck echo. History HCM, isolated VPCs/APCs with brief period of ventricular bigeminy. Current presentation: Doing well at home with no concerns. He is eating well with normal activity. His most recent thyroid level on the 27th of July was within normal limits. He received half his insulin dose this morning for sedation for his echocardiogram. CV/RESP: gallop rhythm, grade II/VI murmur noted best on sternum, PSS, lung fields clear, compressible thorax. BP: 160mmHg. x 2; 180mmHg x 3.

-Current medications: 1) Vetsulin 5.5 units twice a day 2) Plavix/clopidogel 75mg 1/4 tab daily 3) Lasix/furosemide 12.5mg 1 tab twice a day 4) Azithomycin 0.8 mls daily 5) Pimobenan/vetmedin 1.25mg 1/2 tab twice a day *Sedated with propofol for study.
- Pertinent previous echo findings (1/11/21 MML): LA 1.9cm; LA:Ao 1.7; IVS 0.73 cm; PW 0.74 cm; LVOT 1.2 m/s.

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. The average heart rate is 150bpm. The underlying rhythm is sinus in origin, with a p for every QRS complex and vice versa. Isolated VPCs and APCs throughout; singles only without couplets or runs identified. ECG diagnosis: Normal sinus rhythm with premature beats.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available.

Left ventricle: The LV diameter is normal with depressed myocardial function. The LV wall thicknesses are moderately increased with regions of irregularity. The LV myocardium appears remodeled. The papillary muscles are hypertrophied.

Left atrium: The left atrium and auricle are severely dilated. Significant smoked noted. No obvious organized thrombus.

Mitral valve: The mitral valve is normal in structure and mobility. No systolic anterior motion is seen. Trace central mitral regurgitation.

Aortic valve/Aorta: Aortic valve is normal. Decreased aortic outflow velocity, laminar flow. No AI.

Right ventricle: Right ventricular diameter is normal. The right ventricular wall appears normal.

Right atrium: The right atrium is normal.

Tricuspid valve: Tricuspid valve is normal with no TR.

Pulmonic valve/Pulmonary artery: The pulmonic valve appears normal in morphology and mobility. Decreased pulmonic outflow velocities with laminar flow. Trace PI.

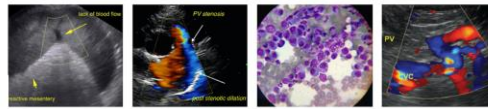
Pericardium/other: No pericardial effusion. No obvious pleural effusion. No obvious cardiac tumors.

2-Dimensional Measurements

Ao diam (cm)	1.0
LA diam (cm)	1.9
LA:Ao (Swe)	1.9
IVS thickness (cm)	0.67
LVID diastole (cm)	1.5
PW thickness (cm)	0.79
LVID systole (cm)	1.06
FS (%)	29

Doppler Measurements

PV Vmax (m/s)	0.5
AoV Vmax (m/s)	0.8
MR Vmax (m/s)	NA
TR Vmax (m/s)	NA
TR PG (mmHg)	NA



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INTERPRETATION OF THE FINDINGS

Hypertrophic cardiomyopathy (HCM) persists with relative stability. The wall thickness is similar to prior, with a persistently dilated LA. Smoke is visualized, potentially more apparent than previous. The systolic function is decreased; however, this is likely secondary to propofol. No additional issues are identified. Even with relative stability, there will always be high risk for spontaneous CHF and/or blood clot events. Continued lifelong full cardiac supportive medications are recommended as below. If the patient is easily medicated, consider a dose increase in Pimobendan as below.

The ECG shows persistent premature beats (APCs and VPCs); however, the frequency is mildly decreased comparatively and no bigeminy is seen. This likely reflects stable arrhythmic disease due to cardiac support. No anti-arrhythmic therapy is necessary at this time. Monitor for signs of sustained arrhythmias, such as collapse or acute lethargy.

The long-term prognosis remains poor even with medications and no reported symptoms, with most cats able to maintain a good quality of life for an average of <1 year following diagnosis of CHF. This cat has already exceeded this expectation and monitoring for recurrent clinical signs is advised. There will always remain risk for progression to CHF, development of blood clots and/or sudden death in the future.

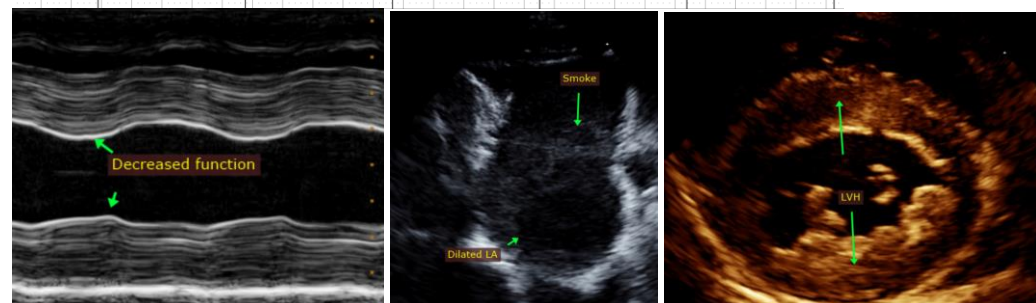
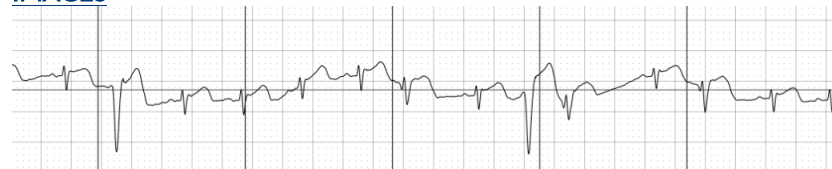
RECOMMENDATIONS

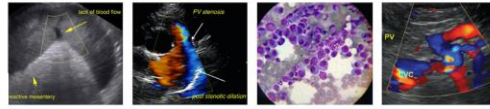
- Continue Plavix as prescribed.
- Continue Lasix as prescribed.
- If able, increase Pimobendan (off label use) to 1.25mg PO q12h.
- Monitor BP/T4 q6m lifelong.
- Monitoring of sleeping breathing rates at home is recommended as the best way to screen for recurrent CHF at home. Avoid steroids and fluid therapy unless absolutely necessary in the future.

PLAN

- A recheck echocardiogram and ECG is recommended in 6 months to assess for progression, sooner if issues arise in the interim.

IMAGES





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Marley Anderson
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.

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Feline
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.

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

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Echocardiogram performed by: Pamela Harrigan, RDCS
Pet Animal Ultrasound Service (4paus.com)

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